STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396035	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scottdale Healthcare & Rehabilitation Center	900 Porter Avenue Scottdale, PA 15683

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 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 residents medication regimen was free from unnecessary psychotropic medication (drugs that affect a person's mental state, emotions, and behavior) for two of 19 residents reviewed (Residents 26 and 40).Findings include:The facility's policy regarding psychotropic medication use, dated September 24, 2025, indicated that non-pharmacological approaches would be used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible.A quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 26 dated October 1, 2025, indicated that the resident had moderate cognitive impairment, was dependent on staff for most daily care needs and had diagnoses that included cancer and dementia.Physician's orders for Resident 26 dated November 15, 2025, included an order for the resident to receive 0.5 milligrams (mg) of Ativan every six hours as needed for restlessness/agitation for 14 days.Review of the Medication Administration Record (MAR) for Resident 26 dated November 2025 revealed that 0.5 mg of Ativan was administered to the resident on November 17 at 1:45 a.m.; on November 19 at 7:18 p.m.; on November 20 at 7:21 p.m.; on November 21 at 8:49 p.m.; on November 22 at 7:00 p.m.; on November 23 at 10:11 p.m.; and on November 29 at 7:09 p.m. There was no documented evidence that non-pharmacological interventions were attempted prior to administering the as needed doses of Ativan on these dates and times. A nursing note for Resident 40, dated December 8, 2025, revealed the resident was admitted to the facility on this date, was receiving hospice services, and had diagnoses that included dementiaPhysician's orders for Resident 14, dated December 9, 2025, included orders for the resident to receive 0.5 milliliters (ml) of Ativan concentrate every two hours as needed for restlessness/anxiety for 14 days.Review of the MAR for Resident 14, dated November 2025, revealed that 0.5 ml of Ativan was administered to the resident on December 9 at 7:08 p.m.; December 11 at 8:55 a.m.; December 13 at 11:27 p.m.; and December 14, 2025, at 10:18 p.m. There was no documented evidence that non-pharmacological interventions were attempted prior to administering the as needed doses of Ativan on these dates and times.Interview with the Director of Nursing on December 17, 2025, at 10:17 a.m. confirmed that there was no documented evidence that non-pharmacological interventions were attempted before administering Ativan to Resident 26 and 40 on the above-mentioned dates and times and there should have been.28 Pa. Code 211.12(d)(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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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that an implanted venous port (a medical device placed under the skin in your chest, arm or belly that allows for easy access to a vein for administering fluids or medications) was flushed according to facility policy for one of 19 residents reviewed (Resident 9) and failed to ensure that a peripherally inserted central catheter (PICC- a thin, flexible tube that is inserted into a vein in the upper arm for long term access) was flushed according to facility policy for one of 19 residents reviewed (Resident 41). Findings include:The facility's policy regarding flushing and locking an implanted venous port dated September 24, 2025, indicated that the purpose of the procedure was to maintain patency of the implanted port, to prevent mixing of incompatible medications and solutions, and to ensure the entire dose of a solution or medication is administered into the venous system. When the port is used intermittently for medication administration, flush (procedure involving the injection of saline into a catheter using a small syringe to clear or maintain patency) with preservative free 0.9 percent sodium chloride (normal saline-a sterile mixture of salt and water) before and after infusion/medication administration in addition to daily flushing. Steps for flushing when giving medication include to document location of catheter, and type and amount of flush used. An admission Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 9, dated, 2025, revealed that the resident was cognitively intact, had diagnoses that included cancer, and had intravenous access.Physician's orders for Resident 9, dated December 5, 2025, included an order for the resident to receive one gram of ertapenem sodium solution (an antibiotic medication) intravenously every evening for a urinary tract infection for 10 days. Review of Medication Administration Records (MARs) for Resident 9, dated December 2025, revealed that staff documented administering the one gram of ertapenem sodium solution intravenously every evening from December 5, 2025, at 8:00 p.m. through December 14, 2025, at 8:00 p.m. However, there was no documented evidence that staff flushed Resident 9's implanted venous port before and after the administration of the ertapenem sodium solution.Interview with the Director of Nursing on December 17, 2025, at 10:17 a.m. confirmed that there was no documented evidence that Resident 9's implanted venous port was flushed before and after the administration of the ertapenem sodium solution on the above-mentioned dates per facility policy.The facility's policy regarding the flushing of peripheral and midline intravenous catheters (a catheter that is placed in a peripheral vein for long-term administration of fluids and/or medication), dated September 24, 2025, indicated that the peripheral or midline catheter was to be flushed with 10 milliliters (ml's) of normal saline (sterile salt and water solution) before and after each use. A nursing note for Resident 41, dated December 12, 2025, at 5:00 p.m. revealed the resident was admitted to the facility from the hospital and had a PICC line in place.Physician's orders for Resident 41, dated December 12, 2025, included an order for the resident to receive 1.25 grams of Vancomycin solution (an antibiotic) intravenously (IV) daily for 26 days and 4.5 grams of Zosyn Solution (antibiotic) intravenously every eight hours for 26 days for left foot cellulitis (bacterial skin infection).Review of the MAR for Resident 41 for December 2025 revealed that the resident received IV Vancomycin daily and Zosyn every eight hours; however, there was no documented evidence that the resident's PICC line was flushed before and after receiving the medication per the facility's policy. Interview with the Director of Nursing on December 17, 2025, at 10:17 a.m. confirmed that there was no documented evidence that Resident 41's PICC line was flushed before and after its use for medication administration per facility policy.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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 policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications (drugs with the potential to be abused) for two of 19 residents reviewed (Resident 6, 14).Findings include: The facility's policy regarding medication administration, dated September 24, 2025, indicated that staff are to document the administration of controlled substances in accordance with applicable law. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6 dated December 1, 2025, indicated that the resident was cognitively intact, required assistance with daily care needs, and had diagnosis that included chronic obstructive pulmonary disease and high blood pressure Physician's orders for Resident 6, dated October 6, 2025, included an order for the resident to receive 0 .5 milliliters (ml) of Morphine (a controlled narcotic pain medication) orally every 4 hours for moderate pain or shortness of breath. A review of Resident 6's-controlled drug record (used to keep count of narcotic medication) for October 2025 revealed that staff signed out 0.5 ml Morphine on October 9, 2025, at 1:20 p.m., October 13, 2025, at 8:00 p.m., October 14, 2025, at 11:53 p.m. However, review of the resident's MAR, dated October 2025, revealed no documented evidence that the 0.5 ml of Morphine was administered to the resident on those dates. Physician's orders for Resident 6, dated October 6, 2025, included an order for the resident to receive 1 ml of Morphine orally every 2 hours for sever pain or shortness of breath. A review of Resident 6's-controlled drug record for October and November 2025 revealed that staff signed out 1 ml Morphine on October 18, 2025, at 7:00 p.m., October 22, 2025, at 7:45 p.m., and November 17, 2025, at 1:55 p.m. However, review of the resident's MAR, dated October and November 2025, revealed no documented evidence that the 1 ml of Morphine was administered to the resident on those dates. Interview with the Director of Nursing on December 17, 2025, at 11:14 a.m. confirmed that there was no documented evidence that Resident 6 received the 0.5 ml or 1 ml of Morphine as ordered on the above referenced dates. A quarterly MDS assessment for Resident 14, dated December 30, 2025, revealed that the resident had moderate cognitive impairment, had occasional pain, received pain medication routinely and as needed, and received an opioid (a controlled pain medication). Physician's orders, dated April 11, 2024, included an order for the resident to receive 50 milligrams (mg) of Tramadol (narcotic pain reliever) every six hours as needed for moderate pain to severe pain.A review of Resident 14's controlled drug record for October and November 2025 revealed that staff signed out 50 mg of Tramadol on October 25 at 7:27 p.m., October 30 at 6:22 p.m., November 18 at 6:40 p.m., and November 26, 2025, at 6:28 p.m. However, review of the resident's MAR, dated October and November 2025, revealed no documented evidence that the 50 mg of Tramadol was administered to the resident on those dates.Interview with the Nursing Home Administrator on December 17, 2025, at 2:28 p.m. confirmed that there was no evidence of the Tramadol being administered to Resident 14. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that call bells were within reach for one of 19 residents reviewed (Resident 32).Findings include: A review of the facility policy for resident call system dated August 24, 2025, indicated that each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Clinical record review for Resident 32 revealed that the resident was admitted to the facility on [DATE], for hospice respite (temporary, short-term inpatient care in a facility like a nursing home, for patients with a terminal illness) care. Nurse's note for Resident 32 dated December 12, 2025, at 7:47 p.m. revealed that the resident's admission assessment was completed and that staff reviewed verbally with the resident the use of the call bell system and using it for a need. The resident did show that he was able to call for the nurse effectively after staff showing him how to use the call bell. Observation of Resident 32 on December 15, 2025, at 11:48 a.m. revealed that Nurse Aide 1 assisted the resident by adjusting his bed and setting up his lunch meal tray. The nurse aide completed the task and walked out of the room. The resident's call bell was on the floor on the left side of his bed in front of his bedside table. Interview with Nurse Aide 1 on December 15, 2025, at 11:48 a.m. confirmed that Resident 32's call bell was not within his reach and the call bell should have been clipped to his bed so he could use it if needed. Interview with the Director of Nursing on December 15, 2025, at 12:42 p.m. confirmed that Resident 32's call bell should have been within his reach. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on 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 a significant change Minimum Data Set assessment for one of 19 residents reviewed (Resident 6).Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs) dated October, 2025 revealed that the facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. The RAI Manual revealed that staff should complete a significant change MDS when a resident has a decline that will not normally resolve itself without interventions by staff, impacts more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the resident's care plan. The RAI Manual revealed that staff should complete a significant change MDS when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. A quarterly Minimum Data Set (MDS) assessment (mandated assessments of a resident's abilities and care needs), dated August 31, 2025, revealed Resident 6 was cognitively intact, required assistance from staff for daily care needs, was on hospice services and had active diagnoses that included chronic obstructive pulmonary disease (COPD-a progressive lung condition characterized by persistent airflow limitation). Physician's orders for Resident 6 dated August 15, 2025, included an order to admit to hospice care with an admitting diagnosis of COPD. A review of Resident 6's clinical record revealed that a significant change MDS was not completed per the RAI Manual. An interview with the Registered Nurse Assessment Coordinator on December 16, 2025, at 1:55 p.m. confirmed that a significant change MDS assessment should have been completed per the RAI Manual and was not. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 three of 19 residents reviewed (Residents 11, 14, and 15).Findings include: The Long-Term Care Facility RAI User's Manual, dated October 2025, indicated that Section N0415E1 (Anticoagulant-medications that prevent blood clots from forming or growing), was to be checked if the resident was taking an anticoagulant medication during the seven day look back period, Section N0415F1 (Antibiotic) was to be checked if the resident was taking an antibiotic medication during the seven day look back period, Section N0415H1 (Opioid-medicines that helps reduce moderate to severe pain) was to be checked if the resident was taking an opioid medication during the seven day look back period, and Section N0415I1 (Antiplatelet-medication that prevents platelets from clumping together and forming blood clots) was to be checked if the resident was taking an antiplatelet medication during the seven day look back period. Physician's orders for Resident 11, dated December 1, 2025, included orders for the resident to receive 50 milligrams (mg) of Tramadol (opioid) four times a day as needed for pain.Review of Resident 11's Medication Administration Record (MAR), dated December 2025, revealed that the resident received Tramadol during the assessment period.However, an admission Minimum Data Assessment (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated December 2, 2025, revealed that Section N0415H1 was not checked, indicating that the resident did not receive an opioid during the look back period. A nursing note for Resident 14, dated October 14, 2025, at 3:22 p.m. revealed that the resident complained of burning/itching to her buttocks and the area was noted to have excoriation (skin damage) and dermatitis (skin inflammation). A physician's order for Resident 14, dated October 14, 2025, included an order for the resident to have Magic Mix (contains Silvadene (antibiotic) that is used to prevent wound infections) applied to the buttocks three times a day.Review of Resident 14's Treatment Administration Record (TAR), dated October 2025, revealed that Magic Mix was applied to the resident's buttocks three times a day.However, a quarterly MDS assessment for Resident 14, dated October 30, 2025, revealed that section N0415F1 was not checked, indicating that the resident did not receive an antibiotic medication during the look back period.Interview with Registered Nurse Assessment Coordinator (RNAC- a registered nurse who is responsible for the completion of MDS assessments) on December 16, 2025, at 2:16 p.m. confirmed that Resident 11 and 14's mentioned MDS assessments were coded inaccurately. Physician's orders for Resident 15 dated October 22, 2025, included for the resident to receive 81 mg of aspirin (an antiplatelet medication) once every day and 2.5 mg of Apixaban (an anticoagulant medication) once every day. Review of the MAR for Resident 32 dated November 2025 indicated that the resident received 81 mg of aspirin and 2.5 mg of Apixaban daily during the seven day look back period and did not receive any opioid medication during the seven day look back period. However, a quarterly MDS for resident 15 dated November 22, 2025, revealed that Section N0415E was not coded (1), indicating that the resident did not take an anticoagulant during the seven day look back period, Section N0415H was coded (1), indicating that the resident did take an opioid during the seven day look back period, and Section N0415I was not coded (1), indicating that the resident did not take an antiplatelet during the seven day look back period. An interview with the Registered Nurse Assessment Coordinator on December 16, 2025, at 2:30 p.m. confirmed that Resident 15's MDS assessment dated [DATE], was coded incorrectly. 28 Pa. Code 211.5(f) Clinical Records.

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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 a review of facility policy and clinical records, as well as interviews with staff it was determined that the facility failed to develop and implement a comprehensive person-centered care plan related to anxiety and the use of antibiotics for one of 19 residents reviewed (Resident 40). Findings include:The facility's policy regarding care plans, dated September 24, 2025, revealed that to complete a care plan, you were to conduct a thorough resident assessment, identify relevant health problems, set measurable goals, choose appropriate interventions, and regularly monitor progress to adjust the plan as needed. Care plans were to be reviewed/revised as needed based on the resident's changing condition, and at least quarterly.A nursing note for Resident 40, dated December 8, 2025, revealed the resident was admitted to the facility on this date, was receiving hospice services, and had diagnoses that included dementiaPhysician's orders for Resident 40, dated December 9, 2025, included an order for the resident to receive 0.5 milliliters (ml) of Ativan concentrate every two hours as needed for restlessness/anxiety for 14 days. A nursing note for Resident 40, dated December 11, 2025, at 4:08 p.m. revealed the resident continued to have redness to the right eye and a new order was received for 0.5% Erythromycin ointment be applied to the right eye four times a day for one week.The Medication Administration Record (MAR) for December 2025 revealed that Resident 40 was receiving Ativan as needed, and Erythromycin ointment to the right eye four times a day from December 11 through December 17, 2025.Review of the resident's current care plan revealed that there was no documented evidence that a care plan was developed to address Resident 40's care needs and interventions related to receiving antibiotic medications or having restlessness/anxiety.Interview with Registered Nurse Assessment Coordinator (RNAC- a registered nurse who is responsible for the development of care plans) on December 16, 2025, at 2:30 p.m. confirmed that Resident 40's care plan did not address restlessness/anxiety.Interview with the Director of Nursing on December 17, 2025, at 10:17 a.m. confirmed that Resident 40's care plan did not include the use of antibiotic medications and should have.28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of 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 three of 19 residents reviewed (Residents 4, 6, and 27).Findings include: A facility policy for Comprehensive Care Planning, dated September 24, 2025, included that the facility would review and revise the care plan as needed based on the patient's changing condition and at least quarterly with completion of a Minimum Data Set assessment. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), for Resident 4, dated November 12, 2025, indicated that the resident had moderate cognitive impairment, required assistance with daily care needs, and had active diagnosis that included diabetes and heart disease. Care plan for Resident 4, dated September 12, 2025, indicated that the resident was receiving oxygen therapy. A review of Resident 4's December 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no documentation that the resident was receiving oxygen services. Interview with the Registered Nurse Assessment Coordinator on December 17, 2025, at 11:36 a.m. confirmed that Resident 4 was not receiving oxygen therapy and her care plan should have been revised to reflect that, however it was not. An annual MDS assessment for Resident 6 dated December 1, 2025, indicated that the resident was cognitively intact, required assistance with daily care needs, and had diagnosis that included chronic obstructive pulmonary disease and high blood pressure Care plan for Resident 6 dated October 28, 2024, indicated that the resident was receiving an anticoagulant medication. Review of the Medication Administration Record (MAR) and nurses notes for Resident 6 dated December 2025 revealed no documented evidence that the resident was anticoagulant medication. An interview with the Registered Nurse Assessment Coordinator on December 17, 2025, at 11:36 p.m. revealed that Resident 6 was not receiving anticoagulant medication and her care plan should have been revised to reflect that, however it was not. A quarterly MDS assessment for Resident 27 dated October 22, 2025, indicated that the resident had moderate cognitive impairment, required assistance from staff for daily care needs, and had diagnosis that included diabetes and dementia. Care plan for Resident 27 dated May 29, 2025, indicated that the resident was taking antidepressant medication. Review of the MAR for Resident 27 dated December 2025 revealed that the resident did not receive any antidepressant medication in December. An interview with the Registered Nurse Assessment Coordinator on December 17, 2025, at 10:34 a.m. confirmed that Resident 27 was not receiving antidepressant medication and her care plan should have been revised to reflect that, however, it was not. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that pressure ulcer care/prevention treatments were provided as ordered for one of 19 residents reviewed (Resident 3). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated November 6, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, was at risk for pressure ulcer (skin impairment caused by pressure) development, and had one Stage 4 (deep wounds that may impact muscle, tendons, ligaments, and bone) pressure ulcer present on admission. Physician's orders for Resident 3, dated February 19, 2025, included an order for the resident to have her coccyx cleansed with wound cleanser, pat dry, apply collagen powder and triad paste onto rolled gauze and gently pack the wound. Apply silver sulfadiazine, zinc, hydrocortisone and nystatin 1% cream to the peri wound and apply bordered foam daily and as needed. A review of Residents 3 September, November 2025 Treatment Administration Record (TAR) was reviewed and there is no documented evidence her treatment was completed per physician orders on September 23, 28, 29 and November 14, 2025. Physician's orders for Resident 3, dated November 25, 2025, included an order for the resident to have her coccyx cleansed with wound cleanser, pat dry, apply betadine soaked rolled gauze and gently pack wound. Apply silver sulfadiazine, zinc, hydrocortisone, and nystatin 1% cream to the peri wound and apply bordered foam daily and as needed. A review of Resident 3's December 2025 TAR was reviewed and there is no documented evidence her treatment was completed per physician orders on December 10, 2025. An interview with the Director of Nursing on December 17, 2025, at 11:14 a.m. confirmed that there was no documented evidence that wound treatments were completed as ordered for Resident 3 on the above dates. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that the resident environment remained as free of accident hazards as possible by failing to ensure that fall/injury prevention interventions were in place for one of 19 residents reviewed (Resident 26).Findings include: A quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 26, dated October 1, 2025, revealed that the resident was cognitively impaired, was dependent on staff for most daily care needs, and had a diagnosis of dementia. The care plan for Resident 26 dated April 7, 2025, indicated that the resident had a history of falling and included an intervention dated May 1, 2025, that the resident was to have bilateral fall mats in place. Physician's orders for Resident 26 dated April 30, 2025, included an order for the resident to have fall mats to bilateral sides of his bed and staff were to check placement of the fall mats every shift. Observations of Resident 26 on December 16, 2025, at 12:22 p.m. revealed that the resident was lying in bed and there were no fall mats on the floor on either side of his bed. An interview with Nurse Aide 2 at the time of the observation confirmed that Resident 26 should have had bilateral fall mats in place, however, he did not. Interview with the Director of Nursing on December 16, 2025, at 12:22 p.m. confirmed that Resident 26 should have had bilateral fall mats in place while in bed. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396035	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scottdale Healthcare & Rehabilitation Center	900 Porter Avenue Scottdale, PA 15683

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on review of facility policies, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication administration error rate of less than five percent. Findings include: Review of a facility policy for administering medications dated September 24, 2025, included that the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication, and the individual administering the medication initials the resident's medication administration record on the appropriate line after giving each medication and before administering the next one. Observations made during medication administration on December 15 and 16, 2025, revealed that two medication administration errors were made during 26 opportunities for error, resulting in a medication administration error rate of 7.69 percent. Physician's orders for Resident 9, dated November 12, 2025, included for the resident to have one spray in each nostril of fluticasone propionate (steroid nasal spray that can be used to treat allergy symptoms) 50 micrograms per actuation suspension one time a day for allergies. Physician's orders dated November 20, 2025, included for the resident to receive 500 milligrams (mg) of sodium chloride (medication containing a specific dose of salt or sodium chloride used to replenish lost electrolytes or treat low blood sodium) one time a day. Physician's orders dated December 15, 2025, included for the resident to receive two sprays of saline spray nasal solution in both nostrils every six hours as needed for dryness, may self-administer it. Observations during the medication administration on December 16, 2025, at 7:34 a.m. revealed that Licensed Practical Nurse 3 administered a 1000 mg tablet of sodium chloride and provided the resident with saline spray nasal solution for the resident to self-administer one spray in each nostril. After completion of the medication administration, Licensed Practical Nurse 3 returned to the medication cart and documented that he administered 500mg of sodium chloride and one spray to each nostril of fluticasone propionate 50 micrograms per activation suspension. Interview with Licensed Practical Nurse 3 on December 16, 2025, at 8:35 a.m. confirmed that he did administer 1000 mg of sodium chloride tablet when he should have cut it in half and gave 500 mg, and he confirmed that he did administer the as needed saline spray, however, he thought he had administered the ordered fluticasone propionate, also reporting at the time of this interview that he did not believe that the fluticasone propionate was in his medication cart. Interview with the Director of Nursing on December 17, 2025, at 8:47 a.m. confirmed that medications are to be administered as ordered. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396035	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 maintain compliance with nursing home regulations 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 correction for a State Survey and Certification (Department of Health) survey ending November 19, 2024, 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 December 17, 2025, identified repeated deficiencies related to accuracy of Minimum Data Set (MDS) assessments (mandated assessment of a resident's abilities and care needs), the development of individualized care plans, care plan timing and revision, and preventing issues with the accountability of controlled medications (drugs with the potential to be abused). The facility's plan of correction for a deficiency regarding a failure to ensure that MDS assessments were accurate upon submission, cited during the survey ending November 19, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to accurate MDS assessments. The facility's plan of correction for a deficiency regarding the development of individualized care plans, cited during the survey ending November 19, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident's care plans were developed for their individual needs. The facility's plan of correction for a deficiency regarding care plan timing and revision, cited during the survey ending November 19, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding care plan timing and revision. The facility's plans of correction for deficiencies regarding the failure to account for controlled medications, cited during the survey ending November 19, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F755, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to the accountability of controlled medications. Refer to F641, F656, F657, F755 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.