

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395661	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/31/2025
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NAME OF PROVIDER OR SUPPLIER: CASSELMAN HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 201 HOSPITAL DRIVE MEYERSDALE, PA 15552
STATE LICENSE NUMBER: 136802	

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F 0000	INITIAL COMMENT	F 0000		
F 0641	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and a complaint survey completed on July 31, 2025, it was determined that Casselman Healthcare and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0641		
SS=D				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0641 SS=D	Continued from page 1 483.20(g)(h)(i)(j) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F 0641	The MDS assessments (Minimum Data Set, a standardized assessment tool) for R3, R38, and R53 were modified per Resident Assessment Instrument (RAI) manual requirements. The Nursing Home Administrator re-educated the Director of Nursing and MDS Coordinator on the need to ensure coding for Gabapentin, Pregabalin, and Silvadene are accurate on the MDS. Whole house audit was completed by the MDS Coordinator to identify any other resident who may have orders for Gabapentin, Pregabalin, or Silvadene that were miscoded. Any identified MDS coding errors were fixed and the MDS resubmitted per RAI manual requirements. The Interdisciplinary team will review new orders daily (M-F) to identify any Gabapentin, Pregabalin, and Silvadene to note the need to correctly code the MDS when scheduled to be completed. The audit outcomes will be presented to the Quality Assurance Committee for review and recommendations.	Completion Date: 08/22/2025 Status: APPROVED Date: 08/19/2025

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F 0641 SS=D	Continued from page 2 This REQUIREMENT is not met as evidenced by:	F 0641		

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F 0641 SS=D	Continued from page 3 Based on review of the Resident Assessment Instrument User's Manual and residents' clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for three of 28 residents reviewed (Residents 3, 38, 52). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, revealed that Section N0415F1 (antibiotic medication) was to be checked if the resident received an antibiotic medication during the seven-day assessment period and Section N0415K1 was to be checked if the resident received an anticonvulsant medication during the seven-day assessment period. Physician's orders for Resident 3 dated May 1,	F 0641		

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F 0641 SS=D	Continued from page 4 2025, included an order for the resident to receive 300 milligrams (mg) of Gabapentin two times a day for diabetic neuropathy (nerve damage that can cause pain, numbness, tingling, and weakness in the hands and feet, and sometimes other parts of the body). The resident's Medication Administration Record (MAR) for May 2025 revealed that the resident received Gabapentin twice a day from May 1 through 28, 2025. A quarterly MDS assessment for Resident 3, dated May 24, 2025, revealed that Section N0415K1 was not checked, indicating that the resident did not receive any anticonvulsant medications during the seven days of the assessment period. Physician's orders for Resident 38 dated March 18, 2024, included an order for the resident to receive 100 mg of Pregabalin three times a day for neuropathy. The resident's Medication Administration Record (MAR) for May 2025 revealed that the resident received Pregabalin three times a day from May 1 through 31, 2025.	F 0641		

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F 0641 SS=D	Continued from page 5 A quarterly MDS assessment for Resident 38, dated May 9, 2025, revealed that Section N0415K1 was not checked, indicating that the resident did not receive any anticonvulsant medications during the seven days of the assessment period. Physician's orders for Resident 53 dated May 1, 2025, included an order for the resident to have 1% Silvadene External Cream (antibiotic) applied to the sacrum gluteal fold (horizontal crease or fold located at the base of the buttocks) every day and evening shift for wounds. The resident's Treatment Administration Records (TAR's) for May 2025 revealed that the resident received Silvadene External Cream every day and evening from May 2 through 10, 2025. A quarterly MDS assessment for Resident 53, dated May 9, 2025, revealed that Section N0415F1 was not checked, indicating that the resident did not receive any antibiotic medications	F 0641		

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F 0641 SS=D	Continued from page 6 during the seven days of the assessment period. An interview with the Director of Nursing on July 30, 2025, at 2:59 p.m. confirmed that assessments for Residents 3, 38, and 53 were coded incorrectly. 28 Pa. Code 211.5(f) Medical records.	F 0641		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 7 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Care plan for R4 and R 9 was discontinued immediately and modified care plan shown to surveyor. The Nursing Home Administrator educated the MDS Coordinator and Director of Nursing and other members of the interdisciplinary team on the need to ensure care plans are being discontinued when medication orders are discontinued. Whole house medication audit for last 30 days will be completed and any modifications needed to care plans will be completed as appropriate. Members of the interdisciplinary team will audit discontinued orders daily (M-F) for three weeks to ensure all appropriate care plans have been discontinued. The audit outcomes will be presented to the Quality Assurance Committee for review and recommendations.	Completion Date: 08/22/2025 Status: APPROVED Date: 08/19/2025

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F 0657 SS=D	Continued from page 8 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 two of 28 residents reviewed (Residents 4 and 9). Findings include: A facility policy for Care Plan Revisions Upon Status Change dated April 7, 2025, indicated that the comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 4 dated May 2, 2025, indicated that the resident was cognitively intact, required assistance with daily care needs, and had diagnoses that included Multiple Sclerosis (disease in which the immune system eats away at	F 0657		

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F 0657 SS=D	Continued from page 9 the protective covering of nerves). The Care plan for Resident 4 dated October 13, 2023, indicated that the resident was receiving diuretic therapy ("water pills," to increase urine production and help the body eliminate excess fluid and sodium). Review of the Medication Administration Record (MAR) for Resident 4 dated July 2025, revealed no documented evidence that the resident was receiving a diuretic medication. An interview with Licensed Practical Nurse Assessment Coordinator on July 31, 2025, at 9:53 a.m. confirmed that Resident 4 was not receiving diuretic medications and that Resident 4s care plan should have been revised to reflect that, however it was not. An admission MDS assessment for Resident 9 dated July 2, 2025, indicated that the resident was cognitively intact, required assistance with daily care	F 0657		

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F 0657 SS=D	Continued from page 10 needs, and had diagnoses that included necrotizing fasciitis (a severe bacterial infection that rapidly destroys skin, fat, and muscle tissue). The Care plan for Resident 9 dated July 3, 2025, indicated that the resident was receiving anticoagulant therapy (medications that prevent blood clots from forming or existing clots from getting larger). Review of the MAR for Resident 9 revealed that the resident had not received any anticoagulant medications since July 8, 2025. An interview with the Nursing Home Administration on July 31, 2025, at 12:04 p.m. revealed that the Resident 9 was no longer receiving anticoagulant medication and that his care plan should have been revised to reflect that, however, it was not. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0657		

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F 0657 SS=D	Continued from page 11	F 0657		
F 0658 SS=E	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	Past noncompliance: no plan of correction required.	Completion Date: 08/18/2025 Status: APPROVED Date: 08/19/2025

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F 0658 SS=E	Continued from page 12 Based on Review of Pennsylvania's Nursing Practice Act and information submitted from the facility, it was determined that the facility failed to ensure that a licensed practical nurse's license remained current for one of one licensed practical nurse's reviewed (Licensed Practical Nurse 2). This deficiency was cited as past non-compliance. Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, for the expiration and renewal of licensure revealed that notice of the renewal period of a license will be sent to each active licensee prior to the expiration date of the licensee's license. The applicant for license renewal may complete and submit an application online or may mail a completed application form to the Board's administrative office. When applying for licensure renewal, a registered nurse shall complete and submit the renewal application, including disclosing any license to practice nursing or any	F 0658		

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F 0658 SS=E	Continued from page 13 allied health profession in any other state, territory, possession or country, pay the biennial renewal fee, verify the completion of mandatory continuing education and child abuse recognition and reporting requirements, disclose any discipline imposed by a state licensing board on any nursing or allied health profession license or certificate in the previous biennial period, and any criminal charges pending or criminal conviction, plea of guilty or nolo contendere, admission into a probation without verdict, or accelerated rehabilitation during the previous biennial period. Information submitted by the facility staff on January 3, 2025, revealed that Licensed Practical Nurse 2's license expired on June 30, 2024, and that she continued to work from July 1, 2024, until a whole house audit on January 1, 2025 revealed that her license had expired. No care concerns were identified during this time. Licensed Practical Nurse 2 was immediately removed from the schedule and not permitted to	F 0658		

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F 0658 SS=E	Continued from page 14 return to work until she renewed her license on January 3, 2025. An interview with the Human Resources Director on July 31, 2025 at 11:06 a.m. revealed that the facility suspended License Practical Nurse 2 when they learned that her license had expired and that she was not permitted to return to work until she renewed her licensed on January 3, 2025. The facility's corrective actions taken following the incident included: 1. An immediate audit of all licensed staff was conducted and results were reviewed. 2. The licensed practical nurse was suspended and disciplined for failing to renew her license timely. 3. Staff education was completed regarding renewing their licenses prior to expiration. All of the staff was educated by January 3, 2025.	F 0658		

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F 0658 SS=E	Continued from page 15 4. Monthly audits will be completed and reviewed at QAPI meetings. 5. Human Resources will now offer reminders to the staff prior to expiration. 6. Human Resources will offer support to staff who may struggle to use the computer to renew. 7. On-going audits will be submitted to the facility's QAPI meetings as appropriate for review. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F658 on January 3, 2025. 28 Pa. Code 201.14(a) Responsibility of license. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0658		

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F 0658 SS=E	Continued from page 16	F 0658		
F 0684 SS=D		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395661	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/31/2025
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NAME OF PROVIDER OR SUPPLIER: CASSELMAN HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 136802	STREET ADDRESS, CITY, STATE, ZIP CODE: 201 HOSPITAL DRIVE MEYERSDALE, PA 15552
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F 0684 SS=D	Continued from page 17 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	R42 is care planned as non-complaint with taking medications including medications ordered as part of the bowel protocol. R42 is care planned as combative and easily agitated and at times will not allow staff to touch him which includes bowel protocol measures ordered. Resident42 was ordered MiraLAX for constipation. Staff will encourage resident to take bowel protocol medications as ordered. Re-education will be complete by the Director of Nursing for all licensed nursing staff on following bowel protocols and documentation of refusals. An audit was conducted of all residents during the annual survey to ensure all residents that had not had a bowel movement after day 3 were given bowel protocols completed as ordered. The Director of Nursing or designee will audit bowel protocol is being followed per order daily for 6 weeks. The audit outcomes will be presented to the Quality Assurance	Completion Date: 08/22/2025 Status: APPROVED Date: 08/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395661	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/31/2025
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F 0684 SS=D	Continued from page 18	F 0684	Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395661	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/31/2025	
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F 0684 SS=D	Continued from page 19 Based on a review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to follow physician's orders related to bowel protocols for one of 28 residents reviewed (Resident 42). Findings include: A facility policy for Bowel Movements Monitoring dated April 7, 2025, indicated that all residents bowel movements will be documented. If a resident has not had a bowel movement for three full days, the licensed nurse will follow bowel protocol as ordered by the physician. All shifts will then monitor for effectiveness. If initial laxative is ineffective, then a second laxative if ordered is given as per order. Resident will be monitored on all shifts for bowel movements to see if second laxative was effective. If the second laxative was ineffective, then an enema will be given per physician order. All three shifts will monitor resident for bowel movement to see if enema was effective. If enema is ineffective, notify	F 0684		

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F 0684 SS=D	Continued from page 20 the physician. A quarterly MDS assessment for Resident 42 dated July 3, 2025, indicated that the resident was cognitively impaired, required assistance with daily care needs, was always incontinent of bowel, and had diagnoses that included paranoid schizophrenia (a chronic mental health condition characterized by persistent delusions and hallucinations). Physician's orders for Resident 42, dated May 10, 2022, included an order for the resident to receive 30 milliliters (ml) of Milk of Magnesia Suspension (laxative- used to produce a bowel movement) as needed for constipation if no bowel movement by the third day/nine shifts and document effectiveness. Resident 42's bowel movement records dated June 2025 and July 2025 indicated that the resident did not have a bowel movement on June 17, 2025, through June 23, 2025. There was no documented evidence that 30 ml of Milk of Magnesia Suspension was offered to or refused by the resident after the	F 0684		

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F 0684 SS=D	Continued from page 21 third day/ninth shift of no bowel movement. Review of Resident 42's Medication Administration Record dated June 2025, revealed that 30 ml of Milk of Magnesia Suspension was administered on June 21, 2025, (five days after no bowel movement), however, it was ineffective, and no further interventions were provided. Bowel movement records revealed that Resident 42 did not have a bowel movement for five days from July 11, 2025, through July 15, 2025. There was no documented evidence that 30 ml of Milk of Magnesia Suspension was offered or declined after three days/nine shifts of no bowel movement. Bowel movement records revealed that the resident did not have a bowel movement on July 18, 2025, through July 25, 2025, however there was no documented evidence that the resident was offered or declined 30 milliliters (ml) of Milk of Magnesia Suspension after three days/nine shifts of no bowel movement.	F 0684		

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F 0684 SS=D	Continued from page 22 Interview with the Director of Nursing on July 30, 2025, confirmed that the staff did not follow the facility's bowel policy and physicians orders for Resident 42 on the above-mentioned dates. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0684		
F 0729 SS=D	483.35(e)(4)-(6) Nurse Aide Registry Verification, Retraining §483.35(e)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.	F 0729	Past noncompliance: no plan of correction required.	Completion Date: 08/18/2025 Status: APPROVED Date: 08/19/2025

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F 0729 SS=D	Continued from page 23 §483.35(e)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(e)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by:	F 0729		

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F 0729 SS=D	Continued from page 24 Based on a review of facility job descriptions and personnel files, as well as staff interviews, it was determined that the facility failed to ensure that staff renewed their nurse aide registry to allow individuals to work as a nurse aide for one of three nurse aides reviewed (Nurse Aide 3). This deficiency was cited as past non-compliance. Findings include: The facility's job description, undated, revealed that a nurse aide certification was necessary to perform functions of the position. The personnel file for agency Nurse Aide 3 revealed that her certification on the nurse aide registry expired on May 31, 2024. The facility was unaware that Nurse Aide 3's certification on the nurse aide registry had expired until they were notified on January 1, 2025, by Nurse Aide 3. Nurse Aide 3 worked in the facility from June 1, 2024 through	F 0729		

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F 0729 SS=D	Continued from page 25 January 1, 2025 and was immediately removed from the schedule when it was discovered that her registry had expired. Interview with the Director of Human Resources on July 31, 2025 at 11:06 a.m. confirmed that Nurse Aide 3's certification on the nurse aide registry expired on May 31, 2024, and should have been renewed prior to expiring and that she continued to work from June 1, 2024 until January 1, 2025 when it was discovered. The facility's corrective actions taken following the incident included: 1. An immediate audit of all nurse aides was conducted and results were reviewed. 2. The nurse aide was suspended and disciplined for failing to renew her registry timely. 3. Staff education was completed regarding renewing their registry prior to expiration. All of the	F 0729		

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F 0729 SS=D	Continued from page 26 staff was educated by January 3, 2025. 4. Monthly audits will be completed and reviewed at QAPI meetings. 5. Human Resources will now offer reminders to the staff prior to expiration. 6. Human Resources will offer support to staff who may struggle to use the computer to renew. 7. On-going audits will be submitted to the facility's QAPI meetings as appropriate for review. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F658 on January 3, 2025. 28 Pa. Code 201.29 Personnel policies and procedures.	F 0729		

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F 0729 SS=D	Continued from page 27	F 0729		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 28 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	R37 medication label was corrected immediately at the time of survey. R37 no longer resides at facility. Re-education will be conducted by the Director of Nursing for all licensed staff on the need to ensure that any labels needed for medication direction change are put onto the medication card. Medication direction change orders were reviewed to ensure all previous direction changes are correct on the medication labels. Medication change orders will be reviewed daily during Morning Meeting (M-F) and labels verified for accuracy by Director of Nursing or designee. Pharmacy representative will be included in the on-going audits and will assist with audits of the medication change orders and medication labels during monthly reviews. The audit outcomes will be presented to the Quality Assurance Committee for review and recommendations.	Completion Date: 08/22/2025 Status: APPROVED Date: 08/19/2025

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F 0761 SS=D	Continued from page 29 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 medications were properly labeled for one of 28 residents reviewed (Resident 37). Findings include: The facility's policy regarding labeling of medications, dated April 7, 2025, indicated that all medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. Labels for individual drug containers must include appropriate instructions and precautions. The pharmacy must be informed of any changes or changes in directions for use of the medication. Physician's orders for Resident 37, dated July 1, 2025, indicated that the resident was to receive two 300 milligram (mg) capsules of Gabapentin (a	F 0761		

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F 0761 SS=D	Continued from page 30 medication used to treat nerve pain) daily and one 300 mg capsule of Gabapentin at bedtime. Observations during the medication administration on July 31, 2025, at 8:24 a.m. revealed that Licensed Practical Nurse 1 obtained Resident 37's blister pack (commonly used as unit-dose packaging for pharmaceutical tablets, capsules or lozenges) containing the resident's Gabapentin. The label on the blister pack containing the Gabapentin revealed that the resident was to receive one 300 mg capsule of Gabapentin daily and two 300 mg capsules of Gabapentin at bedtime. Interview with Licensed Practical Nurse 1 at the time of observation confirmed that the label on the blister pack containing the resident's Gabapentin did not match the resident's current orders for Gabapentin and that there should have been a "change in direction sticker" (a label used to indicate that a change has been made to the instructions or directions for something, often medication or a process) on the blister pack containing the resident's	F 0761		

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F 0761 SS=D	Continued from page 31 Gabapentin. Interview with the Director of Nursing on July 31, 2025, at 1:48 p.m. confirmed that there should have been a "change in direction sticker" on Resident 37's blister pack of Gabapentin to alert staff of the change in orders. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(3) Nursing Services.	F 0761		
F 0773 SS=D		F 0773		

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F 0773 SS=D	Continued from page 32 483.50(a)(2)(i)(ii) Lab Srvc's Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by:	F 0773	The TSH lab (thyroid stimulating hormone) for R3 was completed and results received prior to end of survey. Lab result was reviewed with MD and no adverse impact to the resident as a result of delayed lab test. Re-education will be conducted by the Director of Nursing for all registered Nurses on the need to ensure all ordered TSH labs are written on the lab requisition form. An audit was conducted of all the TSH to ensure all labs were completed as ordered. New process was put in place with a Lab Form being completed on every lab day (Mon, Wed), that includes residents name, lab testing to be completed, signature of phlebotomist and documentation of Y= Completed, N=Not completed, UTO=Unable to obtain, or refusal and Nurse Signature. The Director of Nursing or designee will audit every Monday and Wednesday for 6 weeks. The audit outcomes will be presented to the Quality Assurance Committee for review and recommendations	Completion Date: 08/22/2025 Status: APPROVED Date: 08/19/2025

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F 0773 SS=D	Continued from page 33 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to obtain laboratory studies as ordered by the physician for one of 28 residents reviewed (Resident 3). Findings include: The facility's policy regarding laboratory services and reporting, dated April 7, 2025, revealed that the facility would provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. The facility would provide or obtain laboratory services to meet the needs of its residents. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated June 25, 2025, revealed that the resident was cognitively intact and had diagnoses that included hypothyroidism (when	F 0773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395661	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/31/2025
NAME OF PROVIDER OR SUPPLIER: CASSELMAN HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 HOSPITAL DRIVE MEYERSDALE, PA 15552		
STATE LICENSE NUMBER: 136802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0773 SS=D	Continued from page 34 the thyroid gland doesn't make and release enough hormone into your bloodstream). A pharmacy review for Resident 3, dated May 3, 2025 revealed the resident was taking levothyroxine (medication used to treat hypothyroidism) and to consider monitoring TSH/thyroid panel (thyroid stimulating hormone-hormone produced by the pituitary gland). Physician's orders for Resident 3, dated May 14, 2025, included an order for staff to obtain a TSH level for hypothyroidism when the next labs were drawn. A care plan, dated July 14, 2022, revealed the resident had hypothyroidism and labs were to be obtained as ordered. Laboratory results, dated June 2, 2025, revealed that the TSH level was not included with the laboratory tests that were drawn that day. Interview with Director of Nursing on July 29, 2025, at 3:14 p.m. confirmed that there was no	F 0773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395661	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/31/2025	
NAME OF PROVIDER OR SUPPLIER: CASSELMAN HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 136802		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 HOSPITAL DRIVE MEYERSDALE, PA 15552		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0773 SS=D	Continued from page 35 documented evidence that Resident 3's TSH level was drawn as ordered. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0773		



Certified End Page

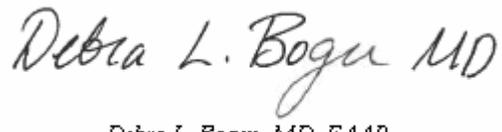
CASSELMAN HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 136802

SURVEY EXIT DATE: 07/31/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY