STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and Civil Rights Compliance survey completed on March 20, 2025, it was determined that Redstone Highlands Health Care 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 0000		
F 0610 SS=D		F 0610		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0610 SS=D	Continued from page 1 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	I hereby acknowledged the CMS 2567-A, issued to Redstone Highlands Health Care Center for the survey ending March 20, 2025 and attest that all deficiencies listed on the form will be corrected in a timely manner. This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Redstone Highlands Healthcare Center agrees with the allegations and citations listed on the statement of deficiencies. Redstone Highlands Healthcare Center maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Redstone Highlands Healthcare Center's written credible allegation of compliance. By submitting this plan of correction, Redstone Highlands	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0610 SS=D	Continued from page 2	F 0610	Healthcare Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Redstone Highlands Healthcare Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. Resident 24 was assessed and noted to have no adverse effects related to the investigation of ruled-out neglect from the incident dated October 12, 2024. The resident is followed to ensure psycho-social needs are met. No new orders from the physician. The resident has had no adverse effects from the completed investigation of injury of unknown origin. A facility-wide sweep of all residents with pain scales presenting with unidentified pain source, if applicable. Any issues identified were corrected at the time of discovery, and an investigation will be initiated to rule out abuse/	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0610 SS=D	Continued from page 3	F 0610	neglect and identify the cause, if applicable. The whole house staff was educated on the Abuse / Neglect Prohibition policy and procedure. The Director of nursing (DON) or designee will conduct audits to ensure all pain scales with unidentified sources are investigated to rule out abuse/ neglect to completion and documented weekly for 4 weeks, then monthly for 2 months. Identified issues will be addressed at the time of discovery. Audit results are reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education/re-education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0610 SS=D	Continued from page 4 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to investigate injuries of unknown origin to rule out abuse or neglect for one of 38 residents reviewed (Resident 24) who suffered an ankle fracture. Findings include: The facility's injury of unknown origin policy, dated September 27, 2024, indicated that any time there was an injury of unknown origin, a thorough investigation will be conducted to determine the cause. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated January 26, 2025, indicated that the resident was cognitively intact and required assistance from staff for her daily care needs.	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0610 SS=D	Continued from page 5 A nursing note for Resident 24, dated October 9, 2024, indicated that the resident's son asked if the resident had seen the doctor regarding the pain in her left foot. Resident 24's x-ray results, dated October 12, 2024, revealed that the resident had a non-union or delayed healing fracture of the distal fibula, just above the malleolus of the left ankle (ankle fracture). There was no documented evidence that a thorough investigation was completed into Resident 24's injury of unknown origin in order to rule out that abuse or neglect was involved as the possible cause(s). Interview with the Director of Nursing on March 20, 2025, at 1:18 p.m. revealed that he interviewed Resident 24 and she denied that anyone abused her; therefore, he concluded the investigation. There was no documented evidence that neglect was ruled out causing the resident to have a fracture.	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0610 SS=D	Continued from page 6 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(2) Nursing Services.	F 0610		
F 0623 SS=B		F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0623 SS=B	Continued from page 7 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	Residents 69 and 48 have since been discharged from the facility. Residents 39,28, and 40 have not been sent out of the facility since findings. A sweep of all resident transfers was conducted to ensure there was documentation evidence of written notice to the resident's responsible party regarding the reasoning for the transfer from the facility. All issues discovered were corrected at the time of discovery. The navigation team was re-educated on written notice to the resident's responsible party when a transfer is facility-initiated. The Nursing home administrator (NHA) or designee will conduct audits to ensure all facility-initiated transfers have documented written notice to the responsible party regarding the reason for transfer weekly X4 weeks, then monthly X2 month. Identified issues will be addressed at the time of discovery. Audit results are reported to the Quality Assurance Performance Improvement committee to identify	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0623 SS=B	Continued from page 8 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	trends and further opportunities for quality improvement and needs for additional education/re-education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0623 SS=B	Continued from page 9 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0623 SS=B	Continued from page 10 Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident and legal guardian in writing regarding the reason for hospitalization for five of 38 residents reviewed (Residents 28, 39, 40, 48, 69). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) Resident 28, dated May 1, 2024, revealed that the resident was cognitively intact, was dependent on staff with daily care needs, and had diagnosis that included high blood pressure and pneumonia. A nursing note for Resident 28, dated May 24, 2024, at 6:04 a.m., revealed that the resident was admitted to the hospital. There was no documented evidence that a written notice of Resident 28's transfer to the hospital was provided to the resident's responsible party	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0623 SS=B	Continued from page 11 regarding the reason for transfer. A nursing note for Resident 39, dated February 27, 2025, at 12:45 a.m., revealed that the resident was admitted to the hospital with a urinary tract infection. There was no documented evidence that a written notice of Resident 39's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer. An admission MDS assessment for Resident 40, dated September 14, 2024, revealed that the resident was cognitively impaired, required maximum assistance for daily care needs, and had diagnoses that included dementia. A nursing note for Resident 40, dated September 10, 2024, revealed that the resident had a fall with resultant hematoma. Orders were received from the physician to send the resident to the hospital for evaluation.	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0623 SS=B	Continued from page 12 There was no documented evidence that a written notice of Resident 40's transfer to the hospital was provided to the resident's responsible party regarding the reason for the transfer. Interview with the Nursing Home Administrator on March 20, 2025, at 9:29 a.m. confirmed that the responsible party was not notified writing regarding the reason for Resident 40's transfer to the hospital. An admission MDS assessment for Resident 48 dated January 21, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs and had diagnoses that included a left hip fracture, diabetes and dementia. A nurse's note for Resident 48, dated February 12, 2025, at 1:46 p.m. revealed that the resident's lab results were reported to the physician and the physician gave orders to send the resident to the hospital due to worsening kidney function. There was no documented evidence that a written notice of Resident 48's transfer to the hospital was	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0623 SS=B	Continued from page 13 provided to the resident and/or the resident's responsible party regarding the reason for transfer. A nurse's note for Resident 48, dated March 1, 2025, at 3:42 p.m., revealed that the resident's lab results were reported to the physician, and the physician gave orders to send the resident to the hospital. There was no documented evidence that a written notice of Resident 49's transfer to the hospital was provided to the resident and/or the resident's responsible party regarding the reason for transfer. Interview with the Nursing Home Administrator on March 20, 2025, at 2:18 p.m. confirmed that there was no documented evidence that a written notice of Resident 48's transfer to the hospital was provided to the resident and/or the resident's responsible party regarding the reason for transfer. An admission MDS assessment for Resident 69, dated January 1, 2025, revealed that the resident was understood, could understand others, and had a	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0623 SS=B	Continued from page 14 diagnosis which included cancer, anemia (a condition where the body does not have enough healthy red blood cells or hemoglobin, the protein in red blood cells that carries oxygen throughout the body), hypertension (high blood pressure), and colostomy (a surgical procedure that creates an opening (stoma) in the abdominal wall to bring the colon (large intestine) to the surface of the body). Nursing notes for Resident 69, dated January 14, 2025, at 6:02 p.m. revealed that the nurse and the resident's nurse on duty attempted to apply ostomy (a surgically created opening, or stoma, on the abdomen to allow waste (stool or urine) to exit the body when the normal digestive or urinary tract is damaged) supplies to the resident's stoma (a surgically-created opening) several times throughout the shift (five to seven times). The nurse contacted the in-house physician, and he stated that they should send the resident to the hospital due to not having excessive stoma supplies/specialized staff within that area of expertise. The nurse notified the resident, who was alert and was agreeable with the	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0623 SS=B	Continued from page 15 send out. A nursing note at 6:37 p.m. revealed that the resident left the facility via ambulance to the emergency department for further evaluation and treatment due to new ostomy issues. A nursing note at 11:26 p.m. revealed that the resident was admitted to the hospital with a diagnosis of dermatitis (a general term for a group of skin conditions that cause inflammation and irritation). There was no documented evidence that a written notice of Resident 69's transfer to the hospital was provided to the resident and/or the resident's responsible party regarding the reason for transfer. Interview with the Assistant Campus Director on March 20, 2025, at 10:40 a.m. confirmed that there was no documented evidence that a written notice of Resident 69's transfer to the hospital was provided to the resident and/or the resident's responsible party regarding the reason for transfer. 28 Pa. Code 201.25 Discharge Policy.	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**
STATE LICENSE NUMBER: **073202**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0623 SS=B	Continued from page 16 28 Pa. Code 201.29(f)(g) Resident Rights.	F 0623		
F 0641 SS=D		F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 17 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Residents 69 and 96 have discharged from the facility. Resident 55 MDS was updated with appropriate coding. A facility-wide sweep of all residents meeting the requirements of anticoagulants and diuretic medications on admission assessments, discharge status in Section A2105 of discharge assessments and accurate discharge to the hospital minimum data set (MDS) tracking's were opened were completed going back to February 1,2025. Any issues identified were corrected at the time of discovery. The Registered Nurse Assessment Coordinators (RNAC) was re-educated regarding the resident assessment instrument (RAI) Manual for Section N: Medications and Section A: Identification Information. The Nursing home administrator (NHA) or designee will conduct audits to ensure that Admission MDS assessments with anticoagulant and diuretics coded were completed correctly per the	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 18	F 0641	RAI Manual, and discharge assessments will have accurate discharge tracks and locations completed correctly per the RAI Manual required schedule weekly X4 weeks, then monthly X2 months. Identified issues will be addressed at time of discovery. Audit results are reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education/re-education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 19 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for one of 38 residents reviewed (Resident 55) and failed to complete accurate discharge Minimum Data Set assessments for two of 38 residents reviewed (Residents 69, 96). Findings include: The Long-Term Care Facility RAI User's Manual, dated October 2024, indicated that Section N0415E (Anticoagulant-medications that prevent blood clots from forming or growing) was to be coded (1) is taking, if the resident received an anticoagulant medication during the seven-day look-back period. Section N0415G (Diuretic-medicines that helps reduce fluid buildup in the body) was to be coded (1) is taking, if the resident received a diuretic medication during the seven-day look-back period.	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 20 Physician's orders for Resident 55, dated February 3, 2025, included an order for the resident to receive 5 milligrams (mg) of Apixaban (an anticoagulant) two times a day. Review of the resident's MAR for February 2025 revealed that the resident received Apixaban daily on February 3 through February 7, 2025. However, an admission MDS assessment for Resident 55, dated February 7, 2025, revealed that Section N0415E was not coded (1) is taking, indicating that the resident did not receive an anticoagulant during the seven-day look-back period. Physician's orders for Resident 55, dated February 4, 2025, included an order for the resident to receive 20 mg of Torsemide (a diuretic) daily. Review of the resident's MAR for February 2025 revealed that the resident received Torsemide daily on February 4 through February 7, 2025. However, an admission MDS assessment for Resident 55, dated February 7, 2025, revealed that Section N0415G was not coded (1) is taking, indicating that the resident did not receive a diuretic	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**
STATE LICENSE NUMBER: **073202**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 21 during the seven-day look-back period. An interview with the RNAC on March 20, 2025, at 12:37 p.m. confirmed that Resident 55's MDS assessment dated February 7, 2025, was not coded accurately. The RAI User's Manual, which gives instructions for completing MDS assessments, dated October 2024, revealed that Section A2105 (Discharge Status) was to be coded one (1) through thirteen (13) depending on the location of the resident's discharge. If the resident was discharged to a short-term general hospital (acute hospital), and then Section A2105 was to be coded four (4). If the resident was discharged to home under the care of a organized home health service organization, then Section A2105 was to be coded twelve (12). Physician's orders for Resident 69, dated February 2, 2025, included an order for the resident to discharge home with all current medications and treatment, as well as to receive home health services	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 22 of physical therapy, occupational therapy, skilled nursing, and home health aide. A social services progress note for Resident 69, dated January 31, 2025, revealed that the resident will discharge home on Sunday with his power of attorney (POA - a legal document that allows someone to act on behalf of another person in specific matters, such as financial or healthcare decisions). The resident will receive home health services. A discharge summary for Resident 69, dated February 2, 2025, revealed that the resident was discharged to home with home health services. A discharge return not anticipated MDS assessment for Resident 69, dated February 2, 2025, revealed that Section A2105 was coded four (4), indicating that the resident was discharged to an short-term general hospital (acute hospital). Interview with the Assistant Campus Director on	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202	6 GARDEN CENTER DRIVE GREENSBURG, PA 15601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 23 March 20, 2025, at 12:40 p.m. confirmed that Section A2105 of Resident 69's discharge return not anticipated MDS assessment of February 2, 2025, was not accurate and should have been coded to indicate that the resident was discharged to home under the care of a organized home health service organization. A death tracking MDS assessment for Resident 96, dated October 2, 2024, revealed that Section A2105 was coded thirteen (13), indicating that the resident was deceased; however, nursing notes for Resident 96, dated October 2, 2024, at 10:05 a.m., revealed that the resident continued to complain of left lower extremity pain, swelling, discoloration, and hypotension (low blood pressure). The physician was made aware, and an order was received to send the resident to the hospital for further evaluation and treatment. A nursing note at 10:56 p.m. revealed that the resident was admitted to the hospital. Interview with the Assistant Campus Director on	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 24 March 20, 2025, at 9:40 a.m. confirmed that the resident did not die at the facility and was sent out to the hospital on October 2, 2024, and confirmed that Section A2105 of Resident 96's death tracking MDS assessment October 2, 2024, was not accurate and should have been coded to indicate that the resident was discharged to a hospital. 28 Pa. Code 211.5(f) Clinical Records.	F 0641		
F 0655 SS=D		F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0655 SS=D	Continued from page 25 483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 0655	Resident 89, 94 and 95 had no adverse reactions related to not having a baseline care plan demonstrating the need for enhanced barrier precautions (EBP), anticoagulants or diuretics. Resident 89 is no longer in the facility. Resident 94 is no longer in the facility. Resident 95 is no longer in the facility Facility-wide sweep of all foley catheters, feeding tubes, anticoagulants and diuretics was conducted to ensure that a baseline care plan was initiated with the related items in place. Any issues identified were corrected at time of discovery. The registered assessment coordinator (RNAC) and all licensed nursing staff were re-educated regarding updating the baseline care plan with enhanced barrier precautions (EBP) for foley catheters and feeding tubes as well as to demonstrate the use of anticoagulants and diuretics. The Assistant Nursing Home Administrator or designee will	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0655 SS=D	Continued from page 26 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 0655	conduct audits to ensure that the baseline care plan is initiated and the proper related items are in place, weekly X4 weeks, and then monthly X2 months. Identified issues will be addressed at time of discovery. Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0655 SS=D	Continued from page 27 Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's baseline care plan included information regarding the resident's immediate care needs for three of 38 residents reviewed (Residents 89, 94, 95). Findings include: The facility's policy regarding care planning, dated September 27, 2024, revealed that the licensed nurse will initiate a baseline care plan upon admission to the facility and complete it within 48 hours. Care plans will be individualized to the residents. The facility's policy regarding Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities), dated September 27, 2024,	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**
STATE LICENSE NUMBER: **073202**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0655 SS=D	Continued from page 28 revealed that residents requiring the use of EBP, will be identified to staff by including the EBP in their care plans. An order for EBP will be obtained for residents with any of the following: indwelling medical devices (e.g. urinary catheters). A care plan for Resident 89, dated March 8, 2025, revealed that the resident required a feeding tube (a flexible plastic tube placed into the stomach or bowel) for nutritional support. There was no documented evidence that a baseline care plan was developed for Resident 89's care and treatment needs related to requiring EBP due to having a feeding tube. A care plan for Resident 94, dated March 11, 2025, revealed that the resident had a foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) related to urinary retention (a condition where a person is unable to empty their bladder completely).	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0655 SS=D	Continued from page 29 There was no documented evidence that a baseline care plan was developed for Resident 94's care and treatment needs related to requiring EBP due to having a foley catheter. Interview with the Nursing Home Administrator on March 20, 2025, at 1:19 p.m. confirmed that a baseline care plan was not developed for Resident 89 or Resident 94's care and treatment needs related to requiring EBP. A care plan for Resident 95, dated March 12, 2025, revealed that the resident had a foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) related to urinary retention (a condition where a person is unable to empty their bladder completely). Physician's orders for Resident 95, dated March 11, 2025, included an order for the resident to receive a five milligram (mg) tablet of Apixaban (an anticoagulant medication used to treat and prevent blood clots and to prevent strokes) two times a day.	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0655 SS=D	Continued from page 30 Physician's orders for Resident 95, dated March 12, 2025, included an order for the resident to receive a 20 mg tablet of Furosemide (a diuretic medication to help treat fluid retention (edema) and swelling) one time a day. There was no documented evidence that a baseline care plan was developed for Resident 95's care and treatment needs related to EBP due to having a foley catheter, the use of anticoagulant, and diuretic medications. Interview with the Assistant Campus Director on March 20, 2025, at 10:40 a.m. confirmed that a baseline care plan was not developed for Resident 95's care and treatment needs related to EBP due to having a foley catheter, the use of anticoagulant, and diuretic medications. 28 Pa. Code 211.12(d)(1) Nursing Services.	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**
STATE LICENSE NUMBER: **073202**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0656 SS=D		F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0656 SS=D	Continued from page 32 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Resident 40's care plan was updated to include the presence of an ostomy and interventions to address the care and maintenance. Resident 55's care plan was updated to include Diabetes Mellitus and the use of a continuous glucose monitor. Facility-wide sweep was conducted to capture other residents who have colostomies and diabetes and their care plans to ensure that colostomy status, diabetes mellitus and continuous glucose monitoring have been included with interventions in the care plans. Any issues identified were corrected at time of discovery. The registered nurse assessment coordinator (RNAC) and licensed nursing staff were re-educated on the need to update the comprehensive care plan accurately and timely when resident changes occur. The Assistant Nursing Home Administrator or designee will conduct audits to ensure that the care plan updates are completed timely weekly X4 weeks, then monthly fX2 months. Identified	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0656 SS=D	Continued from page 33 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	issues will be addressed at time of discovery. Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0656 SS=D	Continued from page 34 Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents for two of 38 residents reviewed (Residents 40, 55). Findings include: A facility policy for Clinical Care Planning, dated September 27, 2025, included that the facility will develop a comprehensive and baseline care plan for all residents. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 40, dated February 3, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had a colostomy (surgical diversion of the colon through an opening in the abdomen). There was no documented evidence that a care plan	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0656 SS=D	Continued from page 35 was developed to address the resident's care needs regarding her colostomy. Interview with the Nursing Home Administrator on March 19, 2025, at 3:24 p.m. confirmed that a care plan should have been developed for Resident 40's colostomy. An admission MDS assessment for Resident 55, dated February 7, 2025, revealed that the resident was cognitively intact, required assistance for personal care needs, and had diagnoses that included diabetes. Physician orders for Resident 55, dated February 26, 2025, included for the resident to receive a Freestyle Libre 3 sensor (a Continuous Glucose monitoring System Sensor -wearable device that tracks your glucose (sugar) levels in real time) injected every 14 days for diabetes. There was no documented evidence that a care plan was developed to address Resident 55's individual	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0656 SS=D	Continued from page 36 care and treatment needs related to her diabetes or the use of a continuous glucose monitoring system. An interview with the Nursing Home Administrator on March 20, 2025, at 12:37 p.m. revealed that there was no documented evidence that a care plan was developed for Resident 55 to address her care and treatment needs related to her diabetes and use of a continuous glucose monitoring system. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0656		
F 0657 SS=D		F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 37 483.21(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	Resident 73's care plan has been updated to demonstrate discontinued orders and interventions appropriate to identified needs. Facility-wide sweep of all discontinued antibiotic therapy was conducted. Any issues identified were corrected at time of discovery. The registered nurse assessment coordinator (RNACs) and licensed nursing staff were re-educated regarding timely resident care plan revisions when resident changes occur. The Assistant Nursing Home Administrator or designee will conduct audits to ensure that care plan revisions are completed timely, weekly for 4 weeks then monthly for 2 months. Identified issues will be addressed at time of discovery. Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 38 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for one of 38 residents reviewed (Resident 73). Findings include: A facility policy for care planning, dated September 27, 2025, indicated that care plans would be individualized to the residents and care plans will be updated by the licensed nurse and interdisciplinary team as needed with changes as applicable. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 73, dated March 8, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included pneumonia (infection of the lungs).	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 39 A care plan for Resident 73, dated March 4, 2025, indicated that the resident was on antibiotic therapy for pneumonia and staff were to administer the antibiotic medication as ordered by the physician. Interview with the Nursing Home Administrator on March 20, 2025, at 12:27 p.m. revealed that Resident 73's care plan was not updated when her antibiotic therapy was completed, and it should have been. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0657		
F 0658 SS=D		F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=D	Continued from page 40 483.21(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	Resident 48 had no adverse reactions to having wound care orders not matching the wound physician's orders from rounding notes. Physician's order has been updated and the electronic medical record (EMR) reflects update. Resident 48 has since been discharged from the facility. A facility-wide sweep on all in-house residents with active wound care orders was conducted to ensure all rounding wound care physician orders were correctly transcribed into the EMR. Any issues identified were corrected at time of discovery. The wound care coordinator and all licensed nursing staff was re-educated on transcription of wound care orders from the rounding wound physician into the EMR. The Assistant Nursing Home Administrator or designee will conduct audits to ensure that EMR orders for wound care match the MD rounding report from the rounding wound physician, weekly X4 weeks then monthly X2 months. Identified	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=D	Continued from page 41	F 0658	issues will be addressed at time of discovery. Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=D	Continued from page 42 Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify a provider's orders for one of 38 residents reviewed (Resident 48). 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. An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 48, dated January 21, 2025, indicated that the resident was cognitively intact, required assistance from staff	F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=D	Continued from page 43 for daily care needs, and had diagnoses that included a left hip fracture, diabetes, and dementia. Physician's orders for Resident 48, dated February 19, 2025, included an order for the resident to have betadine applied to his bilateral heels and then covered with a bordered foam dressing every other day for deep tissue injury (DTI - form of pressure-induced damage to underlying tissues). Physician's orders for Resident 48, dated March 16, 2025, included an order for the resident to have his bilateral heels cleansed with Vashe (a wound cleanser), pat dry, UrgoClean Ag (a wound dressing that supports the continuous debridement of dead tissue with the benefit of silver) and foam bordered dressings (used to promote wound healing) applied and secured with rolled gauze every other day for pressure ulcer. Wound consult reports for Resident 48, dated February 21, 2025, and February 28, 2025, respectively, indicated that the resident was to have	F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=D	Continued from page 44 his bilateral heels cleansed with a wound cleanser, then betadine applied to his bilateral heels and covered with a bordered foam dressing every day for deep tissue injury (DTI). A wound consult report for Resident 48, dated March 14, 2025, indicated that the resident was to have his bilateral heels cleansed with Vashe (antimicrobial solution for wound management), then patted dry, and UrgoClean Ag and foam bordered dressings applied every day. Interview with the wound nurse (Registered Nurse 1) on March 20, 2025, at 10:40 a.m. revealed that she rounds with the consultant wound physician who gives her verbal orders for treatments that she enters into the clinical records. The consultant physician also has an assistant who types his assessments for him. The above-mentioned assessments included orders to change Resident 48's dressings daily; however, the wound consultant gave verbal orders to Registered Nurse 1 to change the dressing every other day. The wound consultant notes that are	F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=D	Continued from page 45 typed by his assistant do not always match the verbal orders given to the facility's wound nurse. They are developing a process to correct that issue. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0658		
F 0684 SS=E		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 46 483.25 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	Resident 15 had no adverse reactions to having an antihypertensive medication (a medication that treats hypertension) administered outside of heart rate parameters set forth by the physician. The physician was made aware of the medication administration outside of the parameters. Resident 70 had no adverse reactions to not having the medical doctor (MD) notified of a weight gain in one day. The resident is no longer in the facility. Resident 95 had no adverse reactions to not having the MD notified of a weight gain in one day. The resident is no longer in the facility. Facility-wide sweep for all residents who have heart rate parameters with antihypertensive medications to ensure that heart rate parameters were followed according to physician order was conducted. Facility-wide sweep for all residents with significant weight loss was conducted to ensure proper physician notification. Any issues	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 47	F 0684	identified were corrected at time of discovery. All licensed nursing staff was re-educated on heart rate parameters surrounding antihypertensive mediations and notification of physician in addition to significant weight change education. The Assistant Nursing Home Administrator or designee will conduct audits to ensure that heart rate parameters with antihypertensive medications are followed and that all significant weight changes have physician notification, weekly 4 weeks and then monthly 2 months. Identified issues will be addressed at time of discovery. Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 48 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice, by failing to ensure that physician's orders were followed for three of 38 residents reviewed (Residents 15, 70, 95). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 15, dated December 29, 2024, indicated that the resident was cognitively impaired, was dependent on staff for daily care needs, and had a diagnosis of hypertension (high blood pressure). Physician's order for Resident 15, dated April 4, 2024, included an order for the resident to receive 100 milligrams (mg) of Labetalol (treats hypertension) two times a day and to hold if heart rate is less than 50 beats per minute (bpm).	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 49 Review of Resident 15's Medication Administration Record (MAR), dated January 2025, February 2025, and March 2025 for 100 mg of labetalol revealed that on January 11, 2025, at 8:00 a.m. the resident's heart rate was 44 bpm, and the labetalol was administered; on January 21, 2025 at 8:00 p.m. the resident's heart rate was 50 bpm and labetalol was held; on February 4, 2025, at 8:00 p.m. the resident's heart rate was 51 bpm and labetalol was held; on February 19, 2025, the resident's heart rate was 51 bpm and labetalol was held; on February 24, 2025, at 8:00 p.m. the resident's heart rate was 50 bpm and labetalol was held; and March 1, 2025, at 8:00 p.m. the resident's heart rate was 47 bpm and labetalol was administered. Interview with Nursing Home Administrator on March 20, 2025, at 12:45 p.m. confirmed that staff were not administering Resident 15's 100mg labetalol per physician's orders. Physician's orders for Resident 70, dated December	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202	6 GARDEN CENTER DRIVE GREENSBURG, PA 15601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 50 6, 2024, included an order for staff to obtain the resident's weight before breakfast every day shift, and they were to notify the physician if the resident had a weight gain of greater than two pounds. Review of the MAR for Resident 70, dated December 2024, revealed that on December 9, 2024, the resident's weight was 114.2 pounds, and on December 10, 2024, the resident's weight was 118.6 pounds. However, there was no documented evidence that the physician was contacted regarding the resident's 4.4-pound weight gain. Interview with the Nursing Home Administrator on March 20, 2025, at 12:27 p.m. confirmed that there was no documented evidence that the physician was contacted regarding Resident 70's 4.4-pound weight gain. Physician's orders for Resident 95, dated March 12, 2025, included an order for staff to obtain the resident's weight before breakfast every day shift, and they were to notify the physician if the resident	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 51 had a weight gain of greater than two pounds. Review of the MAR for Resident 95, dated March 2025, revealed that on March 12, 2025, the resident's weight was 239.8 pounds. The resident refused to have his weights obtained on March 13, 14, and 15, 2025. On March 16, 2025, the resident's weight was 287.6 pounds. However, there was no documented evidence that the physician was contacted regarding the resident's 47.8-pound weight gain. Interview with the Assistant Campus Director on March 20, 2025, at 10:40 a.m. confirmed that there was no documented evidence that the physician was contacted regarding Resident 95's 47.8-pound weight gain. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0684		
F 0755 SS=E		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0755 SS=E	Continued from page 52 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Residents 28, and 36 were noted to not have any adverse effects noted from not having documented medication administration in the electronic medical record (EMR). Resident 4 was noted to not have any adverse effects noted from not having documentation of destroyed controlled substance A facility-wide sweep of all residents in-house with the physician order of Percocet was conducted to ensure all administrations were documented in the narcotic book match the EMR. A facility-wide sweep of all residents with Fentanyl patches had documentation of medication destruction upon removal on narcotic (NARC) signoff sheet. All licensed nurses were educated on medication administration and documentation in the EMR, and destruction of controlled substances. The Director of Nursing or designee will conduct audits to ensure that all Percocet administrations were documented in the narcotic book match the EMR and that Fentanyl	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0755 SS=E	Continued from page 53 This REQUIREMENT is not met as evidenced by:	F 0755	patches have documentation of medication destruction upon removal on NARC sheet weekly X4 weeks and monthly X2 months. Identified issues are addressed at time of discovery. Audit results are reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education/re-education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0755 SS=E	Continued from page 54 Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications for three of 38 residents reviewed (Residents 4, 28, 36). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated December 9, 2024, revealed that the resident was cognitively intact, received routine pain medication, and received an opioid (a controlled pain medication). Physician's orders for Resident 4, dated December 31, 2024, included an order to apply a 25 micrograms (mcg) Fentanyl (a narcotic pain patch) patch every three days for pain. The Medication Administration Record (MAR) and	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0755 SS=E	Continued from page 55 a controlled drug count record (tracks each dose of a controlled medication) for Resident 4, dated December 2024 and January and February 2025, revealed that a new Fentanyl patch was applied to the resident on the following dates: December 31, 2024; January 3, 6, 9, 12, 15, 18, 21, 24, 27, 30, 2025; and February 2, 5, 8, 11, 14, 17, 20, and 23, 2025. There was no documented evidence on the narcotic sheets that the old Fentanyl patch was destroyed on the above dates. Interview with the Nursing Home Administrator on March 20, 2025, at 12:15 a.m. confirmed that there were no narcotic sign-out sheets for December 31, 2024 through February 23, 2025. A quarterly MDS assessment for Resident 28, dated December 12, 2024, indicated that the resident was cognitively intact, was independent for all daily care needs, and had pain. Physician's orders for Resident 28, dated May 29, 2024, included an order for the resident to receive	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202	6 GARDEN CENTER DRIVE GREENSBURG, PA 15601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0755 SS=E	Continued from page 56 one 5-325 milligram (mg) tablet of Oxycodone/Tylenol (a combination controlled narcotic pain medication) every six hours as needed for pain. Resident 28's controlled drug record (used to keep count of narcotic medication) for February and March 2025 revealed that staff signed out one 5-325 mg Oxycodone/Tylenol on February 6, 2025, at 11:35 p.m.; February 7, 2025, at 2:30 p.m.; February 14, 2025, at 9:30 a.m.; February 17, 2025, at 3:13 p.m.; February 21, 2025, at 11:00 a.m.; March 4, 2024, at 6:15 a.m.; and March 8, 2025, at 11:00 p.m. However, review of the resident's MAR, dated February and March 2025, revealed no documented evidence that the 5-235 mg Oxycodone/Tylenol was administered to the resident on those dates. A quarterly MDS assessment for Resident 36, dated December 15, 2024, indicated that the resident was cognitively intact, required assistance from staff for all daily care needs, and had pain.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0755 SS=E	Continued from page 57 Physician's orders for Resident 36, dated April 24, 2024, included an order for the resident to receive one 5-325 milligram (mg) tablet of Oxycodone/Tylenol (a combination controlled narcotic pain medication) every four hours as needed for pain. Resident 36's controlled drug record (used to keep count of narcotic medication) for January, February, and March, 2025, revealed that staff signed out Percocet on January 8 at 7:58 a.m.; January 22 at 11:00 p.m.; January 27 at 11:00 p.m.; January 27 at 8:40 a.m.; January 27 at 5:15 p.m.; February 14 at 8:30 a.m.; February 19 at 8:30 a.m.; February 20 at 8:30 a.m.; February 24 at 9:00 p.m.; February 28 at 9:15 p.m.; March 10 at 8:00 a.m.; and March 11 at 8:40 a.m. However, a review of the resident's MAR, dated January, February, and March 2025, revealed no documented evidence that the Percocet was administered to the resident on those dates. Interview with the Nursing Home Administrator	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0755 SS=E	Continued from page 58 March 20, 2025, at 12:27 p.m. confirmed that there was no documented evidence that Resident 28 received the 5-325 Oxycodone/Tylenol or that Resident 36 received the Percocet as ordered on the above referenced dates. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0755		
F 0761 SS=D		F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0761 SS=D	Continued from page 59 483.45(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	All medication carts were rounded on and ensured to be locked. Any loose medication within the drawer of the medication cart was destroyed by nursing staff via drug buster. The insulin pen within the medication cart was immediately discarded. Controlled substance contents was moved to a permanently affixed box within the refrigerator that was preexisting. A Facility-wide sweep was conducted to include: all medication carts to ensure that they are locked when not in use; that there are no loose medications in the drawers; and that all insulin is dated once removed from the refrigerator. In addition, a facility-wide sweep of medication room refrigerators was conducted to ensure that all controlled substance boxes are permanently affixed to the refrigerator. Any issues identified were corrected at time of discovery. All licensed nursing staff was re-educated on the policies including but not limited to medication storage, disposition and labeling.	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0761 SS=D	Continued from page 60	F 0761	The director of nursing (DON) or designee will conduct audits to ensure that all med carts are locked when not in use, no loose medications are left in the med cart, all insulin pens are dated when outside of the refrigerator and all controlled substance boxes in the medication room refrigerators are permanently affixed, weekly X4 weeks then monthly X2 months. Identified issues will be addressed at time of discovery. Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0761 SS=D	Continued from page 61 Based on review of manufacturer's instructions, facility policies, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were stored in a secure manner, failed to ensure that medications were appropriately secured in one of two medication carts reviewed (first floor medication cart 1), failed to store unopened and unused multi-dose containers of insulin according to manufacturer's instructions for one of 38 residents reviewed (Resident 76), and failed to ensure that refrigerated controlled medications were stored in a separately-locked, permanently-affixed container in one of two medication refrigerators reviewed (first floor medication room refrigerator). Findings include: A facility policy for medication storage, dated September 27, 2024, revealed that medications and biologicals are to be stored properly. The medication should only be accessible to licensed	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0761 SS=D	Continued from page 62 nursing staff, pharmacy personnel, and lawfully authorized staff. Observations on the first floor on March 19, 2025, at 9:07 a.m. revealed an unlocked and unsecured medication cart that was accessible to residents, family, and staff who walked past while Registered Nurse 2 was in a resident's room. Interviews with Registered Nurse 2 at the time of observation confirmed that the cart should have been locked and secured while he was in a resident's room. Observations of the first-floor medication cart 1 on March 20, 2025, at 1:33 p.m. revealed that the second drawer contained nine loose pills that were unsecured and not in the pharmacy's packaging. Interview with Licensed Practical Nurse 2 at the time of observation confirmed that the pills were loose in the bottom of the cart drawers and should not have been. Manufacturer's directions for Insulin Aspart (Novolog - a fast-acting insulin used to lower blood	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0761 SS=D	Continued from page 63 sugar levels), dated February 2023, indicated to store unused pens in the refrigerator at 36 degrees Fahrenheit (F) to 46 degrees F. Unused pens may be used until the expiration date printed on the label if the pen has been kept in the refrigerator. Unopened vials should be thrown away after 28 days, if they are stored at room temperature. Physician's orders for Resident 76, dated March 17, 2025, included an order for the resident to receive Insulin Aspart as per a sliding scale (the amount of insulin given was determined by the blood sugar level) before meals and at bedtime. Physician's orders for Resident 76, dated March 17, 2025, included an order for the resident to receive 10 units of Insulin Aspart with her meals. Observations of the first-floor medication cart 1 on March 20, 2025, at 1:33 p.m. revealed that Resident 76's Insulin Aspart Pen Injector was unopened and not in use in the second drawer of the medication cart. Interview with Licensed Practical	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0761 SS=D	Continued from page 64 Nurse 2 at the time of observation confirmed that Resident 76's Insulin Aspart Pen was not opened, not in use, and should not have been in the medication cart but should have been stored in the refrigerator until ready for use. The facility's policy regarding controlled medication storage, dated September 27, 2024, revealed that controlled medications requiring refrigeration are stored within a locked, permanently-affixed box within the refrigerator. Observations of the first-floor medication room refrigerator on March 20, 2025, at 1:51 p.m. revealed that there was a red plastic box with a metal lockable lid sitting on the second shelf in the refrigerator that contained one box of Ativan Intensol (an antianxiety medication that is a controlled drug); however, the red plastic box with a metal lockable lid was not permanently affixed to the refrigerator and could be removed from the refrigerator.	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0761 SS=D	Continued from page 65 Interview with Assistant Director of Nursing at the time of observation confirmed that the red plastic box with a metal lockable lid containing the Ativan Intensol was not permanently affixed to the refrigerator and could be removed. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.	F 0761		
F 0812 SS=E		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0812 SS=E	Continued from page 66 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	All food products identified as open to air and undated were immediately discarded. This includes one-quarter pound of American cheese, 15 scones, 6 Danishes, 1 apple pie, 1 blueberry container, and 1 brownie mix. Nurse Aide 3 has since been removed from duties and dismissed from Redstone. A facility-wide sweep of all food storage areas and pantries was conducted to ensure proper storage. All issues identified were corrected at the time of discovery. The System Food Service Director and dietary staff were re-educated on the proper storage of food products. The System Food Service Director, dietary and nursing staff was re-educated on proper food handling and PPE etiquette. The System Food Service Director or designee will conduct audits to ensure proper storage of all food products, weekly X4 weeks, monthly x2 months. The Director of Nursing Assistants (DNA) or designee will conduct spot-check compliance audits to ensure proper food	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0812 SS=E	Continued from page 67	F 0812	handling and personal protective equipment (PPE) etiquette during meals weekly X4 weeks, monthly X2 months. Identified Issues are addressed at the time of discovery. Audit results are reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education/re-education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0812 SS=E	Continued from page 68 Based on review of policies, observations, and staff interviews, it was determined that the facility failed to ensure that food was prepared and served under sanitary conditions, in accordance with professional standards for food service safety. Findings include: The facility's policy regarding food and nutrition services, dated September 27, 2024, indicated that employees will wear a clean, appropriate hairnet/hair restraint, and that beards and facial hair will be contained, and food will be stored, labeled and dated when received. Observations in the main kitchen on March 17, 2025, at 9:25 a.m. revealed that there was one-quarter pound of American cheese open to air and undated, 15 scones open to air and undated, six Danish open to air and undated, one apple pie open to air and undated, one blueberry open to air and undated, abd one bag of brownie mix half full open	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0812 SS=E	Continued from page 69 to air and undated. Observations in the kitchenette on March 19, 2025, at 11:45 a.m. revealed that Nurse Aide 3 walked into the kitchenette past the food prep to obtain mustard packs and was not wearing a hair net. Interview with the Executive Chef on March 17, 2025, at 9:35 p.m. confirmed that the food listed above should have been covered and dated. Interview with Nursing Home Administrator on March 19, 2025, at 3:25 p.m. confirmed that Nurse Aide 3 should have been wearing a hairnet while walking into the kitchenette past the food prep. 28 Pa. Code 201.18(e) (2.1) Management. 28 Pa. Code 211.6(f) Dietary Services.	F 0812		
F 0849 SS=E		F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0849 SS=E	Continued from page 70 483.70(n)(1)-(4) Hospice Services §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	A communication was made to the hospice team to ensure all documentation was made available in resident 35's electronic medical record (EMR) as it relates to weekly wound assessment/measurements for the weeks of September 8 through 14, 2024; September 15 through 21, 2024; September 22 through 28, 2024; September 29 through October 5, 2024; October 6 through 12, 2024; October 13 through 19, 2024; and November 17 through 22, 2024. A sweep of all hospice caseloads was conducted to ensure all wound records of hospice services were rendered into the patient's EMR. Any issues identified were corrected at the time of discovery. The skilled nursing interdisciplinary team (IDT) and hospice IDT members were re-educated on having all records of hospice services rendered to the patient available in the patient's electronic medical record. The risk management assistant or designee will conduct audits to	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0849 SS=E	Continued from page 71 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849	ensure all wound documentation of hospice services rendered is made available in the hospice patient's electronic medical record weekly X4 weeks, monthly X2 months. Identified issues will be addressed at the time of discovery. Audit results are reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education/re-education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0849 SS=E	Continued from page 72 drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202	6 GARDEN CENTER DRIVE GREENSBURG, PA 15601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0849 SS=E	Continued from page 73 capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0849 SS=E	Continued from page 74 orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**
STATE LICENSE NUMBER: **073202**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0849 SS=E	Continued from page 75 Based on review of hospice contracts, facility policies, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the designated interdisciplinary team member obtained the required information from the contracted hospice provider for one of 38 residents reviewed (Resident 35) who received hospice services. Findings include: An agreement between the facility and a hospice provider (provider of end-of-life services), dated March 5, 2021, indicated that it is hospice's responsibility to provide services under this agreement at the same level and to the same extent as those services would be provided if the facility resident were in his or her own home. That all records of hospice services rendered to the patient may be accessed if needed. The facility's policy regarding hospice care (specialized care that provides physical comfort and	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0849 SS=E	Continued from page 76 emotional, social and spiritual support for people nearing the end of life), dated September 27, 2024, revealed that relative to patient care and services, the hospice provider is responsible for providing usual and customary hospice services as well by noting any pertinent information relative to each visit provided throughout the course of care. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 35, dated December 14, 2024, revealed that the resident was understood, could understand others, and received hospice care. A care plan for the resident, dated May 10, 2024, revealed that the resident had a Stage 3 pressure ulcer (involves full-thickness skin loss, extending into the subcutaneous tissue layer, but not reaching muscle, tendon, or bone) and staff was to document weekly the treatment, and was to include the measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (fluid, cells, or cellular debris that leaks out of blood vessels and deposits into soft tissues, cavities, or	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0849 SS=E	Continued from page 77 wounds). A care plan, dated September 6, 2024, revealed that the resident was ordered hospice, and staff was to work cooperatively with the hospice team to ensure that his spiritual, emotional, intellectual, physical and social needs were met. A nursing note for Resident 35, dated September 1, 2024, revealed that the resident was readmitted to the facility from the hospital and that the resident had an open area on his coccyx (tailbone area) that measured six centimeters (cm) by five cm by one cm. Review of Resident 35's clinical record and the hospice provider's clinical record revealed no documented evidence of the weekly wound assessments/measurements being completed during the week of September 8 through 14, 2024; September 15 through 21, 2024; September 22 through 28, 2024; September 29 through October 5, 2024; October 6 through 12, 2024; October 13 through 19, 2024; and November 17 through 22, 2024.	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**
STATE LICENSE NUMBER: **073202**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0849 SS=E	Continued from page 78 Interview with the Director of Nursing on March 20, 2025, at 11:25 a.m. confirmed that hospice was following Resident 35's wounds during their visits, and that hospice did not provide any documented evidence of their weekly wound assessments/measurements being completed on the above dates. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0849		
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 79 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Resident 48 had no adverse reactions from Registered Nurse 1's providing wound care without wearing a gown per enhanced barrier precautions (EBP) protocol. Resident 48 has since been discharged in good condition from the facility. Registered Nurse 1 was immediately re-educated on EBP precautions and proper hand hygiene. A facility-wide sweep was conducted of all in-house residents with wounds requiring EBP to ensure EBP is followed during wound / skin treatments. Any issues identified were corrected at the time of discovery. All licensed therapists and nursing staff were re-educated on EBP protocol and proper hand hygiene. The Infection Control Preventionist or Designee will conduct spot-check audits to ensure EBP protocol is being followed along with proper hand hygiene during wound/skin treatments for weekly X4 weeks and monthly X2 months. Identified issues will be addressed at the time of discovery.	Completion Date: **04/12/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202	6 GARDEN CENTER DRIVE GREENSBURG, PA 15601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 80 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	Audit results are reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education/re-education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 81	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**
STATE LICENSE NUMBER: **073202**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 82 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed during the administration of a treatment for one of 38 residents reviewed (Residents 48). Findings include: The facility policy regarding enhanced barrier precautions (EBP), dated September 27, 2024, revealed that an order for EBP will be obtained for residents with wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a multi-drug resistant organism (MDRO). Gowns and gloves will be available near or outside of the resident's room. Personal protective equipment (PPE - clothing and equipment that is worn or used	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 83 in order to provide protection against hazardous substances or environments) for EBP is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. High-contact resident care activities include wound care (any skin opening requiring a dressing). EBP will be used for the duration of the affected resident's stay in the facility or until resolution of the wound. The facility policy regarding handwashing, dated September 27, 2024, included that hands are to be washed before and after taking care of individual residents and when they become soiled in process of resident care. Hands should be washed after glove removal. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs)for Resident 48, dated January 21, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnosis that included a	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 84 left hip fracture, diabetes, and dementia. Physician's orders for Resident 48, dated March 16, 2025, included an order for the resident to have his bilateral heels cleansed with Vashe (a wound cleanser), pat dry, UrgoClean Ag (a wound dressing that supports the continuous debridement of dead tissue with the benefit of silver) and foam bordered dressings applied and secured with rolled gauze every other day for pressure ulcer. Observations on March 20, 2025, at 10:14 a.m. revealed that Registered Nurse 1 provided wound care to Resident 48's right and left heels without wearing a gown. Registered Nurse 1 removed the soiled dressing from Resident 48's left foot, removed her gloves, and donned clean gloves without performing hand hygiene. Interview with Registered Nurse 1 at that time confirmed that she should have washed her hands after removing the soiled gloves and prior to donning clean gloves. An interview with Registered Nurse 1 on March 20,	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=D	Continued from page 85 2025, at 10:40 a.m. confirmed that Resident 48 should have been on enhanced barrier precautions due to having wounds; however, there was no EBPs in place and no EBP supplies available in the resident's room. An interview with the Nursing Home Administrator on March 20, 2025, at 1:19 p.m. confirmed that EBP was not in place for Resident 48 and should have been. An interview with the Nursing Home Administrator on March 20, 2025, at 2:21 p.m. confirmed that Registered Nurse 1 should have washed her hands after glove removal and prior to donning clean gloves, and a gown should have been worn during Resident 48's treatment administration. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0880		

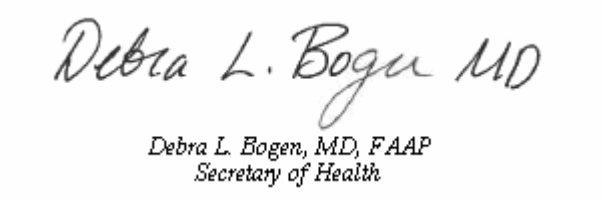
Certified End Page

REDSTONE HIGHLANDS HEALTH CARE CTR

STATE LICENSE NUMBER: 073202

SURVEY EXIT DATE: 03/20/2025

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



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY