

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Hilltop Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 S. Cayuga Avenue Altoona, PA 16602	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record reviews and staff interviews, it was determined that the facility failed to administer medications as ordered by the physician for three of 36 residents reviewed (Residents 11, 13, 124). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated November 12, 2025, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnoses that included coronary artery disease (a disease that limits blood flow to the heart caused by plaque buildup in the arteries) and orthostatic hypotension (low blood pressure when standing quickly). Physician's orders for Resident 11, dated August 11, 2025, included an order for the resident to receive 5 milligrams (mg) of Midodrine (a medication that treats low blood pressure) two times a day for orthostatic hypotension (a drop in blood pressure when changing positions like sitting to standing) and was to be held if the systolic blood pressure (SBP-the top number in a blood pressure reading) was greater than 120 millimeters of mercury (mmHg). A review of Resident 11's Medication Administration Record (MAR) for August, September, and October 2025 revealed that staff administered the 5 mg of Midodrine when the resident's blood pressure was 134/72 mmHg at 8:00 a.m. on August 17; 128/72 mmHg at 5:00 p.m. on August 23; 123/66 mmHg at 8:00 a.m. on August 26; 124/64 mmHg at 8:00 a.m. on September 12; and 126/82 mmHg at 5:00 p.m. on October 6. There was no documented evidence that the Midodrine was held as ordered on the above-mentioned dates/times. Interview with the Director of Nursing on December 10, 2025, at 1:50 p.m. confirmed that Resident 11 received the Midodrine on the above-mentioned dates/times and that staff should have held the medication as ordered. An admission MDS assessment for Resident 13, dated October 9, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs and had diagnoses that included coronary artery disease (a disease that limits blood flow to the heart caused by plaque buildup in the arteries), heart failure, and high blood pressure. Physician's orders for Resident 13, dated July 21, 2025, included an order for the resident to receive 10 mg of Midodrine two times a day for low blood pressure and was to be held if the systolic blood pressure (SBP-the top number in a blood pressure reading) was greater than 120 millimeters of mercury (mmHg). A review of Resident 13's Medication Administration Record (MAR) for July and August 2025 revealed that staff administered the 10 mg of Midodrine when the resident's blood pressure was 126/74 mmHg at 8:00 a.m. on July 16, 2025; 136/74 mmHg at 5:00 p.m. on August 1, 2025; 142/80 mmHg at 5:00 p.m. on August 5, 2025; 130/67 mmHg at 5:00 p.m. on August 25, 2025; and 130/70 mmHg at 5:00 p.m. on August 10, 2025. There was no documented evidence that the Midodrine was held as ordered on the above-mentioned dates/times. Interview with the Director of Nursing on December 10, 2025, at 1:50 p.m. confirmed that Resident 13 received the Midodrine on the above-mentioned dates/times and that staff should have held the medication as ordered. A nursing note for Resident 124 dated December 1, 2025, indicated that he was to be a new admission to the facility from the hospital, and he had diagnoses that included orthostatic hypotension and a recent fall. His orientation (cognition) changes, but at times he is alert and oriented to person, place, time, and condition. Physician's orders for Resident 124, dated December 2, 2025, included an order for the resident to receive 10 mg of Midodrine three times a day for hypotension (low blood pressure) and was to be held if the systolic (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395241	If continuation sheet Page 1 of 10

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood pressure was greater than 120 mmHg. A review of Resident 124's Medication Administration Record (MAR) for December 2025 revealed that staff administered the 10 mg of Midodrine when the resident's blood pressure was 148/96 mmHg at 8:00 p.m. on December 2, 2025; 122/76 mmHg at 8:00 p.m. on December 3; 130/72 mmHg at 8:00 a.m. on December 4; 124/83 mmHg at 4:00 p.m. on December 4; and 126/80 mmHg at 8:00 p.m. on December 7; 158/76 mmHg at 4:00 p.m. on December 8; 132/78 mmHg at 8:00 a.m. on December 9; 148/76 mmHg at 8:00 a.m. on December 10. There was no documented evidence that the Midodrine was held as ordered on the above-mentioned dates/times. Interview with the Nursing Home Administrator on December 11, 2025, at 12:14 p.m. confirmed that Resident 124 received the Midodrine on the above-mentioned dates/times and that staff should have held the medication as ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on a review of facility policy as well as observations and staff interviews, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: The facility's policy for Dietary Staff Attire, dated November 20, 2025 indicated that all employees must wear approved attire for the performance of their duties. All staff members will have their hair off the shoulder, confined in a hair net or cap, and facial hair properly restrained. Observations of Dietary Aide 2 on December 10, 2025, at 12:00 p.m. revealed no beard/mustache covers in place while he was preparing the lunch meal trays. Interview on December 10, 2025, at 12:00 p.m. with Assistant Dietary Manager 1 confirmed that Dietary Aide 2 should have his beard and mustache covered when preparing food. The facility's policy for Food Receiving and Storage, dated November 20, 2025, indicated that all foods belonging to residents must be labeled with the resident's name, the item, and the use by date. Partially eaten food may not be kept in the refrigerator. Beverages must be dated once opened and discarded after twenty-four hours. Observation on December 8, 2025, at 12:20 p.m. revealed that the solarium refrigerator on C wing had resident food items and beverages that were opened and not labeled with resident names or use by dates. These items included Kens salad dressing, a partially eaten Three Musketeers candy bar, and two bottles of Gatorade beverages. Interview at 12:26 p.m. on December 8, 2025, with Licensed Practical Nurse (LPN) 3 on C wing verified that the food items should be labeled and dated once they are opened. Interview at 11:49 a.m. on December 10, 2025, with Assistant Dietary Manager 1 confirmed that the food should have been labeled and dated once opened. 28 Pa. Code 211.6(f) Dietary services. ^		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to inform the resident and/or resident representative in advance of the risks and benefits of psychotropic medication (medications that affect the persons mental state, emotions and behavior) use and the treatment alternatives prior to initiating the administration of the medication for one of 36 residents reviewed (Resident 32). Findings Include: The facility's policy related to the use of psychotropic medications, dated November 20, 2025, indicated that residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: indications for use; dose (including duplicate therapy); duration; adequate monitoring for efficacy and adverse consequences; and preventing, identifying and responding to adverse consequences. When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts an evaluation of the resident. The evaluation will attempt to clarify whether: other causes for symptoms (including symptoms that mimic a psychiatric disorder) have been ruled out; signs and symptoms are clinically significant enough to warrant medication therapy; a particular medication is clinically indicated to manage the symptoms or condition; and the actual or intended benefit of the medication is understood by the resident/representative. Residents (and/or representatives) have the right to decline treatment with psychotropic medications. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 32, dated September 4, 2025, revealed that the resident was cognitively intact, was able to be clearly understood and was able to clearly understand others, received antidepressant medications (psychotropic medication used to treat depression) and antianxiety medications (psychotropic medication used to treat anxiety) and had diagnoses that included depression, anxiety and bipolar disorder (a mental health condition causing mood swings including emotional highs and lows). A psychiatric note for Resident 32, dated September 16, 2025, included recommendations to increase her Prozac (an antidepressant medication) from 50 milligrams (mg) to 70 mg daily for depression/anxiety and increase her Buspar (an antianxiety medication) from 15 mg three times a day to 30 mg twice daily for anxiety. Physician's orders for Resident 32, dated September 16, 2025, revealed that the resident was to receive 70 mg of Prozac daily for depression. Physician's orders for Resident 32, dated September 16, 2025, revealed that the resident was to receive 30 mg of Buspar twice daily for depression/anxiety. There was no documented evidence in Resident 32's clinical record to indicate that the resident/resident representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the increased dose of Prozac and Buspar. Interview with the Nursing Home Administrator on December 11, 2025, at 2:23 p.m. confirmed that there was no documented evidence in Resident 32's clinical record that the resident/resident representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the increased dose of Prozac and Buspar. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(2) Management.28 Pa. Code 201.29(a): Resident rights.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on review of facility policies and clinical records, as well as staff and resident interviews, it was determined that the facility failed to honor a resident's right regarding diet consistency for one of 36 residents reviewed (Resident 105). Findings include: A facility policy regarding Promoting/Maintaining Resident Self-Determination/Resident Right to Refuse, dated November 20, 2025, indicated that the facility shall ensure that all residents are afforded their right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration and privacy in treatment and care for personal needs and communication with and access to persons and services inside and outside the facility. The facility shall protect and promote the rights of each resident and shall encourage and assist each resident in the fullest possible exercise of these rights. Each resident shall have the right to participate in planning his/her care and treatment or any change in his or her care and treatment. Each resident shall have the right to refuse medication and treatment after being fully informed and understanding the probable consequences of such actions. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 105, dated November 23, 2025, revealed that the resident was cognitively intact, was understood and able to understand others, received a mechanically altered diet and had coughing and choking during meals or when swallowing medications. An interview with Resident 105 on December 8, 2025, 11:37 a.m. revealed that she was put on a mechanical food because they said she choked, but she did not choke. She stated that she was to be reassessed today by speech therapy. Physician's orders for Resident 105, dated December 8, 2025, indicated that she was to receive a dysphagia advanced texture diet (Moistened ground meats, fork mashable fruits and vegetables, no raw vegetables, no raw fruit with skin, no hard, toasted or crusty breads, no corn, peas, potato skins, tough or crisp fried potatoes, no dry cookies or cakes). A speech therapy note for Resident 105, dated November 19, 2025, indicated that the resident was referred to therapy by staff for coughing with intake and the resident voiced difficulties chewing/swallowing. The resident stated no recollection of difficulties swallowing or reporting any difficulties swallowing. She stated she consumed regular foods and thin liquids just fine and did not know why her diet was downgraded. The resident expressed that she would prefer to be on a regular diet. A speech therapy note for Resident 105, dated December 2, 2025, indicated that the resident trialed regular Salisbury steak following complaints about her new diet of ground meats (I don't know why they changed me to that! I don't want that shit). She took large bites and experienced a near choking episode, exhibiting redness in the face, watery eyes, and forceful coughing that expelled a bite of meat from the airway. Speech therapy removed the steak for safety and was educated regarding the risk of choking and potential need for emergency intervention (e.g. Heimlich). She was in denial about her need for modified textures, stating that this was rare and she can eat just fine. She continues to demonstrate poor safety awareness with rapid intake, large bites and talking during eating. A speech therapy note for Resident 105, dated December 4, 2025, indicated that the resident was ordered a mechanical soft diet. She stated that she did not like the diet consistency and wants back on a regular diet. Speech therapy spoke with the resident about what happened the last therapy session. She was educated and denied any difficulty chewing/swallowing. She was educated to use small bites, use a slow rate, and alternate solids and liquids and verbally communicated understanding. A speech therapy note for Resident 105, dated December 8, 2025, indicated that the resident was ordered a dysphagia mechanical soft diet. She stated said she did not understand why her breads and sides were now coming pureed. She was educated on the new diet texture system and how the mechanical soft diet now consists of pureed sides. She stated she would not eat the pureed sides. Staff indicated the resident had been found snacking on pretzel rods and crackers. Trialed peanut butter and jelly sandwich and diced fruit during the session and she only needed verbal cues twice with no difficulties chewing/swallowing. It was (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determined that the resident does not need pureed sides. Recommended diet upgrade to dysphagia advanced diet and she will continue to get ground meats. A speech therapy note for Resident 105, dated December 9, 2025, indicated that the resident was ordered an advanced diet. The resident stated again that she did not like the ground meats. Insisted she has no trouble chewing or swallowing and does not need her meats ground. Speech therapy planned to trial regular meats again next session. A speech therapy note for Resident 105, dated December 10, 2025, indicated that the resident was ordered a dysphagia advanced diet and trialed regular ham. On this diet meats are ground. Resident said she does not like the ground meat and would rather get whole meat. No coughing or throat clearing and no overt signs and symptoms of aspiration observed. She had improved performance with regular solids. Speech therapy would like to complete additional trials to ensure consistent performance prior to upgrade being indicated. Interview with the Speech Therapist on December 10, 2025, at 4:13 p.m. indicated that she was the speech therapist that worked with Resident 105 on December 2, 2025, when she coughed when eating regular textured Salisbury steak. She indicated that the resident was taking big bites and had started to cough forcefully. She indicated that during the episode, the resident was still able to cough and talk throughout the episode until she expelled small pieces of chewed up Salisbury steak, not a large chunk. After the episode she educated the resident about her concern and why she needed the altered diet. She indicated that she was aware that the resident did not want the altered diet but stated that due to safety concerns, she would only recommend the safest diet for the resident. Interview with the Director of Nursing on December 10, 2025, at 4:40 p.m. indicated that if a resident preferred to request a regular diet, as Resident 105 had, despite recommendations from speech therapy for an altered diet related to safety, they would educate the resident on the risks and check with the physician to see if they would agree to order the resident's preferred diet. If the physician agreed, they would have the resident sign a waiver. Interview with Resident 105 on December 11, 2025, at 12:10 p.m. indicated that she was upset and wanted to know who was saying she had an issue with choking. She stated that she coughed on a piece of a popcorn haul one time and was told she was choking. She stated that she had no difficulty with chewing or swallowing. She stated that she remembered the day the Speech therapist saw her and she coughed on a small piece of meat. She indicated that she was speaking when she inhaled and a small piece of meat got caught in her throat and caused her to cough. She also remembered trialing regular ham recently and indicated that she had no issues with that. She indicated that she gets chopped meats right now and does not want it. She stated that she did not want to wait until the speech therapist allows her to eat regular meats and would rather she be changed back to regular meats now. Interview with the Nursing Home Administrator on December 11, 2025, at 2:23 p.m. confirmed that Resident 105 is cognizant and able to make her own decisions. She indicated that her choices should be honored and if she wanted a regular diet, she should have one. She indicated that she would talk with her today and see if the physician would change her order. 28 Pa. Code 201.29(j) Resident Rights.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policies 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 two of 36 residents reviewed (Residents 13, 14). Findings include: A facility policy regarding care plans, dated November 20, 2025, indicated that the facility will develop a care plan that describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and that assessment of resident's are ongoing and care plans are revised as information about the residents and the resident's conditions change. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated October 10, 2025, indicated that the resident was cognitively impaired, required assistance with care needs, and had an indwelling catheter (a flexible tube left inside the bladder for continuous urine drainage). A care plan for Resident 13's indwelling catheter (Foley), dated February 18, 2025, indicated that the resident was to have an 18F 10cc foley catheter in place. Physician's orders for Resident 13, dated August 27, 2025, included an order for the resident to have a 16F 10cc foley catheter. Observations of Resident 13 on December 11, 2025, at 10:17 a.m. revealed the resident had a 16F 10cc foley catheter in place. Interview with the Director of Nursing on December 11, 2025, at 11:05 p.m. confirmed that Resident 13's care plan should have been updated to reflect the current foley catheter size. A quarterly MDS assessment for Resident 14, dated October 10, 2025, indicated that the resident was cognitively impaired with a Brief Interview for Mental Status (BIMS-a cognitive assessment tool used to evaluate memory and thinking abilities with scores ranging from 0-15 with lower numbers indicating more significant cognitive impairment) score of 6, and required partial assistance from staff for care. The resident's falls care plan, dated February 2, indicated that the resident had a BIMS of 13 and was alert and oriented. Interview with the Director of Nursing on December 10, at 12:30 p.m. confirmed that Residents 14's fall care plan was inaccurate and should not have indicated that the resident's BIMS was a 13 and that the resident was alert and oriented. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of 35 residents reviewed (Resident 53). Findings include: An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 53, dated October 9, 2025, revealed that the resident was cognitively intact, and had diagnoses that included diabetes. Physician's orders for Resident 53 dated October included an order for the resident to have blood sugars checked twice a day and if blood sugar is less than 70 mg/dL to follow the hypoglycemia protocol, and if the blood sugars are greater than 400 mg/dL to notify the medical doctor and registered nurse supervisor. Review of the Medication Administration Record (MAR) for Resident 53 for October and November revealed no documented evidence of the blood sugars for the resident from October 6, 2025 at 2000 to November 15, 2025 at 0630. Interview with the Director of Nursing on December 11, 2025, at 2:46p.m. confirmed that the blood sugars were obtained but not documented in the MAR and they should have been. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plan of corrections for an annual survey ending January 17, 2025 revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending December 11, 2025, identified repeated deficiencies related to a failure to revise care plans, prepare and store food safely, and ensure infection prevention policies are being followed. The facility's plan of correction for care plan revision, cited during the survey ending January 17, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that care plans were revised as needed. The facility's plan of correction for a deficiency regarding proper food storage cited during the survey ending January 17, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that food was stored safely. The facility's plan of correction for a deficiency regarding proper food storage, preparation and serving, cited during the survey ending January 17, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that food was stored, prepared and served properly. The facility's plan of correction for a deficiency regarding the implementation of their infection control program, cited during the survey ending January 17, 2025 revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F880, revealed that the facility's QAPI committee failed to successfully implement their infection control program. Refer to F657, F812, F880. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of facility 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 while administering medications for one of 36 residents reviewed (Resident 30). Findings include: The facility's medication administration policy, dated November 20, 2025, indicated that staff was to follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications as applicable. Physician's orders for Resident 30, dated May 14, 2025 included orders for the resident to receive 10 milligram (mg) of oxycodone (a controlled substance used to treat pain), 250 mg of azithromycin (an antibiotic), 5 mg of prednisone (a steroid), 20 mg of Lasix (a diuretic), 25-250 mg of Sinemet (a medication to treat Parkinson's disease), one puff of 100/6.2/25 micrograms (mcg) Trelegy inhaler, 2-2.6 mg of senna (a medication to help treat constipation), 20 mg Pepcid (a medication to treat acid reflux), Vitamin B-12, and 60 mg Cymbalta (a medication to treat depression). Observations during medication administration on December 10, 2025 at 8:05 a.m. revealed that while preparing medications for Resident 30, Licensed Practical Nurse 4 did not perform hand hygiene prior to preparing medication or after administration when she began to prepare medication for the next resident. Interview with Licensed Practical Nurse 4 on December 10, 2025, at 8:11 a.m. revealed that she does not perform hand hygiene after each resident; she will do hand hygiene after 3 residents. Interview with the Director of Nursing on December 10, 2025, at 10:37 a.m. confirmed that Licensed Practical Nurse 4 should have performed hand hygiene between each resident. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		