

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

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER Heritage Ridge Senior Living at Johnstown		STREET ADDRESS, CITY, STATE, ZIP CODE 807 Goucher Street Johnstown, PA 15905	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of the Pennsylvania Nursing Practice Act and 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 obtain urine culture results timely for treatment of a urinary tract infection, resulting in a delay in treatment for one of five residents reviewed (Resident 1). 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 mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 6, 2026, revealed that the resident was cognitively impaired, required assistance with care needs, had an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), was incontinent of bowel, and had diagnoses that included neuromuscular disfunction of the bladder (bladder lacks control due to nerve or muscle problems), UTI in the last 30 days and sepsis (a serious, life-threatening bodily response to infection). A nursing note for Resident 1, dated April 6, 2026, at 1:57 p.m. revealed that the nurse was alerted by the social worker that the resident stated during their visit that her pee burns. The registered nurse was notified and the resident was put on the list for the physician. A physician's order for Resident 1, dated April 8, 2026, included an order for staff to obtain a urine specimen for a urinalysis (tests urine to check for infection) to reflux (urine culture is performed if the initial urinalysis detects indicators of a potential infection). A nursing note for Resident 1, dated April 9, 2026, at 10:39 p.m. indicated that the urine results showed 2+ bacteria (moderate amount of bacteria present which often suggests a urinary tract infection) and the physician was made aware. A nursing note for Resident 1, dated April 21, 2026, at 5:19 a.m. revealed that the resident was noted to have rapid respirations, bloody stools and blood in her foley catheter tubing. Physician's orders were received for stat bloodwork. A nursing note for the resident, dated April 21, 2026, at 9:21 p.m. revealed that the Certified Registered Nurse Practitioner (CRNP) reviewed the bloodwork and ordered a urinalysis to reflux. A physician's order for Resident 1, dated April 21, 2026, included an order for staff to obtain a urine specimen for a urinalysis to reflux. A nursing note for Resident 1, dated April 22, 2026, at 5:35 p.m. revealed that the urinalysis results showed 4+ bacteria (a large amount of bacteria suggesting a urinary tract infection and nitrites (occur in urine when there is a urinary tract infection), and a culture and sensitivity (identifies the specific bacteria and determines which medications will successfully treat it) was pending. A new order was obtained for the resident to start Bactrim DS (an antibiotic) twice daily for seven days. Urine culture and sensitivity results for Resident 1 for the urinalysis performed on April 9, 2026, and obtained by the facility on May 13, 2026, at 12:52 p.m. revealed that the resident had a urinary tract infection. Review of Resident 1's clinical record revealed no documented evidence that the culture and sensitivity results were obtained for the physician to review, delaying treatment of the resident's urinary tract infection. Interview with the Director of Nursing on May 13, 2026, at 2:58 p.m. confirmed that there was no documented evidence that Resident 1's urine culture and sensitivity results from (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
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the urinalysis performed on April 9, 2026, were obtained and reviewed by the physician. 28 Pa. Code 211.12(d)(1)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on review of facility policies, clinical records, observations, shower schedules, as well as staff and resident interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for two of five residents reviewed (Residents 3 and 5). Findings include: The facility policy for bathing and showering, dated August 21, 2025, indicated that residents are bathed or showered to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Document if the resident refused the shower/tub bath, the reason why and the intervention taken. Notify the supervisor if the resident refuses the shower/tub bath. An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 3, dated April 17, 2026, revealed that the resident was cognitively impaired, was able to usually understand others, was dependent on staff for showers/bathing, was incontinent of bowel and bladder, had moisture associated skin damage (inflammation of the skin caused by exposure to moisture), and had diagnoses including diabetes and obesity. Observations of Resident 3 on May 12, 2026, at 11:05 a.m. revealed that she was fully dressed and sitting in hallway in her wheelchair. Review of the activities of daily living (ADL) documentation for Resident 3 from April 2026, through May 12, 2026, revealed that she was to receive a shower twice weekly on Tuesdays and Fridays on the day shift. Showers were documented as not given on April 14, April 17, April 28, May 8 and May 12 in the ADLS documentation and in the tasks and there was no documented evidence that the resident refused her showers. An admission MDS assessment for Resident 5, dated May 6, 2026, revealed that the resident was cognitively intact, required maximum/substantial assistance from staff for showers/bathing, was occasionally incontinent of bowel and bladder, had a Stage 2 pressure ulcer and a diabetic foot ulcer and had diagnoses including diabetes and morbid obesity. Interview with Resident 5 on May 12, 2026, at 10:59 a.m. indicated that she had not had a shower since she was admitted to the facility, but did get one yesterday, finally. She stated she was supposed to get them twice a week on Thursdays and Sundays in the evening and the previous Thursday (May 7), the nurse aide said she would come back after supper to give her a shower and she did not. On Mother's day (May 10), the nurse aide never came to get her for a shower. Review of the activities of daily living (ADL) documentation for Resident 5 for May 2026, revealed that she was to receive a shower twice weekly on Sundays and Thursdays on the evening shift. Showers were documented as not given on May 3, May 7 and May 10 in the ADLS documentation and in the tasks and there was no documented evidence that the resident refused her showers. Interview with the Director of Nursing on May 12, 2026, at 2:58 p.m. confirmed that there was no documented evidence that Resident 3 and Resident 5 received and/or refused their showers on the above-mentioned dates. 28 Pa. Code 211.12(d)(5) Nursing services.		