STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395439	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Ridge Senior Living at Johnstown	807 Goucher Street Johnstown, PA 15905

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48941 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or resident representative had an opportunity to develop an advance directive (instructions regarding the provision of health care when the resident is incapacitated) or assist in formulating an advance directive for one of 29 residents reviewed (Resident 33). Findings include: The facility policy regarding advance directives, dated January 20, 2025, indicated that upon admission, the resident or resident representative will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. If the resident or resident representative indicates that he or she has not established advance directives, the healthcare center staff will offer assistance in establishing advance directives. The resident or resident representative will be given the option to accept or decline the assistance, and care will not be contingent on either decision. Nursing staff will document in the medical record the offer to assist, and the resident's or resident representative's decision to accept or decline assistance. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 33, dated November 26, 2024, revealed that the resident was mildly cognitively impaired, required supervision to independent with care needs, had verbal behavioral symptoms expressed towards others occurring one to three days in the look-back period, and had diagnoses that included schizoaffective disorder (a mental health condition and mood disorder), bipolar disorder (a mood disorder), anxiety, depression and post-traumatic stress disorder (a mental and behavioral disorder that develops related to a terrifying event). Review of Resident 33's medical records indicated that they did not have advance directives. There was no documented evidence in the resident's clinical record that the resident and/or resident representative was given the opportunity to formulate an advance directive, and no documented evidence of the resident's and/or resident representative's decision regarding formulating advanced directives. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on February 12, 2025, at 12:39 p.m. confirmed that there was no documented evidence in Resident 33's medical records that the resident and/or resident representative was given the opportunity to formulate an advance directive, and no documented evidence of the resident's and/or resident representative's decision regarding formulating advanced directives. 28 Pa. Code 201.29(a)(d) Resident Rights.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 28177 Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's attending physician was notified about medication refusals of insulin and requests to speak to the physician for one of 29 residents reviewed (Resident 26). Findings include: An admission MDS assessment for Resident 26, dated January 14, 2025, revealed that the resident was cognitively intact, required assistance with personal care needs, and had diagnoses that included stroke and diabetes. Physician's orders for Resident 26, dated January 7, 2025, included an order for the resident to receive six units of insulin lispro (fast-acting insulin to treat high blood sugar) daily with lunch and dinner. Review of the MAR for January 2025 and February 2025 revealed that the resident refused her dinnertime dose on January 21, 27, and 30, and February 4 and 8, 2025. Physician's orders for Resident 26, dated January 8, 2025, included an order for the resident to receive 18 units of insulin lispro daily with breakfast. Review of the MAR, dated January 2025 and February 2025, revealed that the resident refused this dose on January 28 and February 1, 2, 7, and 11. Physician's orders for Resident 26, dated January 20, 2025, included an order for the resident to receive 48 units of insulin glargine (long-acting insulin used to treat high blood sugar) at bedtime. Review of the MAR, dated January 2025 and February 2025, revealed that the resident refused her bedtime insulin on January 30 and February 9. A nurse's note for Resident 26, dated February 1, 2025, at 1:49 p.m., revealed that the resident was refusing her insulins, stating that the amount of insulin was too high. The physician was aware and was to review insulin and medications on rounds Monday, February 3, 2025. A Medication Administration Note for Resident 26, dated February 2, 2025, at 8:24 a.m., revealed that the resident was refusing her morning insulin until she clarifies the dosage with the physician. A certified registered nurse practitioner (a registered nurse with advanced training and education) note for Resident 26, dated February 3, 2025, at 12:47 p.m., revealed that the resident reported concerns of insulin management, and the resident was encouraged to discuss that with the doctor. There was no documented evidence in Resident 26's clinical record as of February 11, 2025, that the physician was made aware that the resident's continued refusal of some of her ordered insulin doses until she clarified with her physician or that the insulin dosage was addressed by the physician as requested by the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on February 12, 2025, at 3:00 p.m. confirmed that the physician was not notified of Resident 26's request for clarification of insulin doses and continued refusals and should have been.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46994 Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident and/or resident's representative and the ombudsman in writing of the transfer and reason for hospitalization for four of 29 residents reviewed (Residents 13, 23, 33, 37). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated November 26, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnosis that included heart failure and diabetes. A nurse's note for Resident 13, dated May 13, 2024, at 6:30 p.m., revealed that the resident was observed lying on the floor in his room with bleeding observed from above his left eyebrow and above his left ear. The resident was transferred to the emergency room for evaluation and treatment. There was no documented evidence that a written notice of Resident 13's transfer to the hospital was provided to the resident and/or resident representative and the ombudsman regarding the reason for the transfer. A quarterly MDS assessment for Resident 23, dated January 14, 2025, revealed that the resident was cognitively intact, was dependent on staff for daily care needs, and had diagnosis that included metabolic encephalopathy (a change in how your brain works due to an underlying condition). A nurse's note for Resident 23, dated October 13, 2024, at 6:30 p.m., revealed that the resident was unable to answer orientation questions or hold a meaningful conversation and was transported to the emergency room for evaluation and treatment. There was no documented evidence that a written notice of Resident 23's transfer to the hospital was provided to the resident and/or resident representative and the ombudsman regarding the reason for the transfer. A quarterly MDS assessment for Resident 33, dated November 26, 2024, revealed that the resident was mildly cognitively impaired, required supervision to independent with care needs, and had diagnoses that included schizoaffective disorder (a mental health condition and mood disorder), bipolar disorder (a mood disorder), and post-traumatic stress disorder (a mental and behavioral disorder that develops related to a terrifying event). A nursing note for Resident 33, dated October 14, 2024, at 1:07 p.m., revealed that a crisis representative arrived at the facility and spoke with resident. The resident was agreeable to be sent to the hospital for a mental health evaluation, and the resident was transported to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that a written notice of Resident 33's transfer to the hospital was provided to the resident and/or resident representative and the ombudsman regarding the reason for the transfer. A quarterly MDS assessment for Resident 37, dated December 4, 2024, revealed that the resident was cognitively intact, required assistance with care needs, and had diagnoses that included diabetes, obstructive uropathy (blockage of the urinary tract), and renal insufficiency (kidneys lose the ability to remove waste and balance fluids). A nursing note for Resident 37, dated October 14, 2024, at 11:48 a.m., revealed that the resident had abnormal blood work and reports of intermittent nausea and vomiting. The certified registered nurse practioner was notified, and the resident was transferred to the hospital for further evaluation. A nursing note for Resident 37, dated November 17, 2024, at 5:25 a.m., revealed that the resident's left nephrostomy tube (thin flexible tube inserted into the kidney through the skin to drain urine directly into a collection bag) was dislodging. The physician was notified, and the resident was transferred to the hospital. A nursing note for Resident 37, dated January 18, 2025, at 12:44 p.m., revealed that the resident's nephrostomy tube was hanging out of the site several inches past the stitch that would have secured it to the skin. The physician was notified, and the resident was transferred to the hospital. There was no documented evidence that a written notice of Resident 37's transfers to the hospital were provided to the resident and/or resident representative and the ombudsman regarding the reason for the transfers. Interview with the Nursing Home Administrator on February 12, 2025, at 3:20 p.m. confirmed that the facility did not provide a written notice to the above residents and/or their representative and ombudsman regarding the reason for the transfer to the hospital on the above-mentioned dates. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 46994 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to provide a written notice of the facility's bed-hold policy to the resident and/or the resident's representative at the time of a transfer for four of 29 residents reviewed (Residents 13, 23, 33, 37). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated November 26, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnosis that included heart failure and diabetes. A nurse's note for Resident 13, dated May 13, 2024, at 6:30 p.m., revealed that the resident was observed lying on the floor in his room with bleeding observed from above his left eyebrow and above his left ear. The resident was transferred to the emergency room for evaluation and treatment. There was no documented evidence that a bed-hold notice was provided to Resident 13 or his responsible party. A quarterly MDS assessment for Resident 23, dated January 14, 2025, revealed that the resident was cognitively intact, was dependent on staff for daily care needs, and had diagnosis that included metabolic encephalopathy (a change in how your brain works due to an underlying condition). A nurse's note for Resident 23, dated October 13, 2024, at 6:30 p.m., revealed that the resident was unable to answer orientation questions or hold a meaningful conversation and was transported to the emergency room for evaluation and treatment. There was no documented evidence that a bed-hold notice was provided to Resident 23 or his responsible party. A quarterly MDS assessment for Resident 33, dated November 26, 2024, revealed that the resident was mildly cognitively impaired, required supervision to independent with care needs, and had diagnoses that included schizoaffective disorder (a mental health condition and mood disorder), bipolar disorder (a mood disorder), and post-traumatic stress disorder (a mental and behavioral disorder that develops related to a terrifying event). A nursing note for Resident 33, dated October 14, 2024, at 1:07 p.m., revealed that a crisis representative arrived to facility and spoke with resident. He was agreeable to be sent to the hospital for a mental health evaluation and the resident was transported to the hospital. There was no documented evidence that a bed hold notice was provided to Resident 33 or his responsible party. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS assessment for Resident 37, dated December 4, 2024, revealed that the resident was cognitively intact, required assistance with care needs, and had diagnoses that included diabetes, obstructive uropathy (blockage of the urinary tract), and renal insufficiency (kidneys lose the ability to remove waste and balance fluids). A nursing note for Resident 37, dated October 14, 2024, at 11:48 a.m., revealed that the resident had abnormal blood work and reports of intermittent nausea and vomiting, and she was transferred to the hospital for further evaluation. A nursing note for Resident 37, dated November 17, 2024, at 5:25 a.m., revealed that the resident's left nephrostomy tube (thin flexible tube inserted into the kidney through the skin to drain urine directly into a collection bag) was dislodging. The physician was notified, and the resident was transferred to the hospital. A nursing note for Resident 37, dated January 18, 2025, at 12:44 p.m., revealed that the resident's nephrostomy tube was hanging out of the site several inches past the stitch that would have secured it to the skin. The physician was notified, and the resident was transferred to the hospital. There was no documented evidence that a bed-hold notice was provided to Resident 37 or her responsible party. Interview with the Nursing Home Administrator on February 12, 2025, at 3:20 p.m. confirmed that the facility did not provide bed-hold notices to the above residents and/or their representative when the residents were transferred to the hospital. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(3) Management.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 42079 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 six of 29 residents reviewed (Residents 9, 17, 21, 26, 37, 42). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, revealed that N0415E anticoagulant (medications used as a blood thinner) was to be coded (1) is taking, if the resident received an anticoagulant medication during the seven-day assessment period. A quarterly MDS assessment for Resident 9, dated November 13, 2024, revealed that Section N0415E was not coded (1), which indicated that the resident did not receive an anticoagulant during the seven-day assessment period. Physician's order for Resident 9, dated June 22, 2024, included an order for the resident to receive 2.5 milligrams (mg) of apixaban (a blood thinner) two times a day for atrial fibrillation (an abnormal fluttering heart beat). Review of the Medication Administration Record (MAR) for Resident 9, dated November 2024, revealed that 2.5 mg of apixaban was administered twice a day during the seven-day assessment period. The Long-Term Care Facility RAI User's Manual, dated October 2024, revealed that O0110K1 hospice was to be coded (B) while a resident, when residents identified as being in a hospice program for terminally ill persons where an array of services was provided for the palliation and management of terminal illness and related conditions. Physician's order for Resident 17, dated August 5, 2024, included an order for the resident to be admitted to hospice services. A care plan, dated July 31, 2024, indicated the resident had a terminal illness. A skin wound note, dated December 30, 2024, indicated that Resident 17 was currently on hospice care. A quarterly MDS assessment for Resident 17, dated January 1, 2024, revealed that Section O0110K1 was not coded (B), which indicated that the resident did not receive hospice services during the seven-day assessment period. Interview with the Registered Nurse Assessment Coordinator on February 12, 2025, at 3:44 p.m. confirmed that above-mentioned MDS assessments for Residents 9 and 17 were coded incorrectly. The Long-Term Care Facility RAI User's Manual, dated October 2024, revealed that Section N0415H Opioid (narcotic medications used to treat pain) was to be coded (1) if the resident received an opioid medication during the seven-day assessment period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's order for Resident 21, dated March 18, 2024, included for the resident to receive 5 milligrams (mg) of oxycodone (an opioid) two times a day. Review of the Medication Administration Record (MAR) for Resident 21, dated November 2024, revealed that 5 mg of oxycodone was administered twice a day during the seven-day assessment period. A quarterly MDS assessment for Resident 21, dated November 27, 2024, revealed that Section N0415H was not coded (1), which indicated that the resident did not receive an opioid during the seven-day assessment period. Physician's order for Resident 26, dated January 7, 2025, included an order for the resident to receive 25 mg of Tramadol (an opioid) every eight hours as needed for pain. Review of the MAR for Resident 26, dated January 2025, revealed that the resident was administered Tramadol daily on January 8 through January 14. An admission MDS assessment for Resident 26, dated January 14, 2025, revealed that Section N0415H was not coded (1), indicating that the resident did not receive an opioid during the seven-day assessment period. Interview with the Director of Nursing on February 12, 2025, at 12:39 p.m. confirmed that above-mentioned MDS assessments for Residents 21 and 26 should have indicated that the residents were receiving an opioid medication and did not. The Long-Term Care Facility RAI User's Manual, dated October 2024, revealed that Section H0100 was to be coded for each appliance that was used at any time in the past seven days. Select none of the above if none of the appliances A-D were used in the past seven days. Physician's orders for Resident 37, dated January 21, 2025, included an order for a left nephrostomy tube (thin flexible tube inserted into the kidney through the skin to drain urine directly into a collection bag). A care plan for Resident 37, dated June 25, 2024, revealed that the resident had a nephrostomy tube. A quarterly MDS assessment for Resident 37, dated January 28, 2025, revealed that Section H0100C was coded, indicating that the resident had an ostomy. Interview with the Director of Nursing on February 12, 2025, at 6:04 p.m. confirmed that Section H0100 was coded inaccurately for Resident 37, and that Section H0100A should have been coded indicating that the resident had a nephrostomy tube. An admission MDS assessment for Resident 42, dated December 27, 2024, revealed that Section N0415H was coded (1), indicating that the resident received an opioid during the seven-day assessment period. Review of the MAR for Resident 42, dated December 2024, revealed that there was no documented evidence that the resident received an opioid during the seven-day assessment period. Interview with the Director of Nursing on February 12, 2025, at 12:39 p.m. confirmed that above-mentioned MDS for Resident 42 was coded incorrectly, indicating that the resident received an opioid when he did not. 28 Pa. Code 211.5(f) Clinical Records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48941 Based on facility policies and clinical record reviews, as well as staff interviews, it was determined that the facility failed to ensure that resident-centered care plans were developed and implemented for three of 29 residents reviewed (Residents 7, 16, 33). Findings include: The facility's policy regarding care plans, dated January 20, 2025, indicated that the comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. Assessments of residents 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 7, dated November 13, 2024, revealed that the resident was cognitively intact, required assistance with care needs, received an antibiotic, anticoagulant (blood thinner), diuretic (a medication used to treat fluid build-up), and insulin, and had diagnoses that included coronary artery disease (CAD-a disease that limits blood flow to the heart caused by plaque buildup in the arteries), congestive heart failure (CHF-the heart cannot pump blood well enough to meet the body's needs), hypertension (HTN-high blood pressure), atrial fibrillation (irregular heart rhythm), diabetes, and presence of a cardiac pacemaker (a surgically-implanted, small battery-powered device to manage irregular heartbeats or heart failure). Physician's orders for Resident 7, dated May 29, 2024, included an order for the resident to receive six units of insulin Lispro subcutaneously with meals, 0.75 mg of Trulicity (a diabetic medication) subcutaneously daily every Thursday, and 2.5 mg of apixaban (an anticoagulant medication) twice daily. Physician's orders, dated August 5, 2024, included an order for the resident to have Accuchecks (blood sugar checks) three times daily with meals and to receive 1 mg of bumetanide (a diuretic medication) daily. Physician's orders, dated August 31, 2024, included an order for the resident to receive 500 milligrams (mg) of Cefadroxil (an antibiotic) daily for preventative. Physician's orders, dated January 8, 2025, included an order indicating that the resident had a dual chamber pacemaker to the left chest wall and follows with CPG cardiology. Physician's orders, dated January 20, 2025, included an order for the resident to receive 14 units of insulin Glargine subcutaneously at bedtime. Physician's orders, dated January 27, 2025, included an order for the resident to use a Dexcom G7 Sensor (Continuous Glucose System Sensor) subcutaneously (injected into the fat layer of the skin) every 10 days and Dexcom G7 Receiver Device (Continuous Glucose System Receiver to measure blood sugars) and ensure that the device is charged every shift. There was no documented evidence that care plans were developed to address Resident 7's diabetic needs including her use of the Dexcom and need for diabetic medications, cardiac needs including the presence of a cardiac pacemaker with her need to follow with a cardiologist, her need for diuretic and anticoagulant medications, or the need for long-term antibiotic therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Registered Nurse Assessment Coordinator on February 12, 2025, at 2:51 p.m. confirmed that Resident 7 did not have a care plan in place to address her diabetic and cardiac needs, her diuretic and anticoagulant medications, or the need to address her long-term antibiotic therapy and should have. A quarterly MDS assessment for Resident 16, dated November 6, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, was receiving an anticonvulsant (medication used to prevent or control seizures), and had a diagnosis of epilepsy (a seizure disorder). Physician's orders for Resident 16, dated November 22, 2024, included an order for the resident to receive 0. 5 mg of clonazepam (an anticonvulsant) twice daily. There was no documented evidence that a care plan was developed to address Resident 16's seizure disorder and need for anticonvulsant medication. Interview with the Registered Nurse Assessment Coordinator on February 12, 2025, at 2:51 p.m. confirmed that Resident 16 did not have a care plan in place to address his seizure disorder and need for anticonvulsant medication. A quarterly MDS assessment for Resident 33, dated November 26, 2024, revealed that the resident was mildly cognitively impaired, required supervision to independent with care needs, had verbal behavioral symptoms expressed towards others occurring one to three days in the look-back period, and had diagnoses that included schizoaffective disorder (a mental health condition and mood disorder), bipolar disorder (a mood disorder), anxiety, depression, and post-traumatic stress disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event). Review of Resident 33's clinical records revealed that he was receiving routine psychological services for his diagnoses of depression, anxiety, bipolar disorder, schizoaffective disorder, and PTSD. A trauma assessment for Resident 33, completed October 15, 2024, identified triggers for reliving traumatic experience, physical and emotional symptoms of reliving trauma, and support and coping strategies/interventions. There was no documented evidence that a care plan was developed to address Resident 33's PTSD, his triggers, and his coping strategies/interventions. Interview with the Registered Nurse Assessment Coordinator on February 12, 2025, at 2:51 p.m. confirmed that Resident 33 did not have a care plan in place to address his PTSD, his triggers, and his coping strategies/interventions. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42079 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 29 residents reviewed (Residents 9, 13). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated November 18, 2024, revealed that the resident was understood, could understand others, had a Brief Interview for Mental Status (BIMS -a structured cognitive interview) of 15 indicating that the resident was cognitively intact, required substantial to max assistance for showering and bathing, and had diagnoses that included congestive heart failure (CHF) and a history of falls. A care plan for self care performance deficit, dated June 21, 2024, indicated that the resident prefers showers twice a week, but may refuse. A care plan for the resident, dated June 24, 2024, revealed that the resident had the potential for actual skin impairment due to ichthyosis vulgaris (a common, inherited skin disorder characterized by dry, scaly, and thickened skin). Physician orders for Resident 9, dated October 5, 2024, included an order for the resident's entire body to be lathered with Vaseline followed by Dove moisturizing lotion. A review of Resident 9's clinical record, including nurse aide tasks, revealed special instructions to provide the resident with a complete bed bath daily and no showers. Following the bed bath, staff were to apply white petrolatum external ointment head to toe, followed by Dove lotion. Interview with the Director of Nursing on February 11, 2025, at 4:01 p.m. confirmed that Resident 9's care plan needed updated to reflect her bed bath and skin care needs. A quarterly MDS assessment for Resident 13, dated November 26, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, had diagnoses that included heart failure and diabetes, and used a chair alarm daily. A care plan for Resident 13, dated May 16, 2024, indicated that the resident was an elopement risk, and a care plan, dated December 27, 2024, indicated that the resident required oxygen therapy. A review of elopement risk evaluations for Resident 13, dated September 9, 2024, and November 20, 2024, revealed that the resident had a score of zero and was not an elopement risk. Review of the clinical record also revealed no documented evidence that Resident 13 was receiving oxygen therapy. An interview with the Director of Nursing on February 11, 2025, at 10:54 a.m. and 12:30 p.m. revealed that Resident 13 was no longer an elopement risk and no longer received oxygen therapy, and his care plans should have been revised. 28 Pa. Code 211.12(d)(5) Nursing Services.

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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. 42079 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to follow physician's orders for care and treatment for five of 29 residents reviewed (Resident 1, 24, 26, 37, 38). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 8, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, was frequently incontinent of bowel, and had a diagnosis of dementia. Physician's orders for Resident 1, dated July 6, 2024, included an order for the resident to receive 30 milliliters (ml) of Milk of Magnesia as needed for constipation if no bowel movements in three days, which as to be administered on the 7:00 a.m. to 3:00 p.m. shift on the first medication pass. Review of Resident 1's bowel record for February 2025 revealed no documented evidence that the resident moved his bowels from February 1 through February 4, 2025, for a total of four days. Review of Resident 1's Medication Administration Record (MAR) for February 2025 revealed no documented evidence that he received Milk of Magnesia as ordered for constipation. Interview with the Director of Nursing on February 11, 2025, at 2:12 p.m. confirmed that there was no documented evidence that Resident 1 received Milk of Magnesia as ordered for constipation. A quarterly MDS assessment for Resident 24, dated November 7, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included Alzheimer's disease. Physician's orders for Resident 24, dated July 31, 2024, included orders for the resident to wear a left hand palm guard after evening care, removing for hygiene, skin checks, and exercise. Review of Resident 24's clinical record, including nurse aide documentation, revealed no documented evidence that a left hand palm guard was applied to the resident as ordered. An interview with Resident 24 on February 12, 2025, at 8:43 a.m. revealed that she does have a palm guard that she is to wear at night; however, they do not always put it on her. She does not refuse to wear it; she thinks they forget to put it on. Interview with the Director of Nursing on February 12, 2025, at 10:10 a.m. confirmed that there was no documented evidence that Resident 24 had her palm guard applied as ordered and stated it was because the order was not transcribed correctly. An admission MDS assessment for Resident 26, dated January 14, 2025, revealed that the resident was cognitively intact, required assistance with personal care needs, and had diagnoses that included stroke and diabetes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 26, dated January 7, 2025, included an order to follow hypoglycemic protocol if the resident's blood sugar was less than 70 mg/dL, with or without symptoms, which included to administer 15 grams of glucose by mouth or carbohydrates found in any of the following: one-half cup of juice, one-half cup of applesauce, one cup milk, one tube glucose gel, or thee glucose tablets, wait 15 minutes and recheck the blood glucose level. Review of the blood glucose records for Resident 26 for February 2025 revealed that on February 8 at 5:00 p. m. the resident's blood sugar was 64 mg/dL. There was no documented evidence that hypoglycemic protocol was followed as ordered. Physician's orders for Resident 26, dated January 7, 2025, included an order for the resident to receive six units of insulin lispro (fast-acting insulin to treat high blood sugar) daily with lunch and dinner. Review of the MAR for January 2025 and February 2025 revealed that the medication was not administered at lunch time on January 18, 20, 22, 23, 25, and 26, 2025. Physician's orders for Resident 26, dated January 8, 2025, included an order for the resident to receive 18 units of insulin lispro daily with breakfast. Review of the MAR, dated January 2025 and February 2025, revealed that the medication was not administered with breakfast on January 10, 14, and 19, 2025. Interview with the Director of Nursing on February 12, 2025, at 3:00 p.m. confirmed that hypoglycemic protocol was not followed as ordered for a low blood glucose and that insulin was not administered on the above dates and times as ordered and should have been. A quarterly MDS assessment for Resident 37, dated December 4, 2024, revealed that the resident was cognitively intact, required assistance with care needs, and had diagnoses that included diabetes, obstructive uropathy (blockage of the urinary tract), and renal insufficiency (kidneys lose the ability to remove waste and balance fluids). A care plan for Resident 37, dated June 25, 2024, revealed that the resident had a percutaneous drain (a small flexible tube inserted through the skin into a body cavity or organ to drain accumulated fluid) and the output needed to be monitored. Review of Resident 37's clinical record, including the resident's Treatment Administration Record (TARs), dated November and December 2024, and January and February 2025, revealed no documented evidence that staff monitored and documented the resident's percutaneous drain output. Interview with the Director of Nursing on February 11, 2025, at 2:12 p.m. confirmed that there was no documented evidence that staff monitored and documented Resident 37's percutaneous drain output as per the care plan. A significant change MDS for Resident 38, dated November 25, 2024, revealed that the resident was understood, could usually understand others, had a Brief Interview for Mental Status (BIMS -a structured cognitive interview) of 6 indicating that the resident was moderately cognitively impaired, required assistance for care needs, and had a diagnosis which included end-stage renal failure, hypertension (high blood pressure), Type I diabetes (unable to produce insulin to lower blood sugar), and received dialysis (procedure that filters waste products and excess fluid from the blood when the kidneys are no longer functioning properly). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 38, dated December 11, 2024, included an order for the resident to receive 10 units of insulin Lantus (long acting insulin) daily in the morning. Review of the MAR, dated December 2024, January 2025, and February 2025, revealed that the medication was not administered on December 18, 2024; January 3, 6, 8, 13, 15, 17, 20, 22, and 27, 2025; and February 3, 6, and 10, 2025. Physician's orders for Resident 38, dated December 25, 2024, included an order for the resident to receive 5 mg of amlodipine (medication used to treat high blood pressure) daily in the morning for hypertension (high blood pressure). Review of the MAR, dated December 2024, January 2025, and February 2025 revealed that the medication was not administered in the morning on December 27 and 29, 2024; January 3, 6, 8, 13, 15, 17, 20, 22, 27, and 31, 2025; and February 3, 6, and 10, 2025. Interview with the Director of Nursing on February 12, 2025, at 3:22 p.m. confirmed that Resident 38's orders were not transcribed correctly, and she did not receive her medication as the physician ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42079 Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure that assistance devices to prevent accidents or injury were in place for three of 29 residents reviewed (Residents 13, 17, 24) Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated November 26, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included heart failure and diabetes. Physician's orders for Resident 13, dated May 29, 2024, included an order for the resident to have a chair alarm to his wheelchair at all times. A nurse's note for Resident 13, dated July 20, 2024, at 2:00 p.m., revealed that the resident had fallen in his bathroom. The resident reported that he was trying to ambulate from his wheelchair to the bathroom. The chair pad alarm was not present on his wheelchair. A facility incident investigation, dated July 20, 2025, indicated that the resident's chair alarm was not in place. Interview with the Director of Nursing on February 11, 2025, at 10:54 a.m. confirmed that Resident 13 did not have a chair alarm on his wheelchair at the time of his fall on July 20, 2024, and should have. A quarterly MDS assessment for Resident 17, dated October 18, 2024, revealed that the resident was cognitively intact and had diagnoses that included dementia and a history of falls. A care plan for the resident, dated December 26, 2023, revealed that the resident was at high risk for falls due to deconditioning and gait balance problems. A fall investigation for Resident 17, dated October 5, 2024, indicated that the resident was trying to plug in his radio and slid off his wheelchair. The chair alarm was not sounding at the time of the fall. An immediate intervention was to replace the chair alarm. Staff were provided education on checking the placement and function of the bed and chair alarms during routine rounds. A fall investigation for Resident 17, dated November 11 2024, indicated that the resident was found sitting on the floor in front of his closet with his back against the foot rests of the wheelchair. Resident 17's roommate alerted staff to the fall. The resident's ordered chair alarm was not sounding at the time of the fall. The resident had a 15 centimeter (cm) by 4 cm abrasion on his back that was bleeding. Interview with the Director of Nursing on February 12, 2025, at 4:56 p.m. confirmed that Resident 17 did not have a functional chair alarm on his wheelchair at the time of his fall on October 5, 2024, and November 11, 2024, and should have. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS assessment for Resident 24, dated November 7, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included Alzheimer's disease. Physician's orders for Resident 24, dated September 3, 2024, included an order for the resident to be transferred using a sit-to-stand lift. A nurse's note for Resident 24, dated June 11, 2024, at 5:37 p.m., revealed that the resident was being transferred to the toilet when she lost her balance due to her left foot getting caught, causing her to be off balance, and the resident slid down the wall and then to the floor. A facility incident investigation, dated June 11, 2024, revealed that the resident was not transferred with a sit-to-stand lift as ordered. Education was provided by the registered nurse on site for safe transfers. Interview with the Director of Nursing on February 12, 2025, at 2:04 p.m. revealed that the facility's incident report indicated that the resident was not transferred with a sit-to-stand lift as ordered at the time of her fall on June 11, 2024. The Director of Nursing revealed that the nurse aide reported using a sit-to-stand lift; however, a witness statement was not available and the incident report indicated that a sit-to-stand was not used. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48941 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 residents received proper care for indwelling urinary catheters (a flexible catheter used to drain urine from the bladder into a drainage collection bag) and nephrostomy tubes (thin, flexible tube inserted into the kidney through the skin to drain urine directly into a collection bag) for two of 29 residents reviewed (Residents 1, 37). Findings include: A facility policy related to catheter care, dated January 20, 2025, indicated that the catheter tubing and drainage bag are kept off the floor and to observe urine level for noticeable increases or decrease. If the level stays the same, or increases rapidly, report it to the physician or supervisor. Follow the facility procedure for measuring and documenting input and output. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 8, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, had an indwelling urinary catheter, had diagnoses that included neurogenic bladder (bladder lacks control due to nerve or muscle problems), and had a urinary tract infection in the last 30 days. A care plan for the resident, dated June 25, 2024, revealed that the resident had an indwelling urinary catheter. Staff was to ensure that the catheter bag and tubing were secure and the tubing was not on the floor, and staff was to monitor and document intake and output as per facility policy. Physician's orders for Resident 1, dated December 30, 2024, included an order for an indwelling foley catheter to straight drainage. Staff were to ensure the catheter tubing and bag were secured to bed frame and not touching the floor and that the privacy bag was in place. Observations of Resident 1 on February 9, 2025, at 2:31 p.m. revealed that the resident was lying in bed with his indwelling urinary catheter drainage bag and the catheter tubing was in direct contact with the floor. Interview with Nurse Aide 1, at the time of the observation, confirmed that the catheter bag and catheter tubing should not have been touching the floor. Interview with the Director of Nursing on February 9, 2025, at 3:20 p.m. confirmed that Resident 1's indwelling catheter drainage bag and tubing should not have been touching the floor. Review of the clinical record for Resident 1 for November and December 2024 and January and February 2025 revealed no documented evidence that his output was monitored and documented for the following days and shifts: November 14 and 21 on the night shift, November 25 on the evening shift, December 1 on the night shift, December 21, 25 and 30 on the evening shift, January 7 and 27 on the night shift, January 17 and 28 on the evening shift, and on February 1 on the night shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on February 12, 2025, at 8:57 a.m. confirmed that there was no documented evidence that Resident 1's indwelling foley catheter output was monitored and documented on the above-mentioned dates/shifts as per the care plan and facility policy. A facility policy related to nephrostomy tube care, dated January 20, 2025, indicated to measure output initially every hour for four hours, then every four hours for 24 hours, then every eight hours. Empty drainage bag once per shift and as needed. A quarterly MDS assessment for Resident 37, dated December 4, 2024, revealed that the resident was cognitively intact, required assistance with care needs, and had diagnoses that included diabetes, obstructive uropathy (blockage of the urinary tract), and renal insufficiency (kidneys lose the ability to remove waste and balance fluids). Physician's orders for Resident 37, dated January 21, 2025, included an order for a left nephrostomy tube. A care plan for Resident 37, dated June 25, 2024, revealed that the resident had a nephrostomy tube, and staff was to monitor and document intake and output as per facility policy. Review of the clinical record for Resident 37 for November and December 2024 and January and February 2025 revealed no documented evidence that staff monitored and documented the resident's nephrostomy tube output on the following dates and shifts: November 1 and 14 on the night shift, November 1 and 28 on the day shift, December 1, 6, and 23 on the night shift, December 25 on the evening shift, January 1, 9, 23 and 27 on the night shift, and February 1 on the night shift. Interview with the Director of Nursing on February 11, 2025, at 2:12 p.m. confirmed that there was no documented evidence that staff monitored and documented Resident 37's nephrostomy tube output on the above-mentioned dates/shifts as per the care plan and facility policy. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46994 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 29 residents reviewed (Resident 26). Findings include: The facility's policy for medication administration, dated January 20, 2025, indicated that the individual administering the medication initials the resident's Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next one. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 26, dated January 14, 2025, revealed that the resident was cognitively intact, required assistance with personal care needs, and had diagnoses that included stroke and diabetes. Physician's orders for Resident 26, dated January 7, 2025; January 22, 2025; and February 5, 2025, included an order for the resident to receive 25 milligrams (mg) of Tramadol (a narcotic pain medication) every eight hours as needed for pain. Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 26, dated January and February 2025, revealed that a 25 mg Tramadol tablet was signed out on January 14, 2025, at 8:24 p.m.; January 21, 2025, at 10:00 a.m.; January 22, 2025, at 11:00 a.m.; January 29, 2025, at 10:00 a.m.; and February 5, 2025, at 10:00 a.m. and 7:37 p.m. However, there was no documented evidence in Resident 26's clinical record, including the Medication Administration Record (MAR), that the signed-out doses of controlled medications were administered to the resident on the above-mentioned dates and times. Interview with the Director of Nursing on February 12, 2025, at 3:56 p.m. confirmed that there was no documented evidence in Resident 26's clinical record to indicate that the signed-out doses of controlled medications mentioned above were administered. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 42079 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that monthly pharmacy medication reviews were completed for seven of 29 residents reviewed (Residents 16, 21, 23, 26, 33, 38, 50). Findings include: The facility policy regarding pharmacy services, dated January 20, 2025, indicated that the consultant pharmacist will provide a documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines; provide appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated; and provide the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review. Review of the clinical records for Residents 16, 21, 23, 26, 33, 38 and 50 revealed no documented evidence that monthly pharmacy medication reviews were completed from August 2024 through January 2025. Interview with the Director of Nursing on February 12, 2025, at 12:12 p.m. confirmed that there was no documented evidence that monthly pharmacy medication reviews were completed for the above-mentioned residents on the above-mentioned months reviewed. Interview with the Nursing Home Administrator on February 12, 2025, at 12:46 p.m. indicated that the facility had switched pharmacies in January 2024, and he thought the Director of Nursing was receiving the monthly pharmacy medication reviews. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46994 Based on a review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to ensure that it was free from significant medication errors for one of 29 residents reviewed (Resident 21). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 21, dated November 27, 2024, indicated that the resident was cognitively intact, required assistance from staff for personal hygiene needs, and had diagnosis that included right femur (thigh bone) fracture. A nurse's note for Resident 21, dated October 2, 2024, at 9:42 p.m. revealed that orders were received to continue administering 2.5 milligrams (mg) of Coumadin (blood thinner) every Monday, Wednesday, and Friday, and 2 mg of Coumadin every Tuesday, Thursday, Saturday, and Sunday. Review of the Medication Administration Record (MAR) for Resident 21, dated October 2024, revealed no documented evidence that Coumadin was administered on October 2 through October 15, 2024. Interview with the Director of Nursing on February 12, 2025, at 8:58 a.m. confirmed that Coumadin should have been administered to Resident 21 on October 2 through October 15, but was not. 28 Pa Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395439	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Ridge Senior Living at Johnstown	807 Goucher Street Johnstown, PA 15905

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42079 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly label a multi-use vial of Aplisol in one of one medication room reviewed. Findings include: The facility's policy regarding medication labeling and storage, dated [DATE], indicated medications and biologicals are stored in a safe, secure, and orderly manner. Nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary method. Manufacturer's directions for use of Aplisol (tuberculin purified protein derivative), dated [DATE], indicated that the vials in use more than 30 days should be discarded due to possible oxidation and degradation, which may affect potency. Observations in the facility's medication room refrigerator in the main medication room on February 12, 2025, at 1:29 p.m. revealed one multi-use vial of Aplisol that was open and undated. Interview with Licenced Practical Nurse 2 at the time of the observation confirmed that the vial was not dated and should be discarded. An interview with the Director of Nursing on February 12, 2025, at 3:01 p.m. confirmed that the multi-use vial of Aplisol should have been dated when opened and discarded when expired. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 48941 Based on clinical record reviews and staff interviews, it was determined that the facility failed to obtain laboratory services as ordered by the physician for one of 29 residents reviewed (Resident 1). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 8, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, was frequently incontinent of bowel, and had a diagnosis of dementia. A nursing note for Resident 1, dated January 20, 2025, at 6:38 p.m., revealed that the resident had a large bowel movement with red staining noted to his sheets around the stool. Physician's orders for Resident 1, dated January 20, 2025, included an order to obtain three stool samples for immuno-fecal occult (hidden) blood with instructions to record each collection in the resident's electronic health record and notify the physician if positive. A nursing note for Resident 1, dated January 21, 2025, at 9:29 a.m., revealed that the resident's first fecal occult blood specimen was negative. A nursing note for Resident 1, dated January 25, 2025, at 4:50 a.m., revealed that two stool samples were needed to be obtained. As of February 11, 2025, there was no documented evidence in Resident 1's clinical record that his remaining two stools were obtained and tested for occult blood. Interview with the Director of Nursing on February 11, 2025, at 2:12 p.m. confirmed that there was no documented evidence in Resident 1's clinical record that his remaining two stools were obtained and tested for occult blood. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42079 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to serve palatable food that was at appropriate temperatures. Findings include: The facility's policy regarding food temperatures and point of service, dated January 20, 2025, indicated that hot foods would be held at temperatures of 135 degrees or above. Best efforts would be made to present hot food hot and cold foods cold at point of service by using thermal lids and bases, heated or chilled plates, and thermal pellets as necessary. Observations of the kitchen's lunch meal tray line on February 10, 2025, revealed that it began at 12:01 p.m. and included barbecued ribs, homestyle baked beans, corn on the cob, and watermelon. The last tray was placed on the cart at 12:14 p.m. The cart left the kitchen and arrived on the unit at 12:17 p.m., and the last tray was removed from the cart and served at 12:27 p.m. The test tray was removed from the cart at 12:42 p. m. The barbecued rib was 114 degrees Fahrenheit (F) and tasted cold and was not palatable, the baked beans were 127 degrees F, the corn was 102 degrees F tasted cold and was not palatable, the watermelon was 53.1 degrees F, the pureed barbecued rib was 113.7 degrees F and was cold and not palatable, the pureed corn was 112 degrees F and was cold and not palatable, the pureed baked beans were 114.8 degrees F and were cold and not palatable. Interview with Director of Dietary on January 14, 2025, at 3:08 p.m. confirmed that the temperatures were not palatable because the tray line and tray passing was delayed. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.6(f) Dietary Services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48941 Based on review of the facility's plans of correction 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 plans of corrections for State Survey and Certification (Department of Health) survey ending February 29, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending February 12, 2025, identified repeated deficiencies related to a failure to develop and implement comprehensive care plans, failure to update/revise care plans, failure to provide quality of care, failure to provide a safe environment that is free of accident hazards, failure to maintain compliance with the regulation regarding complete and accurate accounting of controlled medications, failure to store and label residents medications properly, and failure to ensure food was palatable and served at the proper temperature. The facility's plans of correction for deficiencies regarding developing and implementing comprehensive care plans, cited during the survey ending February 29, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the regulation regarding developing and implementing comprehensive care plans. The facility's plan of correction for a deficiency regarding a failure to update/revise residents' care plans, cited during the survey ending February 29, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding updating/revising residents' care plans. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending February 29, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plan of correction for deficiencies regarding a safe environment that is free of accident hazards, cited during the survey ending February 29, 2024, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding a safe environment that is free of accident hazards. The facility's plan of correction for a deficiency regarding pharmacy services accurate accounting of controlled medications, cited during the survey ending February 29, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding pharmacy services accurate accounting of controlled medications. The facility's plan of correction for a deficiency regarding proper storage and/or labeling of medications, cited during the survey ending February 29, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding storing and labeling resident's medications properly. The facility's plans of correction for deficiencies regarding ensuring that food was palatable and at proper serving temperatures, cited during the survey ending on February 29, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F804, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding ensuring the food was palatable and had proper serving temperatures. Refer to F656, F657, F684, F689, F755, F761, F804. 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. 48941 Based on observations and staff interviews, it was determined that the facility failed to use proper infection control practices to reduce the spread of infections and prevent cross-contamination for one of 29 residents reviewed (Resident 1). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 8, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, had an indwelling urinary catheter (a flexible catheter used to drain urine from the bladder into a drainage collection bag), had diagnoses that included neurogenic bladder (bladder lacks control due to nerve or muscle problems), and had a urinary tract infection in the last 30 days. A care plan for the resident, dated June 25, 2024, revealed that the resident had an indwelling urinary catheter. Physician's orders for Resident 1, dated December 30, 2024, included an order for an indwelling foley catheter to straight drainage, ensure catheter tubing and bag are secured to bed frame and not touching the floor, and ensure privacy bag is in place. Observations of Resident 1 on February 9, 2025, at 2:31 p.m. revealed that the resident was lying in bed with his indwelling urinary catheter drainage bag and the catheter tubing in direct contact with the floor. Interview with Nurse Aide 1, at the time of the observation, confirmed that the catheter bag and catheter tubing should not have been touching the floor. She proceeded to pick the catheter bag and catheter tubing up off the floor with her bare, ungloved hands, then placed the catheter bag and tubing back on the floor, obtained a pair of gloves provided to her by another nurse aide, put the gloves on, and proceeded to place the catheter bag and tubing into the dignity bag. Interview with the Director of Nursing on February 9, 2025, at 3:20 p.m. confirmed that the nurse aide should have had gloves on when handling Resident 1's catheter bag and tubing, and she should not have placed the catheter bag and tubing on the floor while donning her gloves. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.