| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395439 | A. Building<br>B. Wing | 01/14/2026 |

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| Heritage Ridge Senior Living at Johnstown | 807 Goucher Street<br>Johnstown, PA 15905 |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on a review of facility policies and clinical records as well as staff interviews, it was determined that the facility failed to ensure that residents medication regimen was free from unnecessary psychotropic medication (drugs that affect a person's mental state, emotions, and behavior) for two of 33 residents reviewed (Residents 20 and 39).Findings include: The facility's policy regarding psychotropic medication use, dated August 25, 2025, included that non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medication when possible. As needed orders for psychotropic medications are limited to 14 days. A quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 20 dated November 21, 2025, indicated that the resident had cognitive impairment, required assistance from staff for daily care needs, and had diagnosis that included dementia, anxiety and depression. Physician's orders for Resident 20 dated December 31, 2025, included an order for the resident to receive 0.25 milligrams (mg) of Xanax (an antianxiety medication) every four hours as needed for restlessness/anxiety. Review of the Medication Administration Record (MAR) for Resident 20 dated January 2026 revealed that 0.25 mg of Xanax was administered to the resident on January 4 at 2:46 a.m.; on January 7 at 6:54 p.m.; on January 8 at 1:15 p.m.; on January 10 at 2:43 p.m.; on January 11 at 10:06 a.m.; on January 11 at 8:27 p.m.; and on January 14 at 12:46 a.m. There was no documented evidence that non-pharmacological interventions were attempted prior to administering the as needed doses of Xanax on these dates and times. A quarterly MDS assessment for Resident 39 dated October 19, 2025, indicated the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included Alzheimer's dementia. Physician's orders for Resident 39 dated October 6, 2025, included an order for the resident to receive 0.5 mg of lorazepam (a psychotropic medication used to treat anxiety) every eight hours as needed for anxiety for 90 days. Review of the MAR for Resident 39 dated October and November 2025 revealed that the resident was administered 0.5 mg of lorazepam on October 29 at 8:29 p.m., October 30 at 8:48 p.m., October 31 at 8:37 p.m., November 1 at 11:50 p.m., November 11 at 8:24 p.m., November 13 at 8:00 p.m., November 14 at 4:05 a.m., and November 19 at 3:46 p.m. There was no documented evidence that non-pharmacological interventions were attempted prior to administering the as needed doses of lorazepam on these dates and times. Interview with the Director of Nursing on January 14, 2026, at 3:34 p.m. confirmed that there was no documented evidence that non-pharmacological interventions were attempted before administering Xanax to Resident 20 and lorazepam to Resident 39 on the above-mentioned dates and times and there should have been. She also confirmed that there was no duration included in the physician's order on December 31, 2025, and no documented evidence from a physician or prescriber to indicate the rationale to extend the as needed Xanax for Resident 20 beyond 14 days. 28 Pa. Code 211.12(d)(5) Nursing Services. |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that medications were provided as ordered by the physician for three of 33 residents reviewed (Resident 6, 9, 28). Findings include:A facility policy for administering medications dated August 25, 2025, indicated that medications are given in a safe and timely manner, and as prescribed. The following information is checked/verified for each resident prior to administering medications: allergies to medications and vital signs if necessary. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated December 8, 2025, revealed that the resident was cognitively intact, required assistance for care needs, and had a diagnosis that included diabetes.Physician's orders for Resident 6, dated October 23, 2025, included an order for the resident to receive 12 units of Humalog lispro insulin subcutaneously before meals, and to hold for blood glucose less than 90mg/dL.A review of Resident 6's Medication Administration Record (MAR) for November 2025, revealed that the resident's blood glucose was 76mg/dL on November 10, 2025, at 5:00 p.m. and was 83mg/dL on November 20, 2025, at 5:00 p.m., and that the resident received 12 units of Humalog lispro insulin on the above dates and times.Physician orders for Resident 6, dated December 2, 2025, included an order for the resident to receive 12 units of Humalog lispro insulin subcutaneously before meals, and to hold for blood glucose less than 90mg/dL.A review of Resident 6's MAR for January 2026, revealed that on January 1, 2025, at 5:00 p.m. the resident's blood sugar was 80 mg/dl, and that the resident received 12 units of Humalog lispro insulin on the above date and time.An interview with the Director of Nursing on January 14, 2026, at 3:56 p.m. confirmed that the 12 units of Humalog lispro insulin was administered on the above dates and times and should not have been. An admission MDS for Resident 9, dated November 25, 2025, revealed that the resident was cognitively intact, required assistance with daily care needs, and had diagnoses that included Orthostatic hypotension (a sudden drop in blood pressure when standing up from sitting or lying down).Physician's orders for Resident 9, dated November 19, 2025, included an order for the resident to receive 2.5 milligrams (mg) of midodrine (medication used to treat low blood pressure) three times a day; hold for a systolic blood pressure (SBP-top number on a blood pressure reading) greater than 120. Review of the MAR for Resident 9 dated November and December 2025, revealed that 2.5 mg of midodrine was administered to the resident on November 27 when his SBP was 144, on November 28 when his SBP was 145, on December 2 when his SBP was 144, on December 9 when his SBP was 124, on December 11 when his SBP was 136, and on December 14 when his SBP was 140. Interview with the Director of Nursing on January 14, 2025, at 2:39 p.m. confirmed that midodrine was administered to Resident 9 on the above-mentioned dates and times when his SBP was outside the physician ordered parameters. An admission MDS assessment for Resident 28, dated December 9, 2025, revealed that the resident was cognitively impaired, required assistance with personal care needs, and had diagnoses that included hypotension (low blood pressure). Physician's orders for Resident 28, dated December 23, 2025, included an order for the resident to receive 10 milligrams (mg) of Midodrine (used to treat low blood pressure) three times a day and to hold the medication if the resident's systolic blood pressure (SBP-the top number in a blood pressure reading) is greater than 120.Review of the Medication Administration Record (MAR) for Resident 28, dated January 2026, revealed that 10 mg of Midodrine was administered on January 5 at 8:00 a.m. when the resident's SBP was 124, on January 5 at 1:00 p.m. when the resident's SBP was 124, on January 9 at 5:00 p.m. when the resident's SBP was 140, and on January 10, 2026 at 5:00 p.m. when the residents SBP was 134. Interview with the Director of Nursing on January 13, 2026, at 12:33 p.m. confirmed that Midodrine was administered to Resident 28 on the above-mentioned dates and times when it should have been held per physician's orders when the resident's SBP was greater than 120.28 Pa. Code 211.12(d)(1)(5) Nursing Services. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents received proper care for nephrostomy tubes (a small, flexible catheter inserted through the skin in the back directly into the kidney to drain urine when there's a blockage in the urinary system) for one of 33 residents reviewed who had nephrostomy tubes (Resident 4).Findings include:A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated November 12, 2025, revealed that the resident had moderate cognitive impairment, required assistance from staff for daily care needs, had an indwelling urinary catheter (includes nephrostomy tubes), and had diagnosis that included obstructive uropathy (a condition in which the flow of urine is blocked).Review of Resident 4's post procedure note for a nephrostomy tube change, dated December 17, 2025, revealed that current outpatient medications included to flush with 10 milliliters (ml) sodium chloride 0.9% (salt water) daily, flush left and right nephrotomy tubes as directed. A nurse's note for Resident 4 dated January 5, 2026, at 2:31 p.m. revealed that the registered nurse was notified by the Licensed Practical Nurse that upon flushing (gently injecting sterile liquid into the tube to keep it clear of clots) the resident's bilateral nephrostomy tubes as prescribed, the left nephrostomy tube was meeting resistance, was very difficult to flush, and the tubing was milked (process to dislodge clots that may be attached to the sides of the tubes) by the registered nurse with the flush remaining very difficult to push through.Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident 4 dated December and January 2025 revealed no documented evidence that the residents left and right nephrostomy tubes were flushed daily per interventional radiology orders.Interview with the Director of Nursing on January 13, 2026, at 2:10 p.m. confirmed that orders to flush Resident 4's left and right nephrostomy tubes should have been added to the resident's MAR or TAR, however they were not and there was no documented evidence that the residents left and right nephrostomy tubes were flushed daily or as needed. 28 Pa. Code 211.12(d)(3)(5) Nursing Services. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a peripherally inserted central catheter (PICC- a thin, flexible tube that is inserted into a vein in the upper arm) was flushed according to facility policy for one of 33 residents reviewed (Resident 9). Findings include:The facility's policy regarding flushing and locking peripheral and midline catheters dated August 25, 2025, indicated that the purpose of the procedure was to maintain catheter patency, to prevent mixing of incompatible medications and solutions, and to ensure the entire dose of a solution or medication is administered into the venous system. For short and long peripheral and midline catheters used for intermittent infusions, flush (procedure involving the injection of saline into a catheter using a small syringe to clear or maintain patency) the catheter and aspirate for blood return prior to each infusion and at least every 24 hours to assess catheter function. Lock (a peripheral intravenous catheter is capped off and filled with a saline (saltwater) solution instead of being connected to a continuous drip) following each use. When flushing before and after medication administration of fluid administration, document the procedure in the treatment administration record. An admission Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 9, dated, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnosis that included Methicillin-resistant Staphylococcus aureus infection (infection caused by Staphylococcus aureus bacteria that has become resistant to common antibiotics like methicillin) and was receiving intravenous medications. Physician's orders for Resident 9, dated November 19, 2025, included an order for the resident to receive 2 grams of Oxacillin Sodium intravenous solution (an antibiotic used to fight serious bacterial infections) intravenously every four hours for osteomyelitis (an infection and inflammation of bone tissue). Review of Medication Administration Records (MARs) for Resident 9, dated November and December 2025 revealed that 2 grams of Oxacillin Sodium intravenous solution was administered intravenously every four hours from November 19, 2025, at 8:00 p.m. through December 9, 2025, at 6:00 p.m. However, there was no documented evidence that staff flushed Resident 9's PICC before and after the administration of Oxacillin Sodium intravenous solution. Interview with the Director of Nursing on January 14, 2026, at 3:38 p.m. confirmed there was no documented evidence that Resident 9's PICC was flushed before and after medication administration per facility policy on the dates listed above.28 Pa. Code 211.12(d)(1)(5) Nursing Services. |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.<br><br>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to obtain laboratory studies as ordered by the physician for one of 33 residents reviewed (Resident 13).Findings include: The facility's policy regarding laboratory services and reporting, dated August 25, 2025, revealed that the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process the test requisitions and arrange for tests, the laboratory, diagnostic radiology provider, or other testing source will report test results to the facility.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated November 3, 2025, revealed that the resident was cognitively impaired, was dependent on staff for daily care needs and was always incontinent of bladder.Physician's orders for Resident 13, dated November 28, 2025, included an order for staff to obtain a urine culture and sensitivity (a diagnostic test for urinary tract infection).Review of the clinical records for Resident 13 revealed no documented evidence that the urine culture and sensitivity was completed as of January 14, 2026.Interview with Director of Nursing on January 14, 2025, at 11:09 a.m. confirmed that there was no documented evidence that Resident 13's urinary culture and sensitivity was completed as ordered. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>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 August 25, 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 and heated or chilled plates. Interview with Resident 3 on January 12, 2026, at 11:01 a.m. revealed that the food is always cold, the bread is stale, and it doesn't taste good. Interview with Resident 6 on January 12, 2026, at 11:32 a.m. revealed that the food is like cold dog food. Observations of the kitchen's lunch meal tray line on January 14, 2025, revealed that it began at 12:01 p.m. and included spaghetti, mixed vegetables, garlic bread, side salad, coffee and juice. The last tray was placed on the cart at 12:12 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 12:30 p.m. The spaghetti was 122 degrees Fahrenheit (F), the pureed mixed vegetables were 144 degrees F, the garlic bread was 72 degrees F, the side salad was 51 degrees F, the coffee was 153 degrees F, and the juice was 47 degrees F. The spaghetti was cold and not palatable. Interview with Director of Dietary on January 14, 2025, at 12:40 p.m. confirmed that the spaghetti was not at a proper temperature. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.6(f) Dietary Services. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 two of 33 residents reviewed (Residents 4 and 41). Findings include:The RAI User's Manual, dated October 2025, indicated that Section O0110K1B Hospice care (a specialized form of end-of-life care that provides comfort, support, and medical assistance to terminally ill patients and their families) was to be checked to indicate if the resident was receiving hospice services while a resident. Physician's orders for Resident 4 dated May 14, 2025, include for the resident to be admitted to Hospice care. A quarterly MDS assessment for Resident 4, dated November 12, 2025, revealed that Section O0110K1B was not checked, indicating that the resident did not receive hospice service during the seven-day look-back assessment period. Interview with the Director of Nursing on January 13, 2026, at 11:12 p.m. confirmed that Resident 4 was receiving hospice services and her MDS assessment dated [DATE], was coded inaccurately.Physician's orders for Resident 41 dated April 4, 2025, include for the resident to be admitted to Hospice care. A quarterly MDS assessment for Resident 41, dated October 20, 2024, revealed that Section O0110K1B was not checked, indicating that the resident did not receive hospice service during the seven-day look-back assessment period. Interview with the Director of Nursing on January 14, 2025, at 11:11 a.m. confirmed that Resident 41 was receiving hospice services and his MDS assessment dated [DATE], was coded inaccurately.28 Pa. Code 211.5(f) Clinical Records. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to discard a multi-use vial of Tubersol (solution used to detect tuberculosis infection) and an expired multidose medication for one resident (Resident 10) in one of one medication rooms reviewed. Findings include: The facility's policy regarding medication administration, dated [DATE], indicated medications are administered in a safe and timely manner and as prescribed. The expiration date on the medication label is checked prior to administration. When opening a multidose medication the opened date is recorded on the container. Manufacturer's instructions for Tubersol, dated [DATE], indicated that a multi-dose vial of Tubersol solution should be discarded 30 days after it is opened. Physician's orders for Resident 10, dated [DATE], included an order for the resident to receive 20 ml (milliliters) for a total of 40 mg(milligrams) of Omeprazole Oral Solution (used to treat gastroesophageal reflux disease) 2 mg/ml daily. Observations in the facility's medication room refrigerator in the medication room on [DATE], at 11:20 a.m. revealed one multi-use vial of Tubersol that was open and dated [DATE], and a multidose bottle of Omeprazole Oral Solution (used to treat gastroesophageal reflux disease) 2 mg/ml for Resident 10 with an expiration date of [DATE]. An interview with the Director of Nursing on [DATE], at 1:00 p.m. confirmed that the multi-use vial of Tubersol and the multidose bottle of Omeprazole Oral Solution 2 mg/ml for Resident 10 should have been 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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of 33 residents reviewed (Resident 42).Findings include: The facility's policy regarding medication administration, dated August 25, 2025, indicated that after medication administration, the facility staff should take all measures required by facility policy and applicable law, including but not limited to documenting necessary medication administration/treatment information (when the medication was given, prn/as needed medications) on appropriate forms. Document the administration of controlled substances in accordance with applicable law. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 42, dated November 14, 2025, indicated the resident was cognitively impaired, required assistance for daily care needs, took opioid medications, and had diagnoses that included heart failure. Physician's orders for Resident 42, dated June 3, 2025, included an order for the resident to receive 25 milligrams (mg) of Tramadol (a narcotic pain medication) every twelve hours for pain. A review of the Medication Administration Record (MAR) for Resident 42, dated October and November 2025, revealed that 25 mg of Tramadol was administered to the resident on October 30 at 9:00 p.m.; October 31 at 8:00 a.m.; October 31 at 9:00 p.m.; November 1 at 8:00 a.m.; November 1 at 9:00 p.m.; November 2 at 8:00 a.m.; November 2 at 9:00 p.m.; November 3 at 8:00 a.m.; November 3 at 9:00 p.m.; November 4 at 8:00 a.m.; November 4 at 9:00 p.m.; November 5 at 8:00 a.m.; November 5 at 9:00 p.m.; November 6 at 8:00 a.m.; November 6 at 9:00 p.m.; November 7 at 8:00 a.m.; November 7 at 9:00 p.m.; November 8 at 8:00 a.m.; November 8 at 9:00 p.m.; November 9 at 8:00 a.m.; November 9 at 9:00 p.m.; November 10 at 8:00 a.m.; November 10 at 9:00 p.m.; November 11 at 8:00 a.m.; November 11 at 9:00 p.m.; November 12 at 8:00 a.m.; November 12 at 9:00 p.m.; November 13 at 8:00 a.m.; November 13, 2025 at 9:00 p.m. However, a review of the resident's-controlled medication record (a form that accounts for each tablet/pill/dose of a controlled drug), dated October and November 2025 revealed no documented evidence that 25 mg of Tramadol was signed out for administration on the above-mentioned dates and times. Interview with the Interim Director of Nursing on January 14, 2026, at 11:10 a.m. confirmed that she was unable to locate the controlled medication record for Resident 42 therefore there was no documented evidence that 25 mg of Tramadol was signed out for administration on the above-mentioned dates and times. 28 Pa Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing 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) |
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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>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 maintain compliance with nursing home regulations 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 12, 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 January 14, 2026, identified repeated deficiencies related to accuracy of assessment, failure to provide quality of care, failure to provide proper catheter care, failure to store and label residents medications properly, and failure to ensure food was palatable and served at the proper temperature. The facility's plan of correction for a deficiency regarding the accuracy of assessment, cited during the survey ending February 12, 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 F641, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding accuracy of assessment. The facility's plan of correction for a deficiency regarding quality care, cited during the surveys ending February 12, 2025, July 12, 2025, and October 1, 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 F684, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding quality of care. The facility's plan of correction for a deficiency regarding failures to provide proper catheter care, cited during the survey ending February 12, 2025, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F690, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding catheter care. The facility's plan of correction for a deficiency regarding labeling and storing medications, cited during the survey ending February 12, 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 F761, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding labeling and storage of medications. 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 12, 2025, 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 was ineffective in maintaining compliance with the regulation regarding food being served was palatable and at the proper temperature. Refer to F641, F684, F690, F761, F804 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. |