STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395530	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes-Presby	220 Newry Street Hollidaysburg, PA 16648

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of policies, investigation reports, clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of 31 residents reviewed (Resident 55). Findings include:The facility's policy regarding Abuse, Neglect, and Exploitation, dated January 31, 2025, revealed that each resident would be provided with a safe environment where they are not subject to mental, physical, verbal, and sexual abuse, and that residents would be protected from mistreatment, neglect, exploitation, and misappropriation of property.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 55 dated July 13, 2025, revealed that the resident was cognitively impaired, required assistance from staff for her daily care needs, and had diagnoses that included dementia.Resident 55's care plan, dated June 1, 2025, indicated that the resident had dementia, as well as anxiety and agitation.The facility's investigation documents for Resident 55, dated August 15, 2025, indicated that Nurse Aide 1 was observed holding a baby doll that belonged to another resident in front of Resident 55 and would pull it away when Resident 55 reached for it. Nurse Aide 1 stated she knew the doll did not belong to Resident 55 and that she was trying to return the doll to the other resident. Nurse Aide 1 was observed pulling the doll away from Resident 55 and laughing at the resident as she did it. The investigation revealed that Resident 55 experienced visible distress, yelling, and anxiety due to the actions by Nurse Aide 1. A witness statement from Nurse Aide 1, dated August 15, 2025, revealed that she knew the doll did not belong to Resident 55 and that she was taking the doll to give it to the resident that it belonged to. She stated that she did tell Resident 55 it was not her doll and that the resident was visibly upset.A witness statement from Nurse Aide 2 on August 15, 2025 revealed that Nurse Aide 1 was holding another resident's doll in front of Resident 55 and telling the resident that it wasn't hers. She stated that Resident 55 was chasing after Nurse Aide 1 stating that she bought it and that it was hers. She stated that Nurse Aide 1 was making the episode go on for far too long.A witness statement from Nurse Aide 3, dated August 15, 2025, revealed that Nurse Aide 1 was teasing Resident 55 with a doll that belonged to another resident and that Resident 55 was visibly upset. She stated that Nurse Aide 1 appeared to be holding the doll in front of Resident 55 and when the resident would get close she would pull the doll away from her.A witness statement from Nurse Aide 4, dated August 15, 2025, revealed that Nurse Aide 1 was teasing Resident 55 with a baby doll and laughing at Resident 55. A witness statement from Nurse Aide 5, dated August 25, 2025, revealed that when she arrived to work for night shift she overhead very loud laughter and saw that Resident 55 was very upset with a red face and tears in her eyes. She stated that Nurse Aide 1 was teasing Resident 55 and laughing very hard about it.Interview with Director of Nursing on October 16, 2025, at 11:25 a.m. revealed Nurse Aide 1 was terminated for teasing Resident 55 with a baby doll and for causing emotional stress to the resident who was visibly upset.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.11(d) Resident care plan.28 Pa. Code 211.12(d)(1) Nursing services. 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and/or the resident's representative, in writing regarding the reason for transfer to the hospital and failed to notify the ombudsman of the transfer to the hospital, for three of 31 residents reviewed (Residents 4, 8, 75), Findings include:The facility policy for Admission, Transfer and Discharge Notification, dated January 30, 2025, indicated that upon transfer to the hospital the resident and resident representative will be notified in writing, and the ombudsman will be notified.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 14, 2025, indicated that the resident was moderately cognitively impaired, usually understood and usually understands, required assistance from staff for her daily care needs and had diagnoses that included, cerebral infarct (stroke).Review of Resident 4's clinical record indicated that on July 4, 2025 at 1:23 p.m. the registered nurse was called to second floor dining room where Resident 4 was complaining of chest pain. The resident winced when the registered nurse touched her chest. Resident 4 was transported to the hospital where she was admitted .Review of Resident 4's progress notes revealed that there was no documentation that the resident and legal guardian were notified in writing of the purpose for resident's transfer, or that the ombudsman was notified regarding her hospitalization of July 4, 2025.An admission MDS for Resident 8, dated July 18, 2025, indicated that the resident was cognitively intact and required assistance from staff for daily care needs. A nurse's note for Resident 8, dated August 3, 2025 revealed that the resident was sent to the emergency room for an evaluation related to tremors, weakness, and stiff neck. There was no documented evidence that written notification of transfer was provided to Resident 8 or his representative, or that the ombudsman was notified of the transfer to the hospital as required.An admission MDS assessment for Resident 75, dated July 13, 2025, indicated that the resident was cognitively intact and required assistance from staff for his daily care needs.A nursing note for Resident 75, dated July 28, 2025, revealed that the resident was discharged home with his wife.There was no documented evidence that written notification of discharge was sent to the ombudsman as required.Interview with the Assistant Director of Nursing on October 16, 2025 at 9:13 a.m. confirmed that there was no documented evidence that Resident 4 and Resident 8, and their guardians were notified in writing of their transfer to the hospital, or that the ombudsman was notified regarding the hospitalizations, and also confirmed that the ombudsman was not notified of Resident 75's discharge and should have been.28 Pa. Code 201.29(j) Resident Rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 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 five of 31 residents reviewed (Residents 6, 7, 28, 55, 61). Findings include:The Long-Term Care Facility RAI User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (a mandated assessment of a resident's abilities and care needs), dated October 2024, revealed that Section N was to be coded for medications received in the last seven days. Section N0415C was to be coded if the resident received an antidepressant medication in the previous seven days, Section N0415F1 was to be coded if the resident received an antibiotic medication in the previous seven days, and Section N0415K1 was to be coded if the resident received an anticonvulsant medication in the previous seven days. Physician's orders for Resident 6, dated August 29, 2025, included an order for the resident to receive 300 mg of Gabapentin (an anticonvulsant) at bedtime for neuropathy (when nerves are damaged and cause weakness, numbness and pain, usually in the hands and feet). Review of the Medication Administration Record (MAR) for Resident 6, dated August and September 2025, revealed that staff administered the 300 mg of Gabapentin to the resident at bedtime from August 29 through September 3, 2025. However, a quarterly MDS assessment for Resident 6, dated September 3, 2025, revealed that Section N0415K1 was not coded, indicating that the resident did not receive an anticonvulsant medication during the seven-day look-back assessment period.A nursing note for Resident 7, dated August 20, 2025, revealed that the resident was starting on hospice services and that all of his medications were discontinued.Review of the MAR for Resident 7, dated August, 2025 revealed that the resident did not receive antidepressants or anticonvulsants from August 21-August 31, 2025. However, a significant change MDS for Resident 7, dated August 31, 2025, revealed that Section N0415C was coded to indicate that the resident received an antidepressant medication and Section N0415K was coded to indicate that the resident received an anticonvulsant medication during the seven day look back period.Physician's orders for Resident 28, dated August 9, 2025, included an order for the resident to receive 500 mg of Divalproex (an anticonvulsant) at bedtime for seizures.Review of the MAR for Resident 28, dated August 2025, revealed that staff administered 500 mg of Divalproex to the resident at bedtime from August 9 through 31, 2025. However, an admission MDS assessment for Resident 28, dated August 13, 2025, revealed that Section N0415K1 was not coded, indicating that the resident did not receive an anticonvulsant medication during the seven-day look-back assessment period.Physician's orders for Resident 55, dated July 24, 2025, included an order for the resident to receive 500 mg of Cephalexin twice a day for cellulitis (infection of the skin). Review of the MAR for Resident 55, dated July and August, 2025, revealed that staff administered 500 mg of Cephalexin to the resident twice a day from July 24 through July 31, 2025. However, a quarterly MDS assessment for Resident 55, dated August 5, 2025, revealed that Section N0415F1 was not coded, indicating that the resident did not receive an antibiotic during the seven-day look-back assessment period. Physician's orders for Resident 61, dated August 9, 2025, included an order for the resident to receive 100 mg of Gabapentin in the morning and 200 mg in the evening for neuropathy.Review of the MAR for Resident 61, dated September 2025, revealed that staff administered 100 mg of Gabapentin to the resident in the morning and 200 mg of Gabapentin in the evening from September 1 through 9, 2025. However, a significant change MDS assessment for Resident 61, dated September 9, 2025, revealed that Section N0415K1 was not coded, indicating that the resident did not receive an anticonvulsant medication during the seven-day look-back assessment period.An interview with the Regional Registered Nurse Assessment Coordinator on October 16, 2025 at 10:51 a.m. confirmed that the MDS assessments listed above were coded incorrectly.28 Pa. Code 211.5(f) Clinical Records.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that bowel protocols were followed as ordered by the physician for one of 31 residents reviewed (Resident 61).Findings include:A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 61, dated September 9, 2025, revealed that the resident was cognitively intact and was frequently incontinent of bowel movements. Physician's orders for Resident 61, dated April 28, 2025, included orders for the resident to receive 30 milliliters of Milk of Magnesia as needed for no bowel movements for three days, give on day 4 of no bowel movement; a 10 milligram dulcolax suppository rectally as needed for no bowel movement for four days, give on day five of no bowel movement; and a Fleets enema to be given rectally as needed for no bowel movement for five days, give on day six of no bowel movement. Review of Resident 61's bowel records for August and September 2025 revealed that there was no documented evidence that the resident had a bowel movement from August 24 through 27, September 3 through 6, September 16 through 19, and September 25 through 28, 2025. Review of the August and September 2025 MAR's for Resident 61 revealed that staff did not initiate or follow the bowel protocol as ordered by the physician. Interview with the Nursing Home Administrator on October 16, 2025, at 11:08 a.m. confirmed that the physician's orders for bowel medications were not followed for Resident 61. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies, observations and staff interviews, it was determined that the facility failed to store food in accordance with professional standards for food service safety in two of two kitchenettes reviewed (first and second floor).Findings include: The facility policy regarding food storage, dated January 30, 2025, revealed that food should be stored in such a manner as to prevent contamination and to maintain the safety and wholesomeness of the food for human consumption. Observations in the kitchen's walk in dry storage room on September 29, 2025, at 9:37 a.m. revealed that there a bag of decorative sprinkles (approximately 10 pounds) that was open to the air, and one pound of [NAME] powder that expired on April 18, 2022. Observations in the second floor kitchenette's refrigerator/freezer on October 1, 2025, at 8:35 a.m. revealed a head of lettuce that was open to the air in the refrigerator, and two bags of frozen hot dogs (approximately 40) and a bag of six frozen hamburgers that were open to the air in the freezer.Observations in the fist-floor kitchenette freezer on October 1, 2025, at 8:50 a.m. revealed a bag of 16 frozen hot dogs and a platter of 14 frozen hamburgers that were open to the air.Interview with the Dietary Manager on October 1, 2024, at 12:00 p.m. confirmed that all food items in the kitchen/kitchenettes should be sealed in such a way as to prevent air from entering the food, and that expired food should be removed from the kitchen, and they were not.28 Pa. Code 211.6(f) Dietary services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on review of hospice contracts and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the designated interdisciplinary team member obtained the required information from the contracted hospice provider for one of five hospice residents reviewed (Resident 10). Findings include: An agreement between the facility and a hospice provider (provider of end-of-life services) indicated that the hospice provider would provide information to the facility to facilitate coordination of care that included a hospice benefit of elections form (a form signed to indicate that the individual waives all rights to traditional Medicare Part A payments for treatment related to the terminal illness). Physician's orders for Resident 10, dated April 25, 2025, revealed that the resident was to receive hospice services. As of September 30, 2025, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained the hospice benefit of elections form from the hospice provider. Interview with the Social Service Manager and the Hospice Representative on September 30, 2025, at 1:30 p.m. confirmed that there was no evidence that the election of benefits form was on Resident 10's hospice chart, and it should have been. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper hand washing techniques were used during medication administration for six of nine residents observed (Residents 10, 15, 26 34, 53, 59). Findings include:The facility's policies regarding oral medication administration and hand hygiene, dated January 30, 2025, indicated that all employees were to follow the hand washing procedure, which included hand sanitizing, before preparing or handling medications, and after glove removal.Observations during the medication pass on the 200 hall on October 1, 2024, at 7:40 a.m. revealed that Licensed Practical Nurse (LPN) 6 prepared Resident 53's medications and administered them. Without sanitizing his hands he prepared and administered Resident 26's medications, without sanitizing his hands LPN 6 donned gloves, prepared and administered Resident 59's medications, doffed his gloves and without sanitizing his hands he prepared and administered Resident 34's medications, without sanitizing his hands he prepared and administered Resident 15's medications. He then went to Resident 10's room and without sanitizing his hands he prepared and administered her medications. Interview with Licensed Practical Nurse 6 on October 1, 2025, at 8:36 a.m. confirmed that he should have sanitized his hands between residents, and after glove removal, while doing the medication pass. Interview with the Infection Control Nurse on October 16, 2025, at 9:13 a.m. confirmed that Licensed Practical Nurse 6 did not properly sanitize his hands during medication administration and after glove removal, and he should have. 28 Pa. Code 211.12(d)(5) Nursing services.