STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395610	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing and Rehab	349 Votech Drive Johnstown, PA 15904

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure timely medication administration per physician's orders, and failed to notify the physician that a medication was available for administration per physician's orders resulting in a delay in treatment for one of eight residents reviewed (Resident 6). Findings include: A facility policy regarding medication administration, dated November 26, 2025, indicated that medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 6, dated April 20, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, was frequently incontinent of bowel, and had a diagnosis of unspecified diarrhea. A nursing note for Resident 6, dated April 23, 2026, at 2:36 p.m. indicated that stool specimen results were received and indicated that the resident tested positive Clostridium difficile (C-diff-a highly contagious infection of the colon spread through contact). The resident was already on contact precautions (used to prevent the spread of infection passed through direct contact with an infected person or their environment) and the physician was notified. A physician's order for Resident 6, dated April 23, 2026, included orders for the resident to receive 500 milligrams (mg) of Metronidazole (an antibiotic) three times daily for C-diff for 14 days. A nursing note for Resident 6, dated April 24, 2026, at 9:29 a.m. indicated that orders were received from the physician to discontinue the Metronidazole (Flagyl) and give Dificid (an antibiotic specifically used to treat C-diff) 200 mg twice daily for 10 days for treatment of C-diff. A physician's order for Resident 6, dated April 24, 2026, included orders for the resident to receive200 mg of Dificid twice daily for C-Diff for 10 days until May 4, 2026. A nursing note for Resident 6, dated April 25, 2026, at 11:51 p.m. indicated that the facility was waiting for the Dificid to arrive. A nursing note for Resident 6, dated April 26, 2026, at 7:28 p.m. indicated that the facility was waiting for the Dificid to arrive. A nursing note for Resident 6, dated April 27, 2026, at 5:40 a.m. indicated that the nurse spoke with a representative from Polaris pharmacy concerning the Dificid medication. She stated this was a high-cost medication and they would send the payment information and alternative medication from insurance. The form was to be completed by the Director of Nursing or Assistant Director of Nursing and faxed back to pharmacy once received. A nursing note for Resident 6, dated April 27, 2026, at 8:48 a.m. indicated that the facility was waiting for confirmation of the Dificid medication. Review of Resident 6's Medication Administration Record (MAR), for April 2026, revealed that the resident had not received the Dificid medication as ordered since April 24, 2026. There was no documented evidence in the resident's clinical record that the physician was notified that the medication was not available to administer to the resident. An interview with the Assistant Director of Nursing on April 27, 2026, at 1:27 p.m. revealed that Resident 6's Dificid medication was on backorder per the pharmacy, and it was being delivered immediately to the facility this day. Interview with Resident 6, on April 27, 2026, at 2:37 p.m. indicated that she had been waiting for her antibiotic since Friday. She stated she had been asking them all weekend where her antibiotic was, and they stated that it was ordered. She stated that she wanted to get the infection resolved so she could go home. She indicated that there (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were people that were immuno-compromised at home and wanted to be free from infection when she went home. Interview with the Director of Nursing on April 27, 2026, at 2:47 p.m. confirmed that the physician should have been notified that Resident 6's Dificid medication was not available, and should have been informed that the resident did not receive the Dificid as ordered for treatment of her C-diff. She indicated that she spoke to the Certified Registered Nurse Practitioner (CRNP) this day, and he stated that he did not want to change Resident 6's Dificid medication due to it being more effective for the treatment of C-diff; however, he had not been notified until this day that the resident had not been receiving treatment for her C-diff infection. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to distribute and serve food in accordance with professional standards for food service safety by failing to ensure that dietary staff wore appropriate hair coverings while preparing residents' food, and failing to monitor food temperatures in the kitchen. Findings include: The facility's policy regarding the use of hair restraints, dated November 26, 2025 revealed that dietary staff must wear hair nets or caps and/or beard restraints when cooking, preparing or assembling food as a preventive measure against the spread of illness and to prevent hair from contacting exposed food. Observations in the main kitchen on April 27, 2026, at 11:32 a.m., revealed that the Dietary [NAME] was plating corn and placing beef on soft tortilla shells to make quesadillas for the lunch meal. Observations at this time revealed that he had a beard but was not wearing a beard restraint.The facility's policy regarding recording food temperatures, dated November 26, 2025, revealed that food temperatures will be checked before trays are assembled. This practice helps to ensure food is at the proper serving temperatures needed to limit the growth of pathogens capable of causing disease.Observations of the food temperature logs in the kitchen on April 27, 2026, at 11:50 a.m., revealed that the following April 2026, food temperature logs were either not done or were incomplete; April 21 and 22, no lunch temperatures, April 23, no temperatures for breakfast, lunch or supper, April 24, no breakfast or lunch temperatures, and April 26, no breakfast lunch or supper temperatures taken.Interview with the Dietary Manager on April 27, 2026, at 12:10 p.m. confirmed that the Dietary [NAME] was plating food and was not wearing a beard restraint, and should have, and that for the above-mentioned days the food temperatures should have been taken and recorded as per facility policy, and they were not. 28 Pa. Code 211.6(f) Dietary services.