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	01/30/2026

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

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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 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. 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's care plan reflected the resident's specific care needs for two of 35 residents (Resident 2 and Resident 61). Findings Include:A facility policy for comprehensive care plans, dated November 26, 2025, indicated that it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will describe individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated December 12, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included dementia and PTSD. There was no documented evidence that Resident 2's care plan reflected the diagnosis of PTSD with associated triggers. Interview with the Social Worker on January 30, 2026, at 09:18 a.m. revealed that the facility was not completing trauma informed care assessments and that they should be. In addition, the facility did not assess or identify specific triggers that may re-traumatize residents with past traumas to prevent triggers from occurring for Resident 2. Interview with the Director of Nursing on January 30, 2026, at 10:18 a.m. confirmed that Resident 2's care plan should have been updated to reflect the diagnosis of PTSD and potential triggers to avoid. A quarterly MDS assessment for Resident 61, dated November 14, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, received antidepressant medications (a psychotropic medication used to treat depression) and had diagnoses that included anxiety and depression. Psychotropic medications are medications used to treat mental health disorders by altering brain chemistry. A physician's order for Resident 61, dated December 31, 2025, included an order for the resident to receive 5 milligrams (mg) of Olanzapine (a psychotropic medication classified as an antipsychotic medication used to treat mental health disorders) daily at bedtime related to major depression. There was no documented evidence in Resident 61's medical record that a comprehensive care plan was developed to reflect the resident's need for an antipsychotic medication. Interview with the Director of Nursing on January 29, 2026, at 5:45 p.m. confirmed that there was no documented evidence in Resident 61's medical record that a comprehensive care plan was developed to reflect the resident's need for an antipsychotic medication. 28 Pa. Code 211.11(d) Resident care plan

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 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 clinical record reviews, as well as staff interviews, it was determined that the facility failed to follow physician's orders for one of 35 residents reviewed (Resident 80). Findings include: A facility policy for Medication Administration, dated November 26, 2025, indicated that medications will me administered as per the the physicians orders. A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 80, dated January 17, 2026, revealed that the resident was moderately cognitively impaired, had clear speech, understood and understands and had diagnoses that included heart disease and high blood pressure, and on May 13, 2025, was originally ordered 5 milligrams (mg) Lisinopril (a medication to treat high blood pressure) one time a day. A nursing note for Resident 80, dated October 8, 2025, at 12:07 p.m. indicated that the resident had an episode of dizziness and a blood pressure of 92/60 millimeters of mercury (mm/Hg). Physician's orders for Resident 80, dated October 9, 2025, included an order for the resident to receive 2.5 (mg) of Lisinopril one time a day, from October 9, 2025 to January 28, 2026, with the following blood pressure perimeters; hold if systolic (top number, when blood pushes out the heart) is less than or equal to 120 mm/Hg. A review of Resident 80's Medication Administration Record (MAR) for October 2025 through January 2026 revealed that on the following dates the resident received her lisinopril despite the blood pressure being too low to administer; October 23, 2025, 116/78 mm/Hg; November 2, 2025, 116/74 mm/Hg ; November 7, 112/70 mm/Hg; and November 20, 118/76 mm/Hg; December 28, 116/70 mm/Hg; January 1, 2026, 108/68 mm/Hg ; January 5, 108/66 mm/Hg; January 10, 114/76 mm/Hg; January 17, 110/60 mm/Hg; January 19, 112/66 mm/Hg; January 20, 120/88 mm/Hg; January 21, 112/62 mm/Hg; and January 28, 116/58 mm/Hg. On the following dates the resident did not receive the lisinopril despite the blood pressure being within the appropriate range to receive it, November 20, 2025, 124/70 mm/Hg and January 16, 2026, 142/88 mm/Hg . Interview with the Assistant Director of Nursing on January 29, 2026, at 11:20 a.m. confirmed that Resident 80's Lisinopril was not held or administered on the above dates and times as ordered by the physician.28 Pa. Code 211.12(d)(1)(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. 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 a resident received proper care for an indwelling urinary catheter (a tube inserted and held in the bladder to drain urine) for one of 35 residents reviewed (Resident 94). Findings include: The facility's policy regarding urinary catheter care, dated November 26, 2025, indicated that the purpose of this policy was to prevent catheter-associated urinary tract infections. General guidelines related to infection control indicated to make sure the catheter tubing and drainage bag were kept off the floor. An admission note for Resident 94, dated January 27, 2026, indicated that the resident was admitted to the facility for a three-day respite stay. A care plan for the resident, dated January 28, 2026, indicated that the resident had an indwelling urinary catheter related to urinary retention. Physician's orders for Resident 94, dated January 28, 2026, included an order for the resident to have an indwelling urinary catheter due to urinary retention. Observations on January 28, 2026, at 1:06 p.m. revealed that Resident 94 was lying in a low bed with his catheter bag hanging on the left side of his bed in a privacy bag with the catheter tubing lying in direct contact with the floor. Interview with Nurse Aide 1, on January 28, 2026, at 1:09 p.m. confirmed that Resident 94's catheter tubing was lying in direct contact with the floor and it should not have been. Interview with the Director of Nursing on January 28, 2026, at 5:36 p.m. confirmed that Resident 94's catheter tubing should not have been in direct contact with the floor. She indicated that they used to have hooks/clips to help keep the tubing off the floor. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD) (a mental and behavioral disorder that develops related to a terrifying event) for one of 35 residents reviewed (Resident 2).Findings include: Trauma informed care policy dated November 26, 2025, revealed that the facility will deliver care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent and account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated December 12, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included dementia and PTSD. A review of Resident 2's care plan, dated September 29, 2025, indicated that the resident had PTSD and dementia. There was no documented evidence the facility identified Resident 2's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring. Interview with the Social Worker on January 30, 2026, at 09:18 a.m. revealed that the facility was not completing trauma informed care assessments and that they should be. In addition, the facility did not assess or identify specific triggers that may re-traumatize residents with past traumas to prevent triggers from occurring for Resident 2. 28 Pa Code 211.12(a)(d)(3)(5) Nursing services. 28 Pa Code 211.11(d) Resident care plan. 28 Pa. Code 211.16(a) Social services.

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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. Based on review of facility policies and medication package inserts, as well as observations and staff interviews, it was determined that the facility failed to label multi-dose containers of medications with the date they were opened in one of two medication carts reviewed (C hall cart).The facility's policies regarding medication storage and disposal, dated November 26, 2025, revealed that the facility would properly date medication vials after they were opened. An undated package insert for Degludec (a diabetic medication) revealed that it should be used within 56 days upon opening. An undated package insert for NovoLog (a diabetic medication) revealed that the medication should be used within 28 days of opening. An undated package inserts for Humalog Kwikpen (a diabetic medication) revealed that it should be used after 28 days of opening.Observations in the C Hall cart on January 28, 2026, at 9:54 a.m. revealed that there was an 100 unit/ml Humalog Kwik Pen for Resident 31 open and undated, a 100 unit/ml Novolog Flex Pen and a 100 unit/ml Degludec FlexTouch pen for Resident 94 open, undated, and did not have a cap.Interview with Licensed Practical Nurse 3 on January 28, 2026, at 10:08 a.m. confirmed that the medication should have been dated upon opening.Interview with the Director of Nursing on January 28, 2026, at 4:15 p.m. confirmed that the medications should have been dated upon opening, and it should have had a cap.28 Pa. Code 211.9(a)(1) Pharmacy services.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 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 staff provided assistive devices to assist with eating in accordance with physician's orders for one of 35 residents reviewed (Resident 63). Findings include: The facility's policy regarding assistive devices and equipment, dated November 26, 2025, revealed thatcertain devices and equipment that assist with resident mobility, safety and independence are provided for residents. These may include specialized eating utensils and equipment. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 63, dated November 25, 2025, revealed that the resident was cognitively impaired, required set-up assistance with eating, had limited range of motion to his upper extremity on one side, and had a diagnosis of monoplegia (paralysis affecting one limb) following a cerebral vascular accident (stroke) affecting his left side. A nutrition care plan for Resident 63, dated June 21, 2025, indicated that the resident was to have adaptive equipment as ordered. Physician's orders for Resident 63, dated January 5, 2026, included an order for the resident to have an inner lip plate (plate that reduces food spillage) for meals. A nutrition note for Resident 63, dated January 13, 2026, at 9:44 a.m. indicated that the resident utilizes an inner lip plate for adaptive equipment. Observations of Resident 63 during the breakfast meal on January 30, 2026, at 8:38 a.m. revealed that the resident was sitting up in bed eating his breakfast meal served on a regular plate. The resident was having difficulty getting the food onto his fork and he had a large amount of food resting on his chest. The resident's meal ticket on his tray at that time indicated that the resident was to have an inner lip plate for meals. An interview with LPN 2 on January 30, 2026, at 8:40 a.m. confirmed that Resident 63 did not have an inner lip plate for breakfast and should have per his meal ticket. She stated she would address it with dietary. An interview with the Director of Nursing on January 30, 2026, at 8:42 a.m. confirmed that Resident 63 should have had an inner lip plate as ordered. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policies, observations, and staff interviews, it was determined that the facility failed to store food in accordance with professional standards for food service safety. Findings include: Observations of the walk-in cooler on January 28, 2026, at 9:42 a.m. revealed one quarter bushel of moldy cucumbers. Observations of the walk-in freezer on January 28, 2026, at 9:40 a.m. revealed that there was half of a box of Tony's pizzas, half of a bag of chicken tenders, one box of breadsticks that were opened, undated and exposed to the air. Observations of the small refrigerator in the kitchen on January 28, 2026, at 9:47 a.m. revealed half of a container of heavy whipping cream that was opened and undated. Observations of the residents' refrigerator on January 28, 2026, at 9:53 a.m. revealed half of a container of soup that was undated, with a brown and white removable substance around the lid. Interview with the Dietary Director on January 28, 2026, at 9:53 a.m. confirmed that food should be dated when it is opened and should be properly sealed for storage, and that resident food should be thrown out when it shows signs of spoilage.28 Pa. Code 211.6(f) Dietary Services. 28 Pa. Code 207.4 Ice Containers and Storage.