STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395812	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Heights Health & Rehab Center	100 Woodmont Road Johnstown, PA 15905

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48809 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for the care of a Peripherally Inserted Venous Catheter (PICC a type of long-term intravenous catheters) for one of five residents reviewed (Resident 4). Findings include: A facility policy for intravenous catheters, dated October 31, 2023, revealed that dressings for PICC lines will be changed weekly or as needed per physician's orders. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated June 28, 2024, indicated that the resident was cognitively intact, required assistance from staff for care, had a PICC line, and received intravenous (IV- administered directly into a vein) medication. Physician's orders for Resident 4, dated July 13, 2024, included an order for the resident to receive a PICC line dressing and cap change weekly on Mondays. There was no documented evidence in Resident 4's clinical record to indicate that the PICC line dressing and cap were changed weekly on Monday, July 15, 2024, or Monday, July 22, 2024, as ordered. An interview with the Director of Nursing on August 28, 2024, at 12:16 p.m. confirmed that the PICC dressing for Resident 4 should have been changed at least weekly and wasn't. 28 Pa. Code 211.12(d)(1)(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395812	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Heights Health & Rehab Center	100 Woodmont Road Johnstown, PA 15905

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48809 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors for one of five residents reviewed (Resident 1). This deficiency was cited as past non-compliance. Findings include: Physician's orders for Resident 1, dated June 25, 2024, included orders for the resident to receive one 200 milligrams (mg) tablet of lacosamide (medication for seizures) twice a day. A nurse's note for Resident 1, dated July 19, 2024, at 11:30 p.m., revealed that the nurse administered two 200 mg tablets of lacosamide instead of one, and the physician ordered the resident be sent to the emergency room for observation. A nurse's note for Resident 1, dated July 23, 2024, at 4:31 p.m., revealed that the resident returned to the facility at 10:30 a.m. after being admitted to the hospital on July 20, 2024, due to vomiting after receiving two 200 mg tablets of lacosamide. Interview with the Director of Nursing on August 28, 2024, at 2:30 p.m. confirmed that the resident should have only received one 200 mg tablet of lacosamide. Following the incident on July 19, 2024, the facility's corrective actions included. On July 20, 2024; July 23, 2024; and July 24, 2024, education on medication administration and the six rights of medication administration was completed for all licensed practical nurses and professional (registered) nurses. On July 20, 2024, and July 21, 2024, all controlled medications for all residents were reviewed to ensure proper administration. The facility's corrective action was completed as of July 24, 2024. On August 8, 2024; August 12, 2024; August 19, 2024; and August 26, 2024, controlled medication audits were completed to ensure proper administration. Interviews with staff throughout the complaint investigation on August 28, 2024, revealed that they were re-educated and knowledgeable regarding the the six rights of medication administration. 28 Pa. Code 211.9(d) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.