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	09/19/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41233 Based on observations and staff interviews, it was determined that the facility failed to provide a clean, homelike environment for one of nine residents reviewed (Resident 3). Findings include: The facility's policy titled Cleaning and Disinfection of Resident Care Equipment, dated October 31, 2023, revealed that the policy objective was to provide a safe, clean environment and equipment for residents. A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated September 7, 2024, revealed that the resident was cognitively intact, required assistance with most daily care needs, and had diagnoses that included multiple sclerosis (a chronic disease that effects the nervous system). Observation of Resident 3 lying on the bed in her room on September 19, 2024, at 4:10 p.m. with her wheelchair beside the bed revealed that there was a heavy accumulation of removable dust/debris on the wheels and the metal supports under the chair. There was also a white, stuck-on substance under the wheelchair seat cushion and dirt and debris on the seat cushion. The top of the seat backrest was torn and shredded in several places. Interview with Physical Therapist 1 on September 19, 2024, at 4:27 p.m. confirmed that Resident 3's wheelchair was provided to her by physical therapy and that she uses the wheelchair for mobility. She also confirmed that there was a heavy accumulation of removable dust/debris on the wheels and the metal supports under the chair, and that there was a white, stuck-on substance under the wheelchair seat cushion and dirt and debris on the seat cushion. The top of the seat backrest was torn and shredded in several places. In addition, Physical Therapist 1 stated that the chair was filthy. Interview with the Nursing Home Administrator on September 19, 2024, at 5:00 p.m. confirmed that Resident 3's chair should not be torn and the dust, dirt, and debris should not have been there, and that it should have been cleaned. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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: 395812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER: Hilltop Heights Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 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. 41233 Based on review of facility policy, clinical record reviews, and staff interviews, it was determined that the facility failed to follow physician's orders for medication and failed to conduct neurological checks per policy after a fall for one of nine residents (Resident 4) reviewed. Findings include: A facility policy regarding neurological checks, revised July 9, 2024, indicated that a neurological check (a series of tests and questions that assess a patient's nervous system) would be provided by a licensed professional to all residents who have sustained a witnessed, unwitnessed, alleged, reported, or suspected head trauma following an unusual occurrence or change in resident neurological condition. Unless otherwise ordered by the physician, the frequency of neurological assessments will be once every shift for 72 hours post occurrence or change. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated August 16, 2024, revealed that the resident was understood, could understand, was cognitively impaired, and required assistance with care needs. An event report for Resident 4, dated September 17, 2024, revealed that she had an unwitnessed fall with no noted injuries. A nursing note for Resident 4, dated September 17, 2024, indicated that the resident had fallen and was found sitting upright on the right side of the bed. There was no documented evidence in the clinical record that neurological checks were completed per facility policy after the fall. Interview with the Director of Nursing on September 19, 2024, at 3:40 p.m. confirmed that there was no documented evidence of neurological checks following Resident 4's fall and initial assessment. A census record for Resident 4 indicated that she was moved to another room on September 13, 2024, then moved back to her original room on September 17, 2024. Interview with Resident 4 on September 19, 2024, at 12:45 p.m. indicated that she had to move rooms because her roommate was COVID-19 positive. A review of the Medication Administration Record for September 2024 revealed no documented evidence to indicate that Resident 4's medication was administered from the afternoon of September 13 through the morning of September 16, 2024. Interview with the Director of Nursing on September 19, 2024, at 3:40 p.m. confirmed that there was no documented evidence of medication administration for Resident 4 for the dates listed above. She attempted to call the other staff who were scheduled to give the medication but has not received a call back. There was no evidence that medication was administered as ordered by the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Hilltop Heights Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Licensed Practical Nurse 2 on September 19, 2024, at 5:03 p.m. revealed that she administered medication between 6:00 a.m. and 4:00 p.m. during the dates listed above but did not know why there was no documentation of the administration. 28 Pa. Code 211.12(d)(3)(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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 41233 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that the call bell system was in full working order for the residents on the North hall. Findings include: The facility's policy titled Call Lights: Resident Communication System Accessibility, dated October 31, 2023, revealed that the facility is to be adequately equipped with a call bell system that functions properly through the facility. Interview with Nurse Aide 3 on September 19, 2024, at 11:02 a.m. revealed that when a resident activates the call bell on North hall, the light above the resident's room comes on but the sound is not activated. She also revealed that the central call light for the North hall always stays on; this is a light on the ceiling by the nurse's station that makes the nurse aware that a call bell is going off. This light never turns off despite all call bells being answered. She further indicated that with the central light and bell tones not functioning properly, it has made it difficult to know when a bell is ringing if she is on another hallway. Nurse Aide 3 stated that maintenance has been made aware of the situation. Observations in the East and [NAME] halls on September 19, 2024, at 11:40 a.m. revealed that when a resident activated their call bell, the light above their room would come on and a high pitch tone would come on as well. When the staff turned off the call bell, the light and tone both went off. Interview with the Director of Maintenance on September 19, 2024, at 11:27 a.m. indicated that he was not aware of the call bell concern and that he had no written record of the call bell malfunction being reported. The Director of Maintenance attempted to fix the problem and went to the buzzer box in the North hallway and reset it. When he did this the high pitch call bell tone came on and it did not go off despite no call lights being activated and lighting up in the hallway. Approximately one hour later, the Director of Maintenance returned to the surveyor and stated that the issue was resolved. He indicated that a battery needed replaced in a resident's bathroom call system. Interview with the Director of Nursing on September 19, 2024, at 5:30 p.m. confirmed that the call bell system in the North hall was not functioning properly and it should have been. 28 Pa. Code 207.2(a) Administrator's Responsibility. 28 Pa. Code 211.12(d)(5) Nursing Services.