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	05/14/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on a 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 representative was notified about a change in condition for one of eight residents reviewed (Resident 1). This was cited as past non-compliance. Findings include: The facility's policy for a resident's change in condition, dated October 24, 2025, indicated that the physician/provider and family/responsible party will be notified as soon as the nurse has identified the change in condition and the resident is stable. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated April 1, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had one deep tissue injury (a type of pressure ulcer where damage occurs beneath the skin's surface) on admission, and had diagnoses that included a pelvic fracture. A nursing note for Resident 1, dated April 9, 2024, at 7:47 a.m., revealed that new orders were received for isolation precautions due to the resident testing positive for Covid. A nurse's note for Resident 1, dated April 11, 2025, at 8:52 a.m. revealed that the resident's emergency contact person was made aware that Resident 1 was Covid positive, (two days after diagnoses). Interview with the Director of Nursing on May 13, 2024, at 12:26 p.m. confirmed that Resident 1's family was not notified of the resident's positive Covid diagnosis until two days after diagnosis, and they should have been notified as soon as possible according to the facility's policy. Following identification that residents' family or responsible party were not being informed of changes in condition timely, the facility's corrective actions included: A baseline phone call was placed to responsible parties of all residents to update their status and ask if there were any concerns. Education was provided to licensed staff regarding notification of responsible party and physicians. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Audits were completed for two weeks to identify residents that required family/responsible party notification and will continue twice weekly for a total of four weeks then monthly. The findings will be reviewed with the quality assurance performance improvement committee. A review of the facility's corrective actions revealed that they were in compliance with F580 on May 1, 2025. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of clinical records and observations, as well as resident and staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in care needs for one of eight residents reviewed (Resident 2). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated April 6, 2024, revealed that the resident was cognitively intact and was dependent on staff for care needs. Review of Resident 2's smoking care plan, dated February 2, 2025, indicated that the resident was non-compliant with the facility's non-smoking policy and was able to go outside with one staff member; however, a smoking safety assessment for Resident 2, dated July 11, 2024, revealed that the resident was safe to smoke independently and did not require staff assistance. Interview with Resident 2 on May 12, 2025, at 11:50 a.m. revealed that he has always gone outside to smoke by himself and has never required a staff member. Interview with the Director of Nursing and Nursing Home Administrator on May 13, 2025, at 9:36 a.m. confirmed that Resident 2's care plan did not reflect that the resident was able to go outside to smoke by himself but should have. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify a provider's order for treatments for one of eight residents reviewed (Resident 1). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated April 1, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had one deep tissue injury (a type of injury caused by pressure where damage occurs beneath the skin's surface) on admission, and had diagnoses that included a pelvic fracture. Physician's orders for Resident 1 dated April 1, 2025, included an order for staff to cleanse the right gluteus (buttocks area) wound with wound cleaner, apply skin prep to surrounding tissue, apply Hydrogel (dressing designed to provide a moist wound environment to promote healing) to the base of the wound and secure that with bordered foam (an absorbent wound dressing). Physician's orders for Resident 1, dated April 21, 2025, included orders for staff to cleanse the right gluteus wound with wound cleaner, apply skin prep to surrounding tissue, then lightly fill the wound cavity with acetic acid (0.25 percent) (used to treat or prevent wound infections) moist gauze to the base of the wound and secure that with dry gauze/tape twice a day and as needed A wound consultant note for Resident 1, dated April 15, 2025, indicated that the Certified Registered Nurse Practitioner recommended that staff cleanse the right gluteus wound with wound cleaner, apply skin prep to surrounding tissue, then lightly fill the wound cavity with acetic acid (0.25 percent) moist gauze to the base of the wound and secure that with dry gauze/tape twice a day and as needed. Review of the Treatment Administration Record for Resident 1, dated April 2025, revealed no documented evidence that the treatment to the resident's right gluteus was completed according to the wound care consultant's recommendations from April 15 through April 20, 2025. Interview with the Director of Nursing on May 13, 2025, at 12:26 p.m. revealed that there was no documented evidence that the physician was made aware of the April 15, 2025, wound consult recommendations until April 21, 2025. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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 observations and staff interviews, it was determined that the facility failed to ensure that food was served under sanitary conditions in accordance with professional standards for food service safety. Findings include: Observations in the facility's kitchen area on May 12, 2025, at 9:30 a.m. revealed a garbage can near the employee sink that was overflowing with garbage and a brown, removable substance streaked across the floor beside that garbage can. A garbage can near the dietary department entrance in the hallway was overflowing with garbage and an individual-sized syrup container was opened and spilled on the floor near a nonfunctioning upright cooler in the same area. A dirty glove was observed on the floor near two garbage cans in the cooking prep area. The dishwashing area of the dietary department had an unpleasant, musty odor and there were approximately eight broken floor tiles observed. Water was pooling under the broken floor tiles and a significant amount of water accumulated on the floor under the dishwasher, spreading to the back wall under a long sink, traveling to the food cart storage area. The grout lines of the tiles on the floor were observed to have a thick, removable, dark gray substance in them. The milk cooler did not have a thermometer in it to check for safe temperature for milk storage. An upright cooler containing trays that held thickened liquids for the tray line did not have a thermometer in it, the thickened liquids in the cooler were not dated, and water was observed pooling on the trays and on the bottom of the cooler. Observations of the dry storage area revealed an accumulation of black dirt on the floor where the floor and wall meet. Observations in the back of the walk-in freezer revealed water dripping from the ceiling onto a box containing meatballs, a box containing buns, and a box containing rolls, and there was an accumulation of ice on the floor beside those boxes. Observations of the walk-in cooler revealed that water was dripping from the ceiling mid-way into the cooler and dripping/pooling onto a movable cart and a box of beef patties, and the shelving on left side of cooler had observable discolored dirt/debris on it. Observations made on May 13, 2025, at 9:30 a.m. revealed approximately eighteen cups of nectar thick liquids and approximately thirteen cups of honey thickened liquids in the small upright cooler were not dated. Interview with the dietician on May 12, 2025, at the time of the observations at 9:30 a.m. revealed that dietary staff were responsible for the cleanliness of the kitchen area, and they were to sign a paper that was hanging on the wall when cleaning tasks were completed; however, there was no evidence that cleaning tasks were being completed as scheduled. The dietician confirmed that the dishwashing area had an unpleasant odor and an accumulation of water was observed on the floor, that the tile grout on the floor had an accumulation of a dark gray, removable substance. The dietician confirmed that the dry storage area had dirt on the floor near the wall, the walk-in cooler and freezer should not have had water dripping onto food items, the shelving in the walk-in freezer was dirty, the milk cooler should have had a thermometer in it, and the small upright cooler had water pooling in it and the thickened liquids were not dated and should have been. The dietician confirmed that garbage cans were overflowing, and that kitchen had a general appearance of being unclean. Interview with the Dietary Manager on May 13, 2025, at 9:30 a.m. revealed that the thickened liquids in the upright cooler should have been dated and were not. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Maintenance Director on May 13, 2025, at 9:45 a.m. revealed that the garbage disposal was cracked, causing water to accumulate on the floor and the tile grout, that there were broken tiles on the floor, and the unpleasant odor was a result of the accumulating water. 28 Pa. Code 211.6(f) Dietary Services.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations and staff interviews, it was determined that the facility failed to ensure that essential equipment was in safe operating condition in the facility's kitchen. Findings include: Observations in the facility's kitchen on May 12, 2025, at 9:30 a.m. revealed an accumulation of water on the floor near the dishwasher because the garbage disposal under the commercial dishwasher was broken. A note on the upright hot box read unplug, won't shut off. A note on the steamer read awaiting parts. One of three steam tables was not functioning. A small upright cooler had water pooling inside of it, and the long sink in the dishwashing area had water leaking from two faucets. Interview with the Dietician on May 12, 2025, at 10:50 a.m. confirmed that the garbage disposal under the commercial dishwasher was not functioning, the hot box would not shut off and had to be unplugged to turn it off, the steamer had not been working since it was installed because it was installed with missing parts, one steam table was not working, the small upright cooler had water accumulating in it, and the faucets on the long sink in the dishwashing area were leaking. Interview with the Maintenance Director on May 13, 2025, at 9:45 a.m. revealed that the garbage disposal was cracked, causing water to accumulate on the floor. The steamer was installed with missing parts and has not worked since it was installed. He was unable to repair one steam table and it needs replaced. The small upright cooler should not be accumulating water inside it. The faucets in the long sink in the dishwashing area were leaking into the sink. 28 Pa. Code 201.18(b)(3) Administrator's Responsibility.