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	03/04/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that recommendations from a wound consultant were reviewed with the attending physician for two of 12 residents reviewed (Resident 1 and Resident 11). 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. Review of a facility policy for skin and wound best care practices dated August 18, 2025, indicated that communities may engage the services of a consulting wound care provider after consultation with the resident's medical provider and receipt of an order. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated December 13, 2025, indicated that the resident was cognitively intact, had impairment to her range of motion to her lower extremity on one side, was dependent for lower body dressing and toileting hygiene, was dependent for rolling left to right in bed, refused to get out of bed, was always incontinent of bowel and bladder, had no pressure ulcers, received ointments/medications other than to her feet, had a pressure relieving device to her bed and chair, and had diagnoses that included morbid obesity and diabetes. A wound consultant note for Resident 1, dated February 11, 2026, revealed that the resident had gluteal dermatitis and recommended changing the treatment due to difficulty keeping the regions dry due to incontinence and the resident refusing side lying positions. The wound consultant recommended to discontinue the silver sulfadiazine (SSD-a topical antibiotic cream) and change the treatment to the gluteal regions to include distal folds related to Incontinence Associated Dermatitis (IAD-moisture associated skin damage). Staff were to cleanse the area with soap and water, pat dry, apply Nystatin Topical Powder (an antifungal powder used to treat infections in moist areas) to the base of the wound, and secure with a pad with nonwoven dry gauze sheet twice daily and as needed. A review of Resident 1's Treatment Administration Record (TAR), dated February 2026, revealed that the resident's recommended treatment to her gluteal dermatitis was not initiated until February 13, 2026. There was no documented evidence that the physician reviewed that above wound consultant recommendations until February 13, 2026. Interview with the Director of Nursing, Nursing Home Administrator and the facility's Consultant on February 4, 2026, at 4:25 p.m. confirmed that wound care recommendations are made by the wound nurse practitioner and the physician is to review the recommendations and accept or decline the recommendation. They confirmed that the wound recommendations are received from the wound consultant the same day the recommendations are made; however, they often do not review the recommendations with the physician until he comes into the facility for his weekly rounds. The Director of Nursing confirmed that the wound care recommendations for Resident 1's treatment change to her gluteal regions to include distal folds related to IAD, recommended on February 11, 2026, were not reviewed with the attending physician until February 13, 2026, resulting in wound care not being completed as recommended by the wound consultant. A quarterly MDS assessment for Resident 11, dated January 9, 2026, indicated that the resident was cognitively impaired, required (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance from staff for daily care needs, required substantial assistance with bed mobility, was frequently incontinent of bowel and bladder, had a wound infection, had a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin), and had diagnosis that included dementia. A wound consultant note for Resident 11, dated January 7, 2026, revealed that the resident had a left hip abscess (a build-up of pus caused by an infection) and recommended to change the treatment. Staff were to cleanse the area with wound cleanser, apply Bacitracin (a topical antibiotic) ointment to the base of the wound, and secure with dry dressing daily and as needed. A wound consultant note, dated January 14, 2026, revealed that the wound consultant recommended to continue the treatment to the left hip abscess as recommended on January 7, 2026. There was no documented evidence that the physician reviewed that above wound consultant notes to agree or disagree with the recommendations, resulting in wound care not being completed as recommended by the wound consultant. A review of Resident 11's Treatment Administration Record (TAR), dated January 2026, revealed that there was no documented evidence that the treatment to the resident's left hip abscess was completed according to the wound care consultant's recommendations. Interview with the Director of Nursing on March 4, 2026, at 3:39 p.m. confirmed that the wound care recommendations for Resident 11's treatment to her left hip abscess, recommended on January 7 and 14, 2026, were not reviewed with the attending physician, resulting in wound care not being completed as recommended by the wound consultant. 28 Pa. Code 211.12(d)(1)(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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to provide care for pressure ulcers in accordance with professional standards of practice, by failing to ensure that recommendations from a wound consultant were reviewed with the attending physician for one of 12 residents reviewed (Resident 9) who had pressure ulcers, and by failing to ensure that recommendations from a wound consultant were reviewed with the attending physician and initiated timely for a resident with a worsening pressure ulcer (Resident 11). Findings include: Review of a facility policy for skin and wound best care practices dated August 18, 2025, indicated that pressure injuries will be treated with evidence-based interventions as ordered by the provider. Communities may engage the services of a consulting wound care provider after consultation with the resident's medical provider and receipt of an order. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated January 19, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnosis that included traumatic ischemia of muscle (condition where there is inadequate blood supply to the muscle tissue, caused specifically by a traumatic event or injury), and had pressure ulcers (skin breakdown caused by pressure). Physician's orders for Resident 9 dated January 15, 2026, included for the resident to have his Right buttocks and right sacrum (area on the lower back near the base of the spine), right lateral (right side of the body positioned away from the midline), and right proximal (the right side of the body that is situated closer to the center) cleansed with wound cleanser, pat dry, apply hydrogel (advanced wound care products designed to create a moist, soothing environment that promotes faster healing, pain relief, and autolytic debridement (removal of dead, damaged, or infected tissue)) to base of wound, and secure with dry dressing. Change daily and as needed once a day. Physician's orders for Resident 9 dated January 22, 2026, included for the resident to have his left sacrum pressure ulcer/injury cleansed with wound cleanser, apply Bacitracin (an antibiotic) ointment to base of the wound, and secure with dry dressing. Change daily and as needed. A wound consultant note for Resident 9, dated February 4, 2026, revealed that the resident's pressure ulcer on his right sacrum was resolved and to discontinue the treatment. A wound consultant note dated February 11, 2026, revealed that the pressure ulcer to the resident's left sacrum was resolved and to discontinue the treatment. There was no documented evidence that the physician reviewed that above wound consultant notes to agree or disagree with the recommendations. A review of Resident 9's Treatment Administration Record (TAR) dated February 2026 revealed that the resident continued to receive hydrogel to his right sacrum and Bacitracin to his left sacrum through March 3, 2026. Interview with the Nursing Home Administer and the Director of Nursing on March 4, 2026, at 4:26 p.m. confirmed that wound care recommendations are made by the wound nurse practitioner and the physician is to review the recommendations and accept or decline the recommendation. Staff get verbal orders from the physician to accept or decline the recommendations. There was no documented evidence that the physician reviewed the wound care notes or recommendations for Resident 9 on the above-mentioned dates. A quarterly MDS assessment for Resident 11, dated January 9, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, required substantial assistance with bed mobility, was frequently incontinent of bowel and bladder, had a wound infection, had a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin), and had a diagnosis of dementia. A wound consultant note for Resident 11, dated January 7, 2026, revealed that the resident had an unstageable pressure ulcer (full-thickness pressure injury in which the base is obscured by slough and/or eschar) to her left sacrum (last bone in the spine located above the tailbone) that was rapidly progressing, larger and presented with eschar (dead tissue that prevents healing) and slight induration. Recommendations were made to change the treatment to the left sacrum and staff were to cleanse the wound with wound cleanser, apply skin prep to the surrounding tissue or peri wound, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	apply Bacitracin ointment to base of the wound, secure with bordered dressing daily and as needed. A review of Resident 11's Treatment Administration Record (TAR), dated January 2026, revealed that the resident's recommended treatment to her left sacrum was not initiated until January 11, 2026. There was no documented evidence that the physician reviewed the wound care recommendations until January 11, 2026. Interview with the Director of Nursing, Nursing Home Administrator and the facility's Consultant on February 4, 2026, at 4:25 p.m. confirmed that wound care recommendations are made by the wound nurse practitioner and the physician is to review the recommendations and accept or decline the recommendation. They confirmed that the wound recommendations are received from the wound consultant the same day the recommendations are made; however, they often do not review the recommendations with the physician until he comes into the facility for his weekly rounds. They indicated that the delay was acceptable and did not feel it was necessary to call the physician for every recommendation, especially if the wound was stable and not worsening. They confirmed that there was no documented evidence the wound treatment recommendations made on January 7, 2026, to Resident 11's worsening left sacrum was reviewed by the physician and initiated until January 11, 2026. 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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to maintain the sanitation of the kitchen regarding thermal coffee mugs. Findings include:The facility's policy for kitchen sanitation and cleaning, dated August 18, 2025, revealed that the food and nutrition services staff would maintain the sanitation of the kitchen.Observations in the main kitchen on March 4, 2026, at 09:16 a.m. revealed that 25 out of 39 maroon and/or black thermal coffee mugs observed had a moderate to large blackish brown removable substance inside. These mugs were on a rack beside the entrance door to the kitchen and beside the exit of the dishwasher.Interview with the Dietary Aide1 on March 4, 2026 at 9:19 a.m., who was running the dishwasher at the time, confirmed that the thermal coffee mugs observed were washed and in circulation and ready to be used for the residents. He also confirmed that they had a brownish black removable build up inside the cup. He was surprised and indicated that they should not be dirty since they were washed. Interview with the Dietician (the Dietary Manager was not in the facility at the time) on March 4, 2026, at 9:23 a.m. confirmed that the maroon and/or black thermal coffee mugs had a blackish brown removable substance inside. She confirmed that coffee mugs observed were in circulation and ready to be used for the residents.Interview with the Infection Preventionist on March 4, 2026 at 1:30 p.m. confirmed that all items used for serving food should be clean.Interview with the Nursing Home Administrator on March 4, 2026 at 14:02 p.m. confirmed that the 25 maroon and/or black thermal coffee mugs observed should be clean inside, and they were not. 28 Pa. Code 211.6(f) Dietary Services.