

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/08/2026
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of policies, clinical records, and information provided by the facility, as well as staff interviews, it was determined that the facility failed to ensure that a thorough investigation was completed into the resident's and their family member's concern for one of 36 residents reviewed (Resident 102). Findings include: The facility's policy regarding complaint grievances, dated August 18,, 2025, revealed that residents have the right to vice grievances. If a corrective action was taken a summary of that action would be provided. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 103, dated November 7, 2025, revealed that the resident was understood, could understand others, was cognitively impaired, and was dependent on staff for transfers from bed to chair. Interview with a group of residents on January 6, 2026, at 1:15 p.m. revealed that the residents have to wait because there were only two lifts shared between the halls, and Resident 102's family member has filed grievances. A concern form filed by a family member for Resident 102 dated November 7, 2025, indicated that there were not enough lifts for residents. After the investigation, the facility would be ordering another lift to ensure no issues arise. A concern form filed by a family member for Resident 102 dated December 3, 2025, indicated that there continued to be a lack of lifts making resident wait longer to be cared for, that was were to be ordered. Interview with the Nursing Home Administrator on January 8, 2026, at 11:35 a.m. revealed that the facility has not ordered a new lift as a resolution to a grievance 28 Pa. Code 201.29(i) Resident Rights.		

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 - Some	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 two of 36 residents reviewed (Residents 6 and 10). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated October 20, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnosis that included diabetes. Physician's orders for Resident 6, dated October 17, 2025, included an order for the resident to receive 15 units of Novolog U-100 Insulin aspart (a man-made insulin used to control high blood sugar) before meals for diabetes; hold if the resident's blood sugar is less than 150. A review of Resident 6's Medication Administration Record (MAR) for November and December 2025 revealed that 15 units of Novolog U-100 Insulin aspart was administered to the resident on November 3, 2025, at 11:00 a.m. when the residents blood sugar was 128, on November 7, 2025, at 4:00 p.m. when the residents blood sugar was 82, on November 29, 2025, at 4:00 p.m. when the residents blood sugar was 112, on December 19, 2025, at 4:00 p.m. when the resident's blood sugar was 118, and on December 27, 2025, at 4:00 p.m. when the resident's blood sugar was 109. Interview with the Director of Nursing on January 8, 2025, at 11:36 a.m. confirmed that Novolog U-100 Insulin aspart was administered to Resident 6 on the above dates and times when it should not have been. An annual MDS assessment for Resident 10, dated May 4, 2025, revealed that the resident was cognitively intact, required assistance from staff for care, and received insulin for diabetes mellitus (disease that leads to high blood sugar levels). Physician's orders, dated March 27, 2025, included orders for Resident 10 to receive Humalog insulin (a rapid-acting insulin) 10 units before meals but to hold if blood sugar levels were less than 150. Review of Resident 10's Medication Administration Record, dated November and December, 2025, revealed that on November 25 the resident's blood sugar was 121 and according to the parameters the insulin should have been held, however, it was administered. On December 8 his blood sugar was 100 and the insulin should have been held, but was administered. On December 28 at 11:00 a.m. his blood sugar was 142 and the insulin should have been held, however, it was administered. On December 28 at 4:00 p.m. his blood sugar was 148 and the insulin should have been held, however, it was administered. Interview with the Director of Nursing (DON) on January 6, 2026, at 2:48 p.m. confirmed that Resident 10's insulin should have been held on the dates referenced above and it was not. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, as well as staff and resident interviews, it was determined that the facility failed to ensure that dietary staff served the appropriate planned portion sizes, and failed to follow their pre-approved planned menu and recipes. Findings include: Interview with Resident 5 on January 5, 2026, at 10:32 a.m. revealed that she gets small amounts of food and that the serving sizes are not consistent. She stated that she has asked for substitutes or seconds and has been told that they ran out of food or that nothing else is available. Interview with Resident 6 on January 5, 2026, at 10:22 a.m. revealed that he doesn't feel he gets enough food or appropriate food for his diet. Interview with Resident 7 on January 5, 2026, at 10:32 a.m. revealed that his requests for alternative food choices get denied and they tell him that they have run out of those items. Interview with Resident 92 on January 5, 2026, at 11:30 a.m. revealed that he never gets double portions like he is supposed to get. He stated that he often receives even less food than other people he sits with at lunch. He said that if he tries to order something else from the kitchen, he is told that there is no more left. Observations of Resident 92 on January 5, 2026, at 12:39 p.m. revealed that he had one piece of Salisbury steak, one scoop of macaroni and cheese, one scoop of capri vegetables and one very small piece of cake (less than a bite size). Interview with resident 39 on January 5, 2026, at 12:38 p.m. revealed that the portion sizes are not consistent and are often very small. He stated that one night for supper they were served three ravioli, and they were very small ravioli. He further stated that on Christmas they were served three tiny bites of ham that resembled lunch meat and a small scoop of mashed sweet potatoes that were dry and tasteless. Interview with Resident 15 on January 5, 2026, at 2:32 p.m. revealed that he never receives enough food. He stated that he feels the portion sizes are too small. He said that his meals do not usually match the tray ticket, so he is not sure what foods he is served on his tray. He further stated that if he asked for a substitute, he is told they ran out or there is nothing left. Observations of Resident 92's lunch tray on January 6, 2026, at 12:39 p.m. revealed that he had a very small portion of chicken and dumplings (only one dumpling and no chicken or gravy) and a small dinner roll, however, his tray ticket indicated that he was to receive 12 ounces of the chicken and dumplings. Observations of Resident 94's lunch tray at that time revealed that she had a much larger portion size of the chicken and dumplings with gravy over it and that her tray ticket revealed that she was to receive 6 ounces of the chicken and dumplings. Interview with the Dietician on January 6, 2026, at 12:41 p.m. revealed that Resident 92 did not have the 12 ounces of chicken and dumplings as his tray ticket stated and that he should have. She confirmed that the serving sizes were not consistent. She further confirmed that the dinner roll was very small and should have been larger in size. She indicated that the rolls were not permitted time to rise and that was why they appeared so small. Observation of the posted meal menu for lunch on January 7, 2026, indicated the meal would be a stuffed bell pepper, mashed potatoes, Italian blend vegetables, dinner roll, and angel cake with fruit topping. Observations in the kitchen for the lunch meal service on January 7, 2025, at 12:10 p.m. revealed that the main menu item was a stuffed bell pepper, mashed potatoes, and Italian blend vegetables and garlic bread. The available pureed food for the lunch meal was pureed beef tips and pureed creamed corn. Observations of the alternative meal request form provided to residents included that requests for menu changes for lunch must be submitted by 9:30 a.m. Observations of the lunch meal on January 7, 2026, at 12:38 p.m. revealed that the residents received a stuffed pepper for the main entree. However, some residents had a whole pepper, and some residents had one half of a pepper or just some pieces of a pepper. Serving sizes were not consistent. Resident 94's tray ticket indicated that she was to receive one stuffed pepper. Her tray had one half of a stuffed pepper. Observations of the posted meal menu on January 8 at 10:30 a.m. on the bulletin board on the unit and near the kitchen, identified the lunch meal as Resident's choice and buttered corn, but did not specify what the resident's choice was. Interview with the dietician on January 8, 2026, at 12:54 p.m. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed that the dinner rolls posted on the menu for January 7 were changed to garlic bread, however, the change was not posted anywhere for residents to observe, nor where the residents informed verbally. Interview with the dietician and regional dietary manager on January 8, 2026, at 1:20 p.m. revealed that the menu should have been posted prior to 9:30 a.m. on January 8 so that residents were aware of the planned menu and were able to make choices regarding alternative meals by the required 9:30 a.m. The pureed main menu lunch item on January 7 was roast beef because that is what the extension menu identified it should be according to the corporate office. The serving size for the pureed roast beef and corn was listed as 1 serving, however she could not identify how much one serving was supposed to be. Residents receiving the pureed diet were not provided with a menu or information to inform them that they were getting something other than what was on the posted menu. Interview with the regional dietary manager on January 8, 2026, at 4:43 p.m. revealed that the dietary staff were using prepared meals that they were to place in a hot box. She stated the hot box had been broken for some time and therefore they were reheating the already cooked meals in the oven which may account for temperature differences. She stated that the boxes of the prepared foods state to serve one piece or one mold, however, they do not state the amount that the person is supposed to receive according to their diets. The actual serving sizes of some of the items varied and was not consistent as it should have been. Pureed foods were to be served in molds but there was no evidence of how much serving size was in a mold, and the molds were unavailable and were not in use during the survey. 28 Pa. Code 211.6(a) Dietary Services.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to serve food that was palatable and at safe and appetizing temperatures. Findings include: The facility's policy regarding food temperatures, dated August 18, 2025, indicated that hot food should be at least 135 degrees F when plated. Hot food should be palatable at point of delivery. Interview with Resident 5 on January 5, 2026, at 10:32 a.m. revealed that she eats in her room and her food is often cold. Interview with Resident 7 on January 5, 2026, at 10:32 a.m. revealed that the food is usually served cold, and that requests for alternative food choices get denied. Interview with Resident 15 on January 5, 2026, at 2:32 p.m. revealed that the food is never warm, is often over cooked, and that he never receives enough food. Interview with Resident 35 on January 5, 2026, at 2:18 p.m. and again on January 6, 2026, at 12:38 p.m. revealed that the food he is served is often cold and over cooked. He stated that he has no appetite because of his dislike for the food that is served. Interview with resident 39 on January 5, 2026, at 12:38 p.m. revealed that the food is often cold, the portion sizes are not consistent and are often very small, and that it does not taste good. He stated that one night for supper they were served three raviolis, and they were very small ravioli. He further stated that on Christmas they were served three tiny bits of ham that resembled lunch meat and a small scoop of mashed sweet potatoes that were dry and tasteless. Interview with Resident 92 on January 5, 2026, at 11:30 a.m. revealed that the food is often cold and that he never gets double portions like he is supposed to get. Interview with Residents during a resident council group meeting on January 6, 2025, at 1:15 p.m. identified concerns that food is often served cold. Observations in the kitchen for the lunch meal service on January 7, 2025, at 12:10 p.m. revealed that a test tray left the kitchen and arrived on the East Hall at 12:11 p.m. The last tray in the food truck was delivered to a resident at 12:33 p.m. and the test tray was removed from the cart at that time for the temperatures to be checked and the food tasted. The temperature of the stuffed bell pepper was 124.8 degrees F, the mashed potatoes were 131 degrees F, the carrots in the Italian blend vegetables were 131 degrees F, the creamed corn was 124.3 degrees F, and the pureed beef was 123.6 degrees F. These food items tasted cool and were served at unappetizing temperature. Interview with the Dietary Manger on January 7, 2025, at 12:35 p.m. confirmed that food should be served at correct temperatures and be palatable and the lunch tray served on January 7, 2025, was not. 28 Pa. Code 211.6(f) Dietary 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 store food under sanitary conditions. Findings include: The facility's policy for food temperatures, dated August 18, 2025, revealed the temperature of potentially hazardous cold foods must be served at a temperature of 41 degrees Fahrenheit or below. Observations in the main kitchen on January 5, 2026, at 9:16 a.m. revealed the drink cooler containing individual cartons of milk did not have a thermometer in it to determine that the milk was being held to serve at a safe temperature. Interview with the Dietary Manager on January 5, 2026, at 9:16 a.m. confirmed that there should have been a thermometer in the drink cooler, however there was not. 28 Pa. Code 211.6(f) Dietary Services.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly contain and dispose of garbage in two of two outside dumpsters. Findings include: Review of facility policy for waste disposal, dated August 18, 2025, indicated that trash will be deposited into a sealed container outside the premises. Outside dumpster lids and doors will remain closed and secure when not in use. Observation of the facility's outdoor trash receptacle on January 5, 2025, at 9:30 a.m. revealed that the smaller outside dumpster was overfilled with garbage and there was no lid on the dumpster. Observation of the facility's outdoor trash receptacle on January 6, 2025, at 2:24 p.m. revealed that the smaller outside dumpster was overfilled with garbage with no lid on the dumpster, there was garbage in the larger outdoor dumpster with no lid on it, there was one bag of garbage sitting on the cement dock and three bags of garbage on the ground in front of the dock and beside the larger dumpster. An interview with the Registered Dietician on January 6, 2025, at 2:24 p.m. confirmed that there should have been a closed lid on the outside dumpsters. An interview with the maintenance director on January 6, 2025, at 2:24 p.m. revealed that there was no lid on the smaller dumpster because it was supposed to go under the trash compacter which was broken, so the dumpster was moved to beside the trash compacter, and there was garbage on the ground outside of the dumpsters that should not have been there. 28 Pa. Code 201.18(b)(3) Management.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on review of clinical record reviews, observations, and resident and staff interviews, it was determined that the facility failed to maintain resident dignity for one of 36 residents reviewed (Resident 92). Findings include: A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 92, dated October 30, 2025, revealed that the resident was always understood, always understood others, was cognitively intact, and required assistance from staff for daily care needs. Interview with Resident 92 on January 5, 2026 at 11:30 a.m. revealed that he was moved from his room on another hall recently and that his personal belongings are being stored in his shared bathroom. Observations of Resident 92's bathroom on January 5, 2026 at 11:30 a.m. revealed that there were 4 boxes and one large black garbage bag filled with the resident's personal belongings stored on the floor around the toilet. Interview with the Social Services Director on January 5, 2026 at 11:48 a.m. revealed that Resident 92's belongings should not have been stored in his shared bathroom and they should have been sent to storage, or other arrangements should have been made for the storage of the personal belongings. 28 Pa. Code 201.29(j) Resident Rights.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on review of facility policies, as well as observations, resident and staff interviews, it was determined that the facility failed to provide a resident with self determination to have a room move for one of 36 residents reviewed (Residents 85). Findings include: The facility's policy regarding room changes, dated August 18, 2025, indicated that a resident or representative could request a room change. A reason for the request could include roommates being incompatible. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 85, dated December 2, 2025, revealed that the resident was understood, could understand others, was cognitively intact, and receives dialysis (life-sustaining treatment for kidney failure that filters waste and extra fluid from your blood). Interview with Resident 85 on January 7, 2026, at 10:34 p.m., revealed that he wants his room changed. He stated that he asked the Social Services Director again yesterday and she said would look into it. Resident 85 explained that his roommate is very loud and yells out day and night. Resident 85 leaves for dialysis at 4:00 a.m. and gets very little sleep due to the disruptions. He does not care what room he moves to as long as he is not with his roommate. Resident 85 asked the Director of Nursing but was encouraged to seek out the social worker. He has asked multiple times and the Social Worker says she will look into it. Resident 85 said he spends most of his time in the lounge or common areas. He would like to nap in his room, but his roommate hollers and wakes him up, and half the time he sleeps in the hall after he comes back from his dialysis treatment. Observations during all four days of the survey revealed multiple unoccupied rooms that were not on the hall being renovated. Interview with the Director of Social Services on January 7, 2025, at 12:32 and 3:25 p.m. confirmed that Resident 85 has asked for a room change on multiple occasions, however, she asked for his patience due to the room renovations. 28 Pa. Code 201.29(a) Resident Rights.		

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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 facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs regarding medications for one of 36 residents (Resident 4) and regarding indwelling urinary catheters for one of 36 residents reviewed (Resident 13). Findings include: The facility's policy regarding care plans, dated August 18, 2025, revealed that care plans are reviewed on an ongoing basis and revised as indicated by the resident's needs, wishes, or a change in condition. Care plans are evaluated at least with each comprehensive and quarterly assessment. Changes to the care plan due to minor changes in the resident's status will be implemented as indicated. All staff caring for the resident will be familiar with the resident's plan of care. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated November 10, 2025, indicated that the resident was cognitively impaired, required assistance with care needs, and had been on an anticoagulant at time of admission due to recent surgery. Care plan dated November 4, 2025, indicated that Resident 4 received anticoagulant related to surgical repair of fracture of the femur (long bone of leg). Physician's orders confirmed discontinuation of anticoagulant enoxaparin, start date November 4, 2025, with an end date of November 25, 2025. Interview with the Director of Nursing on January 8, 2026, at 11:36 a.m. confirmed that the anticoagulant had been discontinued and the care plan should have been revised to reflect the discontinuation of this medication. An admission Minimum Data Set (MDS) assessments (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated July 1, 2025, indicated that the resident was cognitively intact, and had an indwelling catheter (flexible tube inserted into bladder to drain urine). The current care plan for Resident 13 revealed that the resident was to have an indwelling catheter size 16 French with a 30 cc balloon (holds the tube in place in the bladder). Physician's orders for Resident 13, dated March 20, 2025, included an order for the resident to have a Foley (indwelling) catheter size 18 French with a 10 cc balloon, to be changed based on resident's needs. Observations to verify current size of Resident 13's Foley indwelling catheter verified that Resident 13 currently had size 18 French with 10 cc balloon inserted. There was no documented evidence that Resident 13's care plan was revised to reflect that the resident's indwelling catheter size was changed from a 16 French with 30 cc balloon to an 18 French with 10 cc balloon. Interview with the Director of Nursing on January 7, 2026, confirmed that Resident 13's care plan was not revised to reflect the change in Foley indwelling catheter size. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 36 residents reviewed (Resident 6). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated October 20, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnosis that included Crohn's disease (a bowel disease that causes inflammation anywhere in the digestive tract, leading to symptoms like abdominal pain), and was receiving scheduled pain medication. Physician's orders for Resident 6, dated October 16, 2025, included orders for the resident to receive 50 micrograms (mcg) of Fentanyl transdermal patch (a narcotic pain medication administered through the skin) to be applied at bedtime every three days for pain. Physician's orders dated November 18, 2025, included to remove the old Fentanyl patch and destroy with two nurses every three days. A pharmacy consultation report for Resident 6 dated October 3, 2025, recommended that staff document transdermal Fentanyl patch removal and destruction with two licensed staff signatures or as outlined by policy or regulation. The Medication Administration Record (MAR) and a controlled drug count record (tracks each dose of a controlled medication) for Resident 6, dated November and December 2025, revealed that a Fentanyl patch was applied to the resident on November 3, 6, 9, 12, 15, 18, 21, 24, 27, and 30, 2025 and December 3, 6, 9, 12, and 15, 2025. There was no documented evidence that two staff members signed that the old patch was destroyed after removal on these dates. Interview with the Director of Nursing on January 8, 2025, at 3:56 p.m. confirmed that there was no documented evidence that two staff members witnessed and signed that Resident 6's old patches were destroyed after removal on the above-mentioned dates. 28 Pa. Code 211.9(a)(h) Pharmacy services.		

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 01/08/2026
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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plan of corrections for an annual survey ending December 12, 2024, as well as complaint surveys ending March 27, 2025, May 14, 2025, August 11, 2025, and November 13, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending September January 8, 2026, identified repeated deficiencies related to resident rights, inaccurate MDS assessments, care plan revisions, quality of care, pharmacy services, menus are followed, food that is palatable, and food storage. The facility's plan of correction for a deficiency regarding resident rights, cited during the survey ending December 12, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F550, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident rights were valued. The facility's plan of correction for a deficiency regarding inaccurate MDS assessments, cited during the survey ending December 12, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that MDS assessments would be completed accurately. The facility's plan of correction for a deficiency regarding care plan revision, cited during the surveys ending December 12, 2024, March 27, 2025, and May 14, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that care plans were revised timely. The facility's plan of correction for a deficiency regarding quality care, cited during the survey ending December 12, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that quality care was provided. The facility's plan of correction for a deficiency regarding pharmacy services, cited during the survey ending December 12, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that pharmacy services were adequately provided. The facility's plan of correction for a deficiency regarding menus, cited during the survey ending December 12, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F803, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that their menus were followed. The facility's plan of correction for a deficiency regarding palatable food, cited during the surveys ending December 12, 2024 and August 11, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F804, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that palatable food was served. The facility's plan of correction for a deficiency regarding resident rights, cited during the surveys ending December 12, 2024, May 14, 2025, and November 13, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Hilltop Heights Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Woodmont Road Johnstown, PA 15905	
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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	food would be stored according to regulations.Refer to F550, F641, F657, F684, F755, F803, F804, F812, F867.28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(e)(1) Management.		

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set (MDS) assessments for three of 36 residents reviewed (Residents 2, 6, 39). Findings include: The RAI User's Manual, dated October 2025, indicated that Section B0700 (make self-understood) should be coded with either clearly understood, usually understood, sometimes understood, or rarely/never understood. Section C0100 (should brief interview for mental status be conducted) should be completed if the resident is at least sometimes understood verbally, in writing, or using another method. Section C0100 was to be coded No (0) or Yes (1) to determine whether a Brief Interview for Mental Status (BIMS) (an assessment to determine a resident's cognitive status) should be attempted with the resident. The instructions for determining if a BIMS interview should be attempted indicated that if the resident was at least sometimes understood (verbally or in writing) then the BIMS interview was to be attempted with the resident and coded in Sections C0200 through C0500. If the resident was rarely/never understood, then the BIMS interview was not to be attempted, and a Staff Assessment of Mental Status was to be completed instead and coded in Sections C0600 through C1000. The instructions for determining a resident mental status Section D0100 was to be coded zero (0) No if a mood interview was not to be conducted with the resident because the resident was rarely/never understood and/or unable to respond, and one (1) Yes if a mood interview should be conducted with the resident. The RAI Manual indicated that a mood interview should be attempted with all residents. An annual MDS assessment for Resident 2, dated December 16, 2025, revealed that the resident is understood and understands, Section C0100 was coded Yes (1) that a BIMS assessment was to be conducted; however, Sections C0200-C0500 were coded as rarely/never understood. Section D0150 was also coded Yes (1) that resident mood interview Section D0150 was to be conducted; however, the section was coded as resident rarely/never understood. Interview with the Director of Nursing on January 8, 2026 at 8:33 a.m. confirmed that the annual MDS assessment for Resident 2 was coded inaccurately. The Long-Term Care Facility RAI User's Manual, dated October 2025, indicated that Section N0415E (Anticoagulant-medications that prevent blood clots from forming or growing) was to be coded (1) is taking, if the resident received an anticoagulant medication during the seven day look back period. Physician's orders for Resident 6, dated October 16, 2025, included an order for the resident to receive 1.5 milligrams (mg) of Warfarin (an anticoagulant) once a day. Review of the resident's MAR for October 2025 revealed that the resident received 1.5 mg of Warfarin daily on October 16 through October 19, 2025. However, a quarterly MDS assessment for Resident 6, dated October 20, 2025, revealed that Section N0415E was not coded (1) is taking, indicating that the resident did not receive an anticoagulant during the seven-day look-back period. An interview with the Director of Nursing on January 8, 2025, at 8:37 a.m. confirmed that Resident 6's MDS assessment dated [DATE], was coded inaccurately. The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section N0415G1 Diuretic Medications (a water pill) was to be coded if the resident took the medication during the seven-day look-back period. Physician's orders for Resident 39, dated October 6, 2025, included an order for the resident to receive 40 milligrams Lasix (diuretic) two times per day. The resident's Medication Administration Record (MAR) for October 2025 revealed that the resident received the Lasix on October 6, 7, and 8, 2025. A quarterly MDS for Resident 39, dated October 8, 2025, revealed that Section N0405G1 was not coded, indicating that the resident did not receive diuretic medication during the seven-day look-back assessment period. Interview with the Director of Nursing on January 8, 2026 at 8:33 a.m. confirmed that Resident 39's quarterly MDS assessment was coded to indicate that the resident did not receive an diuretic during the look-back period. 28 Pa. Code 211.5(f) Clinical Records.		