STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A437	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hollidaysburg Veterans Home	500 Municipal Dr Hollidaysburg, PA 16648

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of policies, investigative reports, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect caused by a failure to follow a resident's care plan for assisting with Activities of Daily Living (ADL's) and preventing falls for one of seven residents reviewed (Resident 3), resulting in a fall and fracture for the resident. This deficiency was cited as Past Non-Compliance.Findings include: The facility's policy regarding resident abuse, dated January 5, 2026, revealed that the facility will provide protections for health, safety, welfare, and rights of each resident residing in the nursing home by prohibiting and preventing abuse, neglect, exploitation, misappropriation of resident property, corporal punishment, involuntary seclusion, and any physical or chemical restraints not required to treat a resident's medical condition. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated January 6, 2026, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, was dependent with transfers, and had medical diagnoses that included Parkinsons, dementia, and orthostatic hypotension. A care plan, dated December 30, 2025, revealed that Resident 3 had a potential for falls related to new environment, adjustment to nursing home placement, presence of tremor, orthostatic hypotension, Parkinson's and impaired mobility. Transfer status was to use a full mechanical lift (a medical device designed to safely transfer individuals with limited mobility between position, such as bed to wheelchair or to the bathroom using manual hydraulic or electric power to reduce caregiver strain) for all transfers using a large sling size. A nursing note for Resident 3, dated January 19, 2026, at 8:36 p.m. revealed that the nurse was informed by staff that the resident had fallen from the mechanical body lift. The nurse entered the room, and the resident was observed lying on his right side between the legs of the mechanical body lift with his head located by the center post of the lift located at the doorway in the resident's room. The mechanical lift was safely pulled away from the resident while staff maintained proper head/neck alignment. The sling was observed in same position on hooks of lift while being moved. The mechanical body lift legs were observed in the closed position. The mechanical body lift arm was observed in high position. Blood was observed along the occipital region of Resident 3's head to the left ear and on the floor from a head laceration. Pressure was applied with gauze and bleeding was controlled. Resident 3 complained of headache, pain in the back of the head, neck pain, and back pain. A nursing note for Resident 3, dated January 19, 2026, at 8:59 p.m. revealed that the resident was admitted to the hospital with a diagnosis of scalp laceration requiring staples, closed head injury and a fracture at the sixth thoracic (middle of the back) vertebrae (spine). A statement completed by Nurse Aide 1, dated January 19, 2026, revealed that she was assisting another nurse aide to get the resident out of bed for a shower and he fell out of the sling backwards and hit the floor. The lift pad was positioned correctly and was up his back the proper way. A statement completed by Nurse Aide (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 0600 Level of Harm - Actual harm Residents Affected - Few	2, dated January 19, 2026, revealed that she was assisting another nurse aide with transferring the resident out of bed and he fell out of the sling backwards hitting the floor. A statement completed by Registered Nurse 3, dated January 19, 2026, revealed that she observed the sling that was used to transfer the resident. The sling had long straps at the bottom that required the straps to be placed between the legs and crisscrossed then attached to the mechanical lift. The straps were connected to the lift, with the two right straps together and the two left straps together; they were not crisscrossed. She observed the size of the sling, and it was marked as extra-large. A statement completed by Registered Nurse Supervisor 4, dated January 21, 2026, revealed that he was notified of the fall. Upon his arrival he observed the mechanical lift outside the resident's room. The sling was not attached to the mechanical lift but was observed on the resident's bed. The sling was extra-large with legs, and the material and straps appeared to be in good condition. The sling was collected to get laundered as it was soiled and then collected to keep for the investigation. Investigative documents for Resident 3, dated January 29, 2026, revealed that on January 19, 2026, the Registered Nurse 3, was notified by staff that the resident had fallen from the mechanical body lift and was noted to be bleeding from his head. The resident was observed lying on his right side between the legs of the mechanical body lift with his head positioned by the post of the lift which was located at the doorway. The body mechanical lift was safely pulled away from the resident while staff were maintaining proper head and neck alignment. The resident was sent to the local emergency room and was admitted with fracture at the sixth vertebra. Investigation was initiated and included separate individual reenactments of the incident, verification of sling size and lift techniques utilized during the transfer. The facility's investigation revealed that the fall was caused by utilization of the wrong sling size. Interview with the Director of Nursing on February 11, 2026, at 2:51 p.m. confirmed that the facility's investigation substantiated neglect because Nurse Aide 1 and Nurse Aide 2 did not follow Resident 3's care plan requiring the resident to be transferred with a mechanical body lift using a large sling size. A review of the facility's plan of correction included the following:Reeducation on transporting residents with mechanical lifts and correct lift size per residents.Audits of residents require mechanical lifts for transfers and proper sling size per residents.Audits completed weekly on all staff transporting residents using a mechanical lift.Interviews with nursing staff on February 11, 2026, revealed that they had been educated on proper mechanical lift transfers and proper sling size per residents.A review of the facility's corrective actions revealed that they were in compliance with F600 on January 28, 2026. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of policies, clinical records, and facility reports, as well as staff interviews, it was determined that the facility failed to conduct a thorough investigation to rule out abuse or neglect as the cause of a fracture for one of seven residents reviewed (Resident 2).Findings include:The facility's policy regarding falls, dated January 5, 2026, revealed that upon observation of a resident on the floor/lower level or witnessing a fall, if able, staff were stay with the resident and call for assistance. The Registered Nurse Supervisor was to be notified immediately. Staff were to document complete fall information, to include how the resident was found, environment around the resident, possible reason for fall, any applicable immediate interventions placed, any alteration in skin integrity, changes in prior known condition, and above notifications in the resident's electronic health record.The facility's policy regarding resident abuse/neglect, dated January 5, 2026, revealed that the facility would conduct a thorough investigation to determine facts specific to the case for any and all types of alleged violations, and identify and interview all involved persons including the alleged victim(s), alleged perpetrator(s), witnesses, and any others who may have knowledge of the allegations. The supervisor and Commandant were to be notified immediately of any and all types of alleged violations.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident R2, dated November 18, 2025, revealed that the resident was confused, had wandering behaviors, required maximum staff assistance with dressing, had a history of falls, and had diagnoses that included dementia. Physician's orders and a care plan for Resident 2, initiated on April 29, 2025, revealed that the resident was at risk for falls and was to wear hip savers (a padded under garment to protect the hip area) at all times.A nursing note, dated January 22, 2026, revealed that at 3:25 p.m. Resident 2 was observed laying on his left side on the floor in between two nightstands.He had an open area to the left side of his head measuring 0.5 x 0.5 centimeters (cm), an abrasion noted to the left upper arm, and a skin tear to the left elbow measuring 1.0 x 0.5 cm. The resident yelled out in pain when his left leg was straightened. He had no shortening or deformity noted, but his external rotation was not assessed due to pain. The Certified Registered Nurse Practitioner (CRNP) was notified, and an order was received to send the resident to the hospital for further evaluation.A facility investigation, dated January 22, 2026, revealed Resident 2 had an unwitnessed fall and was found in another resident's room on the floor between two nightstands. The report indicated that the resident had non-skin socks and hip savers on at the time of the fall, and was last observed by staff on January 22, 206, at 3:15 p.m. The last time the resident was toileted was on January 22, 2026, at 7:47 a.m. The resident had severe pain to his left hip, had an abrasion to his left upper arm, a skin tear to his left elbow, and he was unable to fully straighten his left leg due to pain. The resident was sent to the emergency room for further evaluation and was diagnosed with a left hip fracture.A witness statement from Registered Nurse 5 (7:00 a.m. to 3:00 p.m. shift), dated January 22, 2026, revealed that she was at the nurse's station and was notified that Resident 2 was on the floor, and she did not witness the event.Interview with Registered Nurse 5 on February 11, 2026, at 3:14 p.m. confirmed that when she responded to Resident 2 being found on the floor and assessed him, he did not have his hip savers on as care planned and ordered. She stated that she reported this finding to Registered Nurse Supervisor 6. She also reported that she did not notice on the incident report that hip savers were checked as being in place at the time of the fall and confirmed that this was not correct.Interview with Registered Nurse Supervisor 6 on February 11, 2026, at 3:59 p.m. confirmed that Registered Nurse 5 did report to her that Resident 2 did not have his hip savers on at the time of the fall, and she also observed the resident without the hip savers on as care planned and ordered. She (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that when she was reviewing the resident's clinical record for the fall investigation, she saw that hip savers were care planned and ordered and reported this.The facility's investigation information revealed no documented evidence that a thorough investigation was conducted, as there was no documented evidence that the investigation included witness statements from Registered Nurse 5 and Registered Nurse Supervisor 6 that included observations of Resident 2 without hip savers on at the time of the fall on January 22, 2026.Interview with Assistant Director of Nursing 7 and the Director of Nursing on February 11, 2026, at 5:15 p.m. confirmed that they were not aware that Resident 2 did not have his hip savers on at the time of the fall that resulted in a fracture.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of policies, clinical records, and facility reports, as well as staff interviews, it was determined that the facility failed to ensure that protective devices to prevent injuries from falls were applied as care planned and ordered for one of seven residents reviewed (Resident R2) who fell and suffered a fracture and failed to ensure that the residents' environment remained free of accident hazards for one of seven residents reviewed (Resident 3), who fell and suffered a fracture. Findings include:The facility's policy regarding incidents and accidents, dated January 5, 2026, revealed that the facility's purpose was to maintain the residents' safety and prevention of serious injury to the extent possible and to ensure a consistent and effective approach to the management and review of the fall itself. If the resident was determined to be high risk for falls, the interdisciplinary team (IDT) would initiate, individualized preventative measures on an individual basis which may include, but not limited to hip savers (a padded under garment to protect the hip area).A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident R2, dated November 18, 2025, revealed that the resident was confused, had wandering behaviors, required maximum staff assistance with dressing, had a history of falls, and had diagnoses that included dementia. Physician's orders and a care plan for Resident 2, initiated on April 29, 2025, revealed that the resident was at risk for falls and was to wear hip savers at all times.A nursing note, dated January 22, 2026, revealed that at 3:25 p.m. Resident 2 was observed laying on his left side on the floor in between two nightstands. He had an open area to the left side of his head measuring 0.5 x 0.5 centimeters (cm), an abrasion noted to the left upper arm, and a skin tear to the left elbow measuring 1.0 x 0.5 cm. The resident yelled out in pain when his left leg was straightened. He had no shortening or deformity noted, but his external rotation was not assessed due to pain. The Certified Registered Nurse Practitioner (CRNP) was notified, and an order was received to send the resident to the hospital for further evaluation.A facility investigation, dated January 22, 2026, revealed Resident 2 had an unwitnessed fall and was found in another resident's room on the floor between two night stands. The report indicated that the resident had non-skin socks and hip savers on at the time of the fall, and was last observed by staff on January 22, 206, at 3:15 p.m. The last time the resident was toileted was on January 22, 2026, at 7:47 a.m. The resident had severe pain to his left hip, had an abrasion to his left upper arm, a skin tear to his left elbow, and he was unable to fully straighten his left leg due to pain. The resident was sent to the emergency room for further evaluation and was diagnosed with a left hip fracture.A witness statement from Licensed Practical Nurse 8 (11:00 p.m. to 7:00 a.m. shift), dated January 23, 2026, revealed that when she provided care to Resident 2 on the night shift of January 21, 2026, into the morning of January 22, 2026, the resident's hip savers were in place during the last check.A witness statement from Nurse Aide 9, (11:00 p.m. to 7:00 a.m. shift), dated January 23, 2026, revealed Resident 2's hip savers were in place during incontinent care in the morning. A witness statement from Licensed Practical Nurse 10, (7:00 a.m. to 3:00 p.m. shift), dated January 24, 2026, revealed Resident 2's hip savers were on him during the morning skin checks.A witness statement from Nurse Aide 11, (7:00 a.m. to 3:00 p.m. shift), dated January 24, 2026, revealed Resident 2's hip savers were put on him after being showered.A witness statement from Nurse Aide 12, (7:00 a.m. to 3:00 p.m. shift), dated January 23, 2026, revealed Resident 2's hip savers were in place when he was changed after lunch.A witness statement from Registered Nurse 5, (7:00 a.m. to 3:00 p.m. shift), dated January 22, 2026, revealed that she was at the nurse's station and was notified that Resident 2 was on the floor, and she did not witness the event.Interview with Registered Nurse 5, on February 11, 2026, at 3:14 p.m. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	confirmed that when she responded to Resident 2 being found on the floor and assessed him, he did not have his hip savers on as care planned and ordered. She stated that she reported this finding to Registered Nurse Supervisor 6. She also reported that she did not notice on the incident report that hip savers were checked as being in place at the time of the fall and confirmed that this was not correct. Interview with Registered Nurse Supervisor 6 on February 11, 2026, at 3:59 p.m. confirmed that Registered Nurse 5 did report to her that Resident 2 did not have his hip savers on at the time of the fall, and she also observed the resident without the hip savers on as care planned and ordered. She stated that when she was reviewing the resident's clinical record for the fall investigation, she saw that hip savers were care planned and ordered and should have been on. She stated that she did report this. Interview with Assistant Director of Nursing 7 and the Director of Nursing on February 11, 2026, at 5:15 p.m. confirmed that they were not aware that Resident 2 did not have his hip savers on at the time of the fall that resulted in a fracture. A quarterly MDS assessment for Resident 3, dated January 6, 2026, revealed that the resident cognitively impaired, requires assistance from staff for daily care needs, dependent with transfers, and had medical diagnoses that included Parkinsons, dementia, and orthostatic hypotension. A care plan, dated December 30, 2025, revealed that the resident had a potential for falls related to new environment, adjustment to nursing home placement, presence of tremor, orthostatic hypotension, Parkinson's and impaired mobility. Transfer status was to use a full mechanical lift for all transfers with large sling size. A nursing note for Resident 3, dated January 19, 2026, at 8:36 p.m. revealed that the nurse was informed by staff that the resident had fallen from the mechanical body lift. The nurse entered the room, and the resident was observed lying on his right side between the legs of the mechanical body lift with his head located by the center post of the lift located at the doorway in the resident's room. The mechanical lift was safely pulled away from the resident while staff maintaining proper head/neck alignment. The sling was observed remaining in same position on hooks of lift while being moved. The mechanical body lift legs observed being in closed position. The mechanical body lift arm was observed in high position. Blood was observed along the occipital region of head to the left ear and on the floor from a head laceration. Pressure was applied with gauze and bleeding was controlled. Resident complained of headache, pain in the back of the head, neck pain, and back pain. A nursing note for Resident 3, dated January 19, 2026, at 8:59 p.m., revealed that the resident was admitted to the hospital with a diagnosis of scalp laceration requiring staples, closed head injury and a fracture at the sixth thoracic (middle of the back) vertebrae (spine). A statement completed by Nurse Aide 1, dated January 19, 2026, revealed that she was assisting another nurse aide to get the resident out of bed for a shower and he fell out if the sling backwards and hit the floor. The lift pad was positioned correctly and was up his back the proper way. A statement completed by Nurse Aide 2, dated January 19, 2026, revealed that she was assisting another nurse aide with transferring the resident out of bed and he fell out of the sling backwards hitting the floor. A statement completed by Registered Nurse 3, dated January 19, 2026, revealed that she observed the sling that was used to transfer the resident. The sling had long straps at the bottom that required the straps to be placed between the legs and crisscrossed then attached to the mechanical lift. The straps were connected to the lift incorrectly. The two right straps were together and two left straps were together and they were not crisscrossed. She observed the size of the sling, and it was marked as extra-large. A statement completed by Registered Nurse Supervisor 4, dated January 21, 2026, revealed that he was notified of the fall. Upon his arrival he observed the mechanical lift outside the resident's room. The sling was not attached to the mechanical lift but was observed on the resident's bed. The sling was extra-large with legs, and the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	material and straps appeared to be in good condition. The sling was collected to get laundered as it was soiled and then collected to keep for the investigation. Investigative documents for Resident 3, dated January 29, 2026, revealed that on January 19, 2026, the Registered Nurse 3, was notified by staff that the resident had fallen from the mechanical body lift and was noted to be bleeding from his head. The resident was observed lying on his right side between the legs of the mechanical body lift with his head positioned by the post of the lift which was located at the doorway. The body mechanical lift was safely pulled away from the resident while staff were maintaining proper head and neck alignment. The resident was sent to the local emergency room and was admitted with fracture at the sixth vertebra. Investigation was initiated and included separate individual reenactments of the incident, verification of sling size and lift techniques utilized during the transfer. The facility's investigation revealed that the fall was caused by utilization of the wrong sling size. Interview with the Director of Nursing on February 11, 2026, at 2:51 p.m. confirmed that the facility's investigation substantiated that the nurse aides used the incorrect sling size per the resident's care plan. In addition, the facility's investigative documents confirmed that the sling was connected incorrectly due to not having the leg straps crisscrossed. 28 Pa. Code 211.10(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.