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	05/26/2026

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 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 review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician was notified timely about a change in condition for one of six residents reviewed (Resident 2). The facility's policy regarding changes in condition, dated January 1, 2026, indicated that when there was a change in the resident's condition, staff would notify the covering Registered Nurse who would then update the supervisor, physician, and family.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated April 29, 2026, revealed that the resident was cognitively intact, had diagnoses that included chronic obstructive pulmonary disease (a progressive, incurable lung disease that restricts airflow, making it difficult to breath, and used a CPAP (a Continuous Positive Airway Pressure) machine to provide pressured oxygen through a mask to keep his airway open.A progress note for Resident 2, dated May 18, 2026, at 1:19 a.m. indicated that the CPAP machine was observed to be unavailable.Interview with Resident 2, on May 26, 2026, at 11:51 a.m. indicated that when he was at home and the CPAP machine needed fixed/cleaned, the medical supply company gave him a replacement until his was repaired. He further indicted that it bothered him very much to not have his machine and that he could not sleep well. He indicated that he used his oxygen at night but that was not the same as his CPAP machine. At the time of the investigation the CPAP machine was in his room and functioning. Interview with Registered Nurse (RN) Supervisor 4 on May 26, 2026, at 12:25 p.m. indicated that she investigated the concern regarding Resident 2's CPAP machine being unavailable. She indicated that On May 13, 2026, the machine was taken by adaptive/maintenance to change the filters and fix a broken magnet on the strap of the appliance. Maintenance told Licensed Practical Nurse 5 that they were taking the residents CPAP machine to make repairs. There was no communication between the LPN and the RN regarding the removal of the CPAP machine from the residents room. She went on to say that there was some difficulty acquiring the correct filters and with adequately fixing the magnet on the strap. Therefore, the resident was without his CPAP machine from May 13, 2026, until approximately May 22, 2026. RN Supervisor 4 indicated that on May 18, 2026, the computer flagged a notice regarding the machine and that is how she became aware of the situation. At that time she made the physician aware of the situation. She indicated that if the appropriate staff would have been notified as per the procedure, then the provider may have made recommendations and/or a replacement CPAP machine may have been provided.There was no documented evidence that the physician was notified on May 13, 2026, regarding the resident's CPAP machine needing repairs and consequently becoming unavailable to Resident 2 for sleep.Interview with the Director of Nursing on May 26, 2026, at 3:00 p.m. confirmed that there was no documented evidence that the physician was notified timely when Resident 2's CPAP machine was unavailable for him to use, and he should have been.28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure a safe environment for one of six residents reviewed (Resident 3) resulting in a fall with fracture. This deficiency is being cited as past non-compliance.Findings include: A facility policy regarding resident falls dated January 1, 2026, that all unwitnessed falls or a known strike to the head or neck required the neurological evaluation process. A significant change minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 3, dated May 1, 2026, revealed that the resident was cognitively impaired, was occasionally incontinent of urine, and required substantial assistance with toileting hygiene. The resident's care plan, updated April 20, 2026, revealed that the resident had potential for falls and required his urinal to be kept at the bedside. A nursing note following a fall, dated April 14, 2026, indicated that Resident 3 stated he was trying to use his urinal but could not get his fancy pants off, referring to his pull up brief. Resident 3 was noted to be without socks and was incontinent of urine. He had an area of abrasion/bruising noted to left knee measuring 2.0 centimeters (cm) long x 0.6 cm wide and multiple bruises noted to left arm. There was an area above the elbow 4.0 inches (in) long x 0.5 in wide, an area on the mid forearm 2.0 cm long x 1.0 cm wide, an area above the wrist 3.0 in long x 2.0 in wide, and on the wrist 3.5 inches in diameter. A fall investigation for Resident 3, dated April 14, 2026, at 10:30 p.m. revealed that the resident was getting up to use his urinal and was unable to get his pants down. The immediate intervention was to have staff offer toileting assistance on rounds and the resident was to start a bowel and bladder program. Staff would encourage Resident 3 to use his urinal at the bedside. A nursing note dated May 3, 2026, at 10:42 p.m. indicated that Resident 3 was found on the floor perpendicular to the bed. Resident stated he was trying to use the urinal and when he reached forward, he fell out of bed onto the floor, hitting his head. Resident 3 was noted to have urinated on himself. He was noted to have a purple quarter sized mark on the middle of his forehead. Resident 3 was sent to the hospital for evaluation and treatment. A fall investigation for Resident 3, dated May 3, 2026, at 11:07 p.m. revealed that the resident was attempting to use the bedside urinal, and as he was reaching for the urinal he fell out of bed. The immediate intervention was to send the resident to the emergency room for further evaluation due to him hitting his head when he fell out of bed. Neurological checks were started and Resident 3 would be placed on frequent checks (15 minute checks) upon return from the hospital. A witness statement by Licensed Practical Nurse (LPN) 6 on May 3, 2026, at 10:30 p.m. indicated that Resident 3's call bell was activated. He fell out of bed onto the floor, hitting his head. Resident 3 was wearing regular socks. A witness statement by Registered Nurse (RN) 1 on May 4, 2026, not timed, indicated that he was on break when Resident 3 fell and was sent to the hospital. Resident 3 left the facility at 10:52 p.m. for the hospital and returned on May 4, 2026 at approximately 1:40 a.m. There was no documented evidence in Resident 3's clinical record to indicate that 15 minute checks were initiated upon his return from the hospital. A nursing note for Resident 3, dated May 4, 2026, at 6:41 a.m. revealed that the resident was found on the floor at 4:30 a.m. The resident had his pants around his knees from apparently trying to stand to use his urinal. The resident had a 1.5 cm X 0.5 cm skin tear to his right elbow which was cleaned and dressed, he also reported right hip pain. The resident was sent to the hospital for further evaluation. Hospital records for Resident 3 dated May 4, 2026, revealed the diagnosis of a right hip fracture due to a ground level fall. A witness statement with Nurse Aide 2 on May 4, 2026 at 4:30 a.m., revealed while doing 15 minute rounds at approximately on May 4, 2026, 4:15 a.m. Resident 3 was heard moaning and was found on the floor. A witness statement with Nurse Aide 2 on May 7, 2026, indicated that she assisted the resident to the bathroom at 3:30 a.m. on May 4, 2026, at 4:15 p.m. the Resident 3 was sleeping, and then at 4:30 a.m. the resident was found on the floor. A subsequent witness statement by RN 1 on May 4, 2026, at 11:19 a.m. revealed that he only completed the neurological checks and the initial set (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	of vitals upon Resident 3's return from the hospital. RN 1 couldn't find a neurological check sheet so he started a new one, starting with the time of 10:30 p.m. RN 1 left the neurological check sheet with the other time increments so other staff could fill them in. When Resident 3 came back from the hospital RN 1 started with the 1:30 a.m. slot. RN 1 only filled out the 1:30 a.m. time slot. Resident 4 was good, alert and talking, acting like his normal self. A witness statement by RNS 3 on May 6, 2026, at 2:58 p.m. revealed that he was not informed to add any interventions to Resident 3's plan of care when he returned. RNS 3 completed a neurological check at 4:30 a.m. after the second fall. The resident was not wearing an incontinent brief at the time and was only wearing pants, and he was not incontinent at the time of the fall. Resident 3 was confused and could not express what happened. An interview with Quality Assurance Registered Nurse on May 26, 2026 confirmed that there was no documented evidence of neurological checks and no documented evidence that frequent checks (15 minute checks) were initiated as fall interventions after Resident 3 returned from the hospital on May 4, 2026 at 1:30 a.m. Following the incident on May 4, 2026, the facility's corrective actions included: 1. On May 3rd and May 4, 2026 the resident experienced two falls in a short period of time, after the first fall an effective root cause analysis was not identified, and appropriate interventions were not put into place which put the resident at an increased risk to experience the second fall. 2. Any residents experiencing a fall has the potential to be affected by the same deficient practice. All resident falls that occurred 30 days prior to the identification of the deficient practice will be audited to verify that an appropriate root cause analysis (RCA) was identified and a corresponding immediate intervention and care plan update when appropriate. Corrective action completion date: May 11, 2026 3. Education records, dated May 8, 9, 10, 11, 12, 13, 14, 17, 20, 2026 revealed that 90 percent of the Registered Nurses received education regarding the Incident and Accident policy with and emphasis placed on the timely and accurate completion of RCAs and implementation of corresponding immediate interventions. Education also included requirements for completion and documentation of a post-fall RN assessment, as well as obtaining and reviewing staff witness statements. Additional education was provided regarding thorough review of resident care plans and appropriateness of interventions, ensuring care plans are updated with the date of review and/or care plan changes for residents returning from hospitalization related to falls or those experiencing frequent falls within a short period of time. The remaining two registered nurses will receive education prior to their next scheduled shift. Corrective action completion date: May 20, 2026 4. The Director of Nursing or designee will provide ongoing auditing to be completed following each resident fall to observe for identification of an appropriate RCA and implementation of corresponding immediate interventions, including care plan updates when appropriate. During completion of audit, any identified concerns will result in corrective action, with the concern documented and monitored through completion. These audits will continue for a period of 6 months, and the results will be reviewed during the Quality Assurance Committee Meeting to determine whether additional interventions and monitoring is necessary. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F689 on May 20, 2026. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide scheduled toileting following a fall for one of six residents reviewed (Residents 3).Findings include:The facility policy for urinary catheter care, dated January 8, 2026, indicated that changing indwelling catheters or drainage bags at routine, fixed intervals, was not recommended. Rather it was suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system was compromised.An email was sent on March 11, 2026 for nursing supervisors to discuss incontinent care with no double briefing-toileting and changing residents every two hours documentation needs to be in point of care (POC) with all care, staff cannot block chart at the beginning of their shift and then the resident falls and it appears via documentation that the resident hasn't been changed all shift. The blue tile for incontinent care in POC changes to white after the first entry, but they can continue to add in rounds every two hours even though the tile is white.A significant change minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 3, dated May 1, 2026, revealed that the resident was always understood and always understood others, cognitively impaired, and was occasionally incontinent of urine, and required substantial assistance with toileting hygiene. The resident's care plan, dated September 22, 2025, revealed that the resident had a urinary incontinence and required to wears pull ups at all times for management of incontinence and dignity purposes. Check the pull up every two hours, and assist with perineal hygiene and management of incontinence products/clothing if noted to be soiled or wet. nursing note following a fall, dated April 14, 2026, indicated that Resident 3 stated he was trying to use his urinal but could not get his fancy pants off, referring to his pull up brief. Resident 3 was noted to be without socks and was incontinent of urine. He had an area of abrasion/bruising noted to left knee measuring 2.0 centimeters (cm) long x 0.6 cm wide and multiple bruises noted to left arm. There was an area above the elbow 4.0 inches (in) long x 0.5 in wide, an area on the mid forearm 2.0 cm long x 1.0 cm wide, an area above the wrist 3.0 in long x 2.0 in wide, and on the wrist 3.5 inches in diameter. A fall investigation for Resident 3, dated April 14, 2026, at 10:30 p.m. revealed that the resident was getting up to use his urinal and was unable to get his pants down. The immediate intervention was to have staff offer toileting assistance on rounds and the resident was to start a bowel and bladder program. Staff would encourage Resident 3 to use his urinal at the bedside. A nursing note dated May 3, 2026, at 10:42 p.m. indicated that Resident 3 was found on the floor perpendicular to the bed. Resident stated he was trying to use the urinal and when he reached forward, he fell out of bed onto the floor, hitting his head. Resident 3 was noted to have urinated on himself. He was noted to have a purple quarter sized mark on the middle of his forehead. Resident 3 was sent to the hospital for evaluation and treatment. A fall investigation for Resident 3, dated May 3, 2026, at 11:07 p.m. revealed that the resident was attempting to use the bedside urinal, and as he was reaching for the urinal he fell out of bed. The immediate intervention was to send the resident to the emergency room for further evaluation due to him hitting his head when he fell out of bed. Neurological checks were started and Resident 3 would be placed on frequent checks (15 minute checks) upon return from the hospital. Resident 3 returned from the hospital on May 4, 2026 at approximately 1:40 a.m. A nursing note dated May 4, 2026, at 6:41 a.m. indicated that Resident 3 was found on the floor. The resident had his pants around his knees from apparently trying to stand to use his urinal. The resident had a 1.5 cm X 0.5 cm skin tear to right elbow which was cleaned and dressed, he also reported right hip pain. The resident was sent to the hospital for further evaluation. Hospital records for Resident 3 dated May 4, 2026, revealed that he was diagnosed with a right hip fracture due to a ground level fall. A witness statement by Licensed Practical Nurse (LPN) 6 on May 3, 2026, at 10:30 indicated the Resident 3's call bell was activated. He fell out of bed onto the floor, hitting his head. Resident 3 was wearing regular socks. Resident 3 left the facility at 10:52 p.m. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the hospital.A witness statement by Registered Nurse (RN) 1 on May 4, 2026, not timed, indicated that he was on break when Resident 3 fell and was sent to the hospital. A witness statement by RN 1 on May 4, 2026, at 11:19 a.m. revealed that he only completed the neurological checks and the initial set and vitals upon his return from the hospital. He completed the neurological checks and got his vitals when the resident came back from the hospital. RN 1 couldn't find a neurological sheet so he started a new one, and on the sheets it started with the time of 10:30 p.m. RN1 left the neurological check sheet with the other time increments so another staff could have filled them in. RN1 started with the 1:30 a.m. slot noting he came back from the hospital. I only filled out that 1:30 a.m. time slot. Resident 4 was good, alert and talking, acting like his normal self. Now when he fell on May 4,2026, at 4:40 a.m. Registered Nurse Supervisor (RNS) 3 started a new neurological check sheet, entering the one set, then Resident 3 was sent out to the hospital.A witness statement with Nurse Aide 2 on May 4, 2026 at 4:30 a.m., revealed while doing 15 minute rounds at approximately on May 4, 2026, 4:15 a.m. Resident 3 was heard moaning and was found on the floor. A witness statement with Nurse Aide 2 on May 7, 2026, not timed, indicated that she assisted the resident to the bathroom at 3:30 a.m. on May 4, 2026, at 4:15 p.m. the Resident 3 was sleeping, and then at 4:30 a.m. the resident was found on the floor.A witness statement by RNS 3 on May 6, 2026, at 2:58 p.m. revealed that frequent checks (15 minute checks) were started when he returned from the hospital at 1:40 a.m. on May 4, 2026. RNS 3 was no informed to add any interventions to Resident 3's plan of care when he returned. RNS 3 completed a neurological check at 4:30 a.m. after the second fall. The resident was not wearing an incontinent brief at the time and was only wearing pants, and he was not incontinent at the time of the fall. Resident 3 was confused and could not express what happened. A review of toileting documentation revealed that staff did not document every two hours as care planned, Some staff document when they toilet Resident 3 and others will only document once per shift. Interview with the Director of Nursing on May 26, 2026, at 4:55 p.m. confirmed that there was no documented evidence that Resident 3's was toileted every two hours as a fall intervention. This has been a problem and multiple educations have been sent out to staff with instructions on how to document toileting and care.28 Pa. Code 211.12(d)(3)(5) Nursing services.