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	07/18/2024

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 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. 31760 Based on review of facility policies, clinical records, and facility investigation reports, as well as staff interviews, it was determined that the facility failed to ensure that assistance with incontinent care was provided in a manner to maintain dignity for one of 54 residents reviewed (Resident 106). Findings include: The facility's policy regarding resident rights, dignity, and respect, dated July 1, 2024, revealed that the staff, vendors, contractors, agencies, and anyone engaging in work for the facility shall display respect for the residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's goals, preferences, and choices. When providing care and services, staff must respect each resident's individuality, as well as honor and value their input. A Significant Change in Status Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 106, dated March 6, 2024, revealed that the resident was understood, could understand others, was frequently incontinent of bowel and bladder, and had a diagnosis which included Alzheimer's disease. A care plan for the resident, dated March 12, 2024, revealed that the resident had an alteration in elimination related to a cognitive impairment as evidenced by urinary incontinence and that the resident required assistance with toileting hygiene. A statement completed by Dental Hygienist 1, dated May 28, 2024, revealed that Resident 106 came in and was getting himself up off the chair and said, I am sorry I wet myself, she wouldn't let me get up and go. The resident was embarrassed. Dental Hygienist 1 told him it was okay and placed a disposable towel on his chair because his urine had gone through his pants onto his chair. After the resident had gotten back into his wheelchair and she had taken him out of the room, she brought in another resident to place in the chair. She explained to the resident that she had to wait for her to clean the area up, and the resident was pushy-like and huffy again. (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

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	07/18/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement completed by Nurse Aide 2, dated May 25, 2024, revealed that on May 24, 2024, at 2:30 p.m. the aide brought Resident 106 back to the floor after he was seen by the dentist, so Nurse Aide 2 pushed him back to his room. He said he needed to go to the bathroom. He then said, I told the aide I needed to go to the bathroom when I was down there. Nurse Aide 2 took him back to his room and took him to the bathroom. His wheelchair, ROHO cushion (a cushion that provides individuals with skin integrity issues an optimal environment to efficiently distribute pressure, minimize shear forces and prevent skin breakdown) was soaked and his pants were soaked. Nurse Aide 2 changed him and put him to bed. An incident summary for Resident 106, dated May 31, 2024, revealed that the resident was escorted down to the dental hygienist on May 24, 2024, by Nurse Aide 3. It was reported that the resident was incontinent while awaiting the dental visit and had soaked through his clothing onto the dental chair and onto the floor. Nurse Aide 3 reported that she had transported the resident down to the dentist and the resident had reported he had to use the bathroom and Nurse Aide 3 asked him if he could hold it, to which he replied yes. At no point was it reported that Nurse Aide 3 called the floor to check on the resident's transfer status or competence, and she stated that no profile sheet was given to her or obtained by her. Nurse Aide 3 then reported she went to get another resident and left the resident with the dentist,and the dentist reported that the resident self-transferred into the dental chair. Upon Nurse Aide 3's return to the dentist room, the resident was incontinent, and Nurse Aide 3 returned him to his unit and told staff he returned, and then left as it was the end of the shift, so she reported to second shift that they had to finish him up for her. Interview with Registered Nurse Supervisor 4 on July 16, 2024, at 2:25 p.m. revealed that the dental hygienist indicated that she heard Resident 106 outside the dental room but had a resident in the room. She indicated that Dental Hygienist 1 stated she knew what happened and that she should have done something because the resident was incontinent. So not to cause a big scene or make the resident feel worse, she placed a towel down on the chair and covered him with a towel instead of having someone provide incontinent care. 28 Pa. Code 201.29(j) Resident Rights.

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	07/18/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 31760 Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to accommodate a resident's preference for a shower for one of 54 residents reviewed (Resident 57). Findings include: A quarterly admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 57, dated June 19, 2024, revealed that the resident was understood, could understand others, and had diagnoses which included a stroke with hemiplegia (paralysis on one side of the body) and Chronic Obstructive Pulmonary Disease (COPD - a common lung disease causing restricted airflow and breathing problems). A care plan for the resident, dated October 18, 2022, revealed that the resident had a potential for Activities of Daily Living (ADL) self-care deficit related to the presence of mobility deficits to left upper extremity secondary to a stroke. Staff were to shower the resident two times per week on the 3:00 p.m. to 11:00 p.m. shift after supper on Mondays and Thursdays. Physician's orders for Resident 57, dated October 19, 2022, included an order for staff to shower the resident two times per week on the 3:00 p.m. to 11:00 p.m. per the resident's request on Mondays and Thursdays. Review of Resident 57's bathing records for May, June, and July 2024 revealed that the resident received a shower on Tuesday, May 7, 14, and 28, 2024; on Tuesday, June 4, 18, and 25, 2024, and on Tuesday, July 2, 9, and 16, 2024, and did not receive a shower on Mondays as he preferred and was ordered. Review of Resident 57's bathing records for May, June, and July 2024 revealed that the resident received a shower on Friday, May 3, and 17, 2024; on Friday, June 21, 2024; and on Friday, July 5, and 12, 2024, and did not receive a shower on Thursdays as he preferred and was ordered. Review of Resident 57's bathing records for May, June, and July 2024 revealed that the resident did not receive a shower on Monday, May 20, 2024, and Monday ,June 10, 2024, as he preferred and was ordered. Review of Resident 57's bathing records for May, June, and July 2024 revealed that the resident did not receive a shower on Thursday, May 23, 2024; on Thursday, May 30, 2024; on Thursday, June 6, 2024; on Thursday, June 13, 2024; and on Thursday, June 27, 2024, as he preferred and was ordered. Interview with Assistant Director of Nursing 5 on July 18, 2024, at 2:55 p.m. confirmed that there was no documented evidence of why Resident 57 was provided a shower on Tuesdays and Fridays instead of Mondays and Thursdays, as he preferred and was ordered. 28 Pa. Code 211.12(d)(5) Nursing Services.

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	07/18/2024

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 - Minimal harm or potential for 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. 31760 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 provide assistance with toileting for one of 54 residents reviewed (Resident 106), resulting in the resident being incontinent of bladder. Findings include: The facility's policy regarding abuse prevention, dated July 1, 2024, indicated that it is the process of the facility to provide protections for the health, safety, welfare, and rights of each resident residing in the facility by prohibiting and preventing abuse, neglect, exploitation, misappropriation of resident property, corporal punishment, involuntary seclusion, and any physical or chemical restraints to treat a resident's medical condition. The facility's policy regarding resident rights, dignity, and respect, dated July 1, 2024, revealed that the staff, vendors, contractors, agencies, and anyone engaging in work for the facility shall display respect for the residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's goals, preferences, and choices. When providing care and services, staff must respect each resident's individuality, as well as honor and value their input. A Significant Change in Status Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 106, dated March 6, 2024, revealed that the resident was understood, could understand others, was frequently incontinent of bowel and bladder, and had a diagnosis which included Alzheimer's disease. A care plan for the resident, dated March 12, 2024, revealed that the resident had an alteration in elimination related to a cognitive impairment as evidenced by urinary incontinence and that the resident required assistance with toileting hygiene. A statement completed by Dental Hygienist 1, dated May 28, 2024, revealed that Resident 106 came in and was getting himself up off the chair and said, I am sorry I wet myself, she wouldn't let me get up and go. The resident was embarrassed. Dental Hygienist 1 told him it was okay and placed a disposable towel on his chair because his urine had gone through his pants onto his chair. After the resident had gotten back into his wheelchair and she had taken him out of the room, she brought in another resident to place in the chair. She explained to the resident that she had to wait for her to clean the area up, and the resident was pushy-like and huffy again. (continued on next page)

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	07/18/2024

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 - Minimal harm or potential for actual harm Residents Affected - Few	A statement completed by Nurse Aide 2, dated May 25, 2024, revealed that on May 24, 2024, at 2:30 p.m. the aide brought Resident 106 back to the floor after he was seen by the dentist, so Nurse Aide 2 pushed him back to his room. He said he needed to go to the bathroom. He then said, I told the aide I needed to go to the bathroom when I was down there. Nurse Aide 2 took him back to his room and took him to the bathroom. His wheelchair, ROHO cushion (a cushion that provides individuals with skin integrity issues an optimal environment to efficiently distribute pressure, minimize shear forces and prevent skin breakdown) was soaked and his pants were soaked. Nurse Aide 2 changed him and put him to bed. An incident summary for Resident 106, dated May 31, 2024, revealed that the resident was escorted down to the dental hygienist on May 24, 2024, by Nurse Aide 3. It was reported that the resident was incontinent while awaiting the dental visit and had soaked through his clothing onto the dental chair and onto the floor. Nurse Aide 3 reported that she had transported the resident down to the dentist and the resident had reported he had to use the bathroom and Nurse Aide 3 asked him if he could hold it, to which he replied yes. At no point was it reported that Nurse Aide 3 called the floor to check on the resident's transfer status or competence, and she stated that no profile sheet was given to her or obtained by her. Nurse Aide 3 then reported she went to get another resident and left the resident with the dentist,and the dentist reported that the resident self-transferred into the dental chair. Upon Nurse Aide 3's return to the dentist room, the resident was incontinent, and Nurse Aide 3 returned him to his unit and told staff he returned, and then left as it was the end of the shift, so she reported to second shift that they had to finish him up for her. Interview with Registered Nurse Supervisor 4 on July 16, 2024, at 2:25 p.m. revealed that the dental hygienist indicated that she heard Resident 106 outside the dental room but had a resident in the room. She indicated that Dental Hygienist 1 stated she knew what happened and that she should have done something because the resident was incontinent. So not to cause a big scene or make the resident feel worse, she placed a towel down on the chair and covered him with a towel instead of having someone provide incontinent care. 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.

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	07/18/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 43856 Based on a review of the Pennsylvania Nurse Practice Act, facility policies, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a registered nurse provided care and services according to accepted standards of clinical practice for three of 54 residents reviewed (Residents 21, 100, 124) and the facility failed to ensure that physician's orders were clarified for one of 54 residents reviewed (Resident 118). 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. A facility policy regarding medication administration, dated July 1, 2024, indicated that after clearly identifying the resident via the name band and the resident's photo, the medication was to be administered to the resident and followed with a beverage. Staff were to remain with the resident until he/she has swallowed the medication. A quarterly (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 21, dated May 29, 2024, revealed that Resident 21 was cognitively intact, required minimal assistance with his daily care needs, and had a diagnosis of chronic kidney disease (when the kidneys are damaged and cannot filter blood properly). Observation of medication administration in the dining room during the lunch meal on July 15, 2024, at 12:26 p.m. revealed that Licensed Practical Nurse 6 placed a medication cup with Resident 21's medications in it on the table where he was eating lunch and walked away. An annual MDS assessment for Resident 100, dated April 17, 2024, revealed that Resident 100 was cognitively intact, was independent with his daily care needs, and had a diagnosis of non-traumatic brain disfunction (damage to the brain that occurs after birth due to internal factors). Observation of medication administration in the dining room during the lunch meal on July 15, 2024, at 12:22 p.m. revealed that Licensed Practical Nurse 6 placed a medication cup with Resident 100's medications in it on the table where he was eating lunch and walked away. A annual MDS assessment for Resident 124, dated May, 20, 2024, revealed that Resident 124 was cognitively intact, was independent with his daily care needs, and had diagnoses of coronary artery disease (when the coronary arteries narrow or become blocked. Observation of medication administration in the dining room during the lunch meal on July 15, 2024, at 12:18 p.m. revealed that Licensed Practical Nurse 6 placed a medication cup with Resident 124's medications in it on the table where he was eating lunch and walked away. (continued on next page)

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	07/18/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Licensed Practical Nurse 6 on July 15, 2024, at 12:28 p.m. confirmed that she placed the medication cups on the table for Resident's 21, 100 and 124 and walked away. Interview with the Director of Nursing on July 16, 2024, at 1:22 p.m. confirmed that Licensed Practical Nurse 6 should have observed Residents 21, 100 and 124 swallow the medication and she did not. A facility policy for venous access devices (devices that are inserted into the body through a vein to enable the administration of fluids, blood products, medication, and other therapies to the bloodstream) and intravenous therapy management, dated July 1, 2024, indicated that an implanted venous port that is not accessed should be flushed with 20 milliliters of saline followed by 500 units of heparin every 30 to 90 days based on physician's orders. A quarterly MDS assessment for Resident 118, dated June 12, 2024, indicated that the resident was cognitively intact, was independent with personal hygiene needs and eating, and had diagnoses that included Waldenstrom macroglobulinemia (an uncommon blood cell cancer). Physician's orders for Resident 118, dated December 11, 2023, included for staff to check his right upper chest port (a type of venous access device placed under the skin) every shift. The care plan for Resident 118, dated December 11, 2023, indicated that the resident had impaired skin integrity, a port to his right chest, and staff were to check the port to the right chest every shift. Review of the MAR and nursing notes for Resident 118, dated April 2024 through July 2024, revealed no documented evidence that physician's orders were obtained to flush the resident's right upper chest port every 30 to 90 days per facility policy. Interview with Assistant Director of Nursing 5 on July 18, 2024, at 3:11 p.m. confirmed that physician's orders for care and treatment of Resident 118's right upper chest port should have been clarified with the physician but were not. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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	07/18/2024

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 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. 46994 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that physician's orders regarding medication administration were followed for two of 54 residents reviewed (Residents 118, 152). Findings include: The facility policy for bowel monitoring, dated July 1, 2024, indicated that if a resident has not had a bowel movement within the last nine shifts, an oral administration of a bowel stimulant should be administered. If the resident does not have a medium or large bowel movement within the next shift, a rectal administration of a bowel stimulant should be administered. If the resident does not have a medium or large bowel movement within the next shift after the rectal bowel stimulant, an enema should be administered. If the resident does not have a medium or large bowel movement after one hour of receiving the enema, an abdominal assessment should be completed, and the physician should be notified. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 118, dated June 12, 2024, indicated that the resident was cognitively intact, was independent with personal hygiene needs and eating, and had diagnoses that included Waldenstrom macroglobulinemia (an uncommon blood cell cancer). Physician's orders for Resident 118, dated December 11, 2023, included orders for the resident to receive 30 milliliters (ml) of magnesium hydroxide (an oral bowel stimulant) as needed if no bowel movement for 72 hours, and one Dulcolax suppository (a bowel stimulant inserted rectally) as needed if no bowel movement within 24 hours after administration of magnesium hydroxide. Review of Resident 118's bowel records for April and May 2024 revealed that the resident had a bowel movement on April 28, 2024, and did not have a bowel movement from April 29 through May 2, 2024. Medication Administration Records (MARs) for Resident 118 for April and May 2024 revealed that staff did not administer magnesium hydroxide as ordered on May 1, 2024, which was 72 hours without a bowel movement. The bowel records revealed that the resident had a bowel movement on May 10, 2024, and did not have a bowel movement from May 11 through May 15, 2024. The MAR revealed that staff did not administer magnesium hydroxide on May 13, 14 or 15, which was 72, 96 and 120 hours with no bowel movement. The resident's bowel records, dated June 2024, revealed that the resident had a bowel movement on June 6, and did not have a bowel movement on June 7 through June 10, 2024. The MAR revealed that staff did not administer magnesium hydroxide on June 9 or 10, 2024, which was 72 and 96 hours with no bowel movement. Interview with Assistant Director of Nursing 5 on July 18, 2024, at 3:05 p.m. confirmed that Resident 118's physician's orders for constipation were not followed on the above days. An annual MDS assessment for Resident 152, dated May 8, 2024, revealed that the resident was sometimes understood, sometimes understood others, was cognitively impaired, required partial assistance with daily care needs, and had diagnoses that included atrial fibrillation (an irregular and often very rapid heart rhythm). (continued on next page)

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	07/18/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 152, dated May 5, 2023, included an order for the resident to receive a 6.25 milligram (mg) tablet of Carvedilol (a medication to treat high blood pressure) every 12 hours at 9:00 a.m. and 9:00 p.m. and to hold medication if systolic blood pressure (first number in blood pressure) is less than 95 mmHg or if the heart rate is less than 55 beats per minute A review of Resident 152's MAR revealed that the resident received the medication twice a day from January 2024 to present. There was no documented evidence that a blood pressure or heart rate was taken prior to medication administration. Interview with Assistant Director of Nursing 5 on July 18, 2024, at 10:46 a.m. confirmed that Resident 152 did not have blood pressure or heart rate checked prior to medication administration and should have per physician's orders. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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	07/18/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46994 Based on facility policies and clinical records, as well as 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 54 residents reviewed (Residents 160). Findings include: A facility policy for medication administration, dated July 1, 2024, indicated that when administering a narcotic, the medication nurse will compare the amount of narcotic recorded on the narcotic administration and disposition record (a form that accounts for each tablet/pill/dose of a controlled drug) making sure amounts are correct in addition to clicking complete on the electronic Medication Administration Record (eMAR) following administration. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 160, dated May 8, 2024, indicated that the resident was cognitively impaired, required partial to moderate assistance for her daily care needs, and had diagnoses that included breast cancer. Physician's orders for Resident 160, dated May 13, 2024, included an order for the resident to receive 0.125 milliliters (ml) of Oxycodone concentrate (a liquid narcotic pain medication) (20 milligrams per ml) every six hours as needed for pain or shortness of breath. Physician's orders, dated June 3, 2024, included for the resident to receive 2.5 mg of Oxycodone concentrate 20 mg/ml every two hours as needed for pain or shortness of breath. Review of the narcotic administration and disposition records for Resident 160, dated November 27, 2023, and May 6, 2024, indicated that 2.5 mg of Oxycodone was signed out as administered on May 13, 2024, at 10:55 p.m.; June 15, 2024, at 5:40 p.m.; June 17, 2024, at 9:30 p.m.; and July 13, 2024, at 4:47 p.m. Review of the eMAR for Resident 160, dated May, June and July 2024, revealed no documented evidence that the signed-out doses of Oxycodone were administered on the above-mentioned dates and times. Interview with the Quality Assurance Coordinator on July 18, 2024, at 3:00 p.m. confirmed that there was no documented evidence that the signed-out doses of Oxycodone were administered to Resident 160 on the above-mentioned dates and times. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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	07/18/2024

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 46994 Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that staff provided assistive devices to eat in accordance with the resident's care plan for one of 54 residents reviewed (Resident 118). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 118, dated June 12, 2024, indicated that the resident was cognitively intact, was independent with personal hygiene needs and eating, and had diagnoses that included Waldenstrom macroglobulinemia (an uncommon blood cell cancer). Physician's orders for Resident 118, dated December 11, 2023, included an order for the resident to have built-up utensils for meals. A care plan for Resident 118, dated December 12, 2023, indicated that the resident had the potential for altered nutrition and that built-up utensils were to be used for meals. Observations of Resident 118 during the lunch meal on July 16, 2024, at 1:03 p.m. revealed that the resident was in his room eating his meal using regular utensil and did not have built-up utensils. Interview with the resident at that time revealed that he prefers to have the built-up utensils but did not receive them for lunch that day. He reported that he frequently gets meals without the built-up utensils. Interview with Registered Nurse 7 on July 16, 2024, at 1:03 p.m. confirmed that Resident 118 did not have built-up utensils for the lunch meal as ordered. Interview with Assistant Director of Nursing 8 on July 17, 2024, confirmed that Resident 118 should have had built-up utensils for his meals as ordered. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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	07/18/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48809 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that food was stored and prepared under sanitary conditions. Findings include: The facility's policies regarding food preparation and service, as well as sanitization, dated [DATE], indicated that all refrigeration and storage areas must be well lit, clean and free from overhead leakage and dampness. All food items must be stored in properly-covered containers, labeled, dated upon opening, and stored at least six inches off the floor on acceptable shelving. Prepackaged foods will be discarded by dietary services on the expiration date. Food brought into residents by family will be labeled by nursing with resident's name and date and will be discarded by dietary services on the expiration date. Observations in the main kitchen on [DATE], at 9:08 a.m. revealed that the refrigerator in had an opened and undated container of beef broth that was half full and an area of standing water approximately twelve inches by five inches and one centimeter deep on right side of refrigerator. Interview with Dietary Manager on [DATE], at 9:15 a.m. confirmed that the beef broth should have been dated when opened and that there should not be a puddle of water in the refrigerator. Observations of the left kitchenette on the first floor of [NAME] on [DATE], at 1:03 p.m. revealed a half full frozen coffee drink from [NAME] Donuts and a strawberry sundae from the Meadows in the freezer without a name or date on the containers. Interview with Registered Nurse 9 on [DATE], at 1:05 p.m. confirmed that the coffee and ice cream sundae should have had a resident's name and date on it. Observations of the second floor left hall kitchenette on [DATE], at 1:11 p.m. revealed two expired wildberry magic cups with an expiration date of February 2024. Interview with Licensed Practical Nurse 10 on [DATE], at 1:11 p.m. confirmed that the magic cups were expired and should have been thrown away. Interview with the Dietary Manager on [DATE], at 2:47 p.m. confirmed that the [NAME] Donuts coffee and strawberry sundae in the first floor kitchenette freezer should have had a resident's name and date on them, and the two expired wildberry magic cups found in the second floor left hallway kitchenette should have been discarded. 28 Pa. Code 211.6(f) Dietary Services.

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	07/18/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48809 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents' clinical records were complete and accurately documented for one of 54 residents reviewed (Resident 154). Findings include: The facility's policy for Medication Administration, dated July 1, 2024, indicated that after administering the narcotic, the medication nurse will record the date the narcotic was administered, sign their name, record the amount of the narcotic administered, record the time the narcotic was administered, and the remaining balance of the narcotic on the Narcotic Administration and Disposition Record. The specific time the narcotic was given will be reflected on the eMAR when the licensed nurse clicks Complete indicating that the narcotic was administered. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 154, dated April 16, 2024, revealed that she was understood and understood others, was cognitively impaired, and received pain medication as needed. Physician's orders for Resident 154, dated April 9, 2024, included an order for the resident to receive 5-325 milligrams (mg) of NORCO (a medication used to treat pain) every 8 hours as needed. Resident 154's Medication Administration Record (MAR) dated May 8, 2024, revealed that the NORCO was administered at 8:45 p.m. Narcotic sign-out sheets for Resident 154, dated May 8, 2024, revealed that the narcotic was signed out for administration at 5:17 p.m. Resident 154's MAR, dated June 15, 2024, revealed that the NORCO was administered at 9:00 a.m. and 7:58 p.m. Narcotic sign-out sheets for Resident 154, dated June 15, 2024, revealed that the NORCO was signed out for administration at 9:00 a.m. and 6:00 p.m. Interview with the Director of Nursing on July 18, 2024, at 1:22 p.m. revealed that the NORCO should have been administered at the same time it was signed out on the narcotic sheet. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.

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	07/18/2024

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 46994 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the designated interdisciplinary team member obtained the required information from the contracted hospice provider for one of 54 residents reviewed who were receiving hospice services (Resident 160). Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 160, dated May 8, 2024, indicated that the resident was cognitively impaired, required partial to moderate assistance for her daily care needs, had diagnoses that included breast cancer, and was receiving hospice services. The care plan for Resident 160, dated May 6, 2024, included that the resident was receiving hospice services with UPMC family hospice and hospice staff were to give written and oral reports to the facility after each visit with the resident. A nurse's note for Resident 160, dated May 3, 2024, at 8:39 p.m., included that the resident returned from the hospital at 6:40 p.m. and the hospice nurse was at the facility to assess the resident. A nurse's note, dated May 6, 2024, included that the nurse spoke with a hospice representative to discuss the resident's consult for hospice and the resident was admitted to hospice on May 3, 2024. As of July 18, 2024, at 8:30 a.m. there was no documented evidence readily available in Resident 160's clinical record, or in the hospice provider's clinical record, that the facility obtained the hospice benefit of elections form, certification of terminal illness form, the resident's hospice plan of care, or the hospice registered nurse and nurse aide progress notes. Interview with Assistant Director of Nursing 5 and the Nursing Home Administrator on July 18, 2024, at 3:16 p.m. confirmed that hospice forms and communication should be part of the hospice provider's clinical record on the unit but were not. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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	07/18/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43856 Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for two of 54 residents reviewed (Residents 87, 128). Findings include: Facility policy for hand hygiene, dated July 1, 2024, indicated that hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub. Hand hygiene must be performed before donning (put on) and after removing personal protective equipment, including gloves. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 87, dated July 3, 2024, revealed that the resident was cognitively intact, was dependent on staff for care needs, was always incontinent of bowel and bladder, and had diagnoses that included chronic kidney disease. Observations of Resident 87 on July 16, 2024, at 12:48 p.m. revealed that Nurse Aide 11 was wearing gloves as she provided urinary incontinence care to the resident as she was lying in bed. The nurse aide used wipes to cleanse the urine off the resident's skin, removed the old brief, and applied a clean brief. She then removed her gloves and placed them in a garbage can and then proceeded to move the resident's bedside table around, touching personal items including adjusting a fan to blow on the resident. Nurse Aide 11 did not perform hand hygiene after removing her gloves and prior to touching the resident's personal belongings. Interview with Nurse Aide 11 immediately after the observation revealed that she thought she probably should have performed hand hygiene after removing her gloves and prior to touching the resident's personal belongings. Interview with Assistant Director of Nursing 8 confirmed that hand hygiene should be performed anytime gloves are removed. CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated July 12, 2022, indicates that multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. (continued on next page)

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	07/18/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy regarding Enhanced Barrier Precautions (EBP), dated July 1, 2024, indicated that gloves and a gown are used during high contact resident care, which includes device care or use including feeding tubes. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 128, dated June 26, 2024, revealed that the resident was cognitively impaired, required extensive assistance from staff for daily care needs, and had a feeding tube (a soft, flexible plastic tube inserted in the gastrointestinal tract to provide nutrition). A care plan for Resident 128 regarding EBP, dated May 24, 2024, revealed that the resident had EBP in place due to feeding tube placement. Physician's orders for Resident 128, dated June 6, 2024, included an order for the resident to have EBP in place due to feeding tube placement every shift. Observations of Resident 128 on July 18, 204, at 12:16 p.m. revealed that the resident had signage at the entrance to his room to indicate that infection control measures for EBP were in place related to his feeding tube. Licensed Practical Nurse 12 and Registered Nurse 9 were wearing gloves while accessing the feeding tube; however, they were not wearing gowns. Interview with Licensed Practical Nurse 12 and Registered Nurse 9 on July 18, 2024, at 12:28 p.m. revealed that they did not wear a gown when accessing the feeding tube and they should have. Interview with the Director of Nursing on July 18, 2024, at 1:24 p.m. confirmed that Resident 128 had EBP, and staff should have been wearing a gown and gloves while accessing a feeding tube 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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	07/18/2024

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 48809 Based on observations and staff interviews, it was determined that the facility failed to ensure that the main kitchen walk-in freezer was maintained in good condition. Findings include: Observations in the walk-in freezer in the main kitchen on July 15, 2024, at 9:12 a.m. revealed that there was a large accumulation of ice on the fans. Interview with the Dietary Director on July 15, 2024, at 9:12 a.m. confirmed that there was a large accumulation of ice and that it should not be built up on the fans. 28 Pa. Code 207.2 (a) Administrator's Responsibility.