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	06/12/2025

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to maintain confidentiality of residents' personal health information during medication administration for one of 59 residents reviewed (Resident 78). Findings include: The facility policy regarding privacy of health information, dated July, 1 2024, indicated that the facility was to protect the confidentiality of a resident's health information. Observations of the [NAME] building's North Hall on June 11, 2025, at 12:21 p.m. revealed a medication cart at the end of the hallway, the computer on top of the medication cart was on, and Resident 78's personal information was visible on the screen. Interview with Licensed Practical Nurse 1 on June 11, 2025, at 12:27 p.m. confirmed that she should have covered Resident 78's personal information on the computer screen when leaving the medication cart. Interview with the Director of Nursing on June 11, 2025, at 1:41 p.m. confirmed that the computer screen with Resident 78's personal health information should have been covered when the nurse was not at the medication cart. 28 Pa. Code 211.5(b) Clinical Records.

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 - 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. Based on review of policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one 59 residents reviewed (Resident 139). Findings include: The facility's abuse policy, dated July 1, 2024, indicated that each resident had the right to be free from abuse, neglect and misappropriation of resident property. Abuse is defined as, the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being, which includes verbal, sexual, physical and mental abuse. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 139, dated January 7, 2025, indicated that the resident was moderately cognitively impaired, required moderate assistance from staff with activities of daily living, and had diagnoses that included glaucoma (weakening of the eyesight) and Parkinson's disease (a brain disorder resulting in tremors and slowness of movement). Resident 139's urinary incontinence care plan, dated January 5, 2023, indicated that staff members were to assist the resident with toileting, perineal hygiene, and management of incontinence products/clothing upon resident request and as needed. A written statement from Nurse Aide 3, dated March 2, 2025, revealed that she saw Nurse Aide 2 go into the Resident 139's room and heard her say, Stop ringing your bell you're not going to get anyone else but me to help you. You can change your own underwear. She further indicated that Nurse Aide 2 left the room and the resident rang again. Nurse Aide 3 answered the call bell and he complained about Nurse Aide 2 and asked to speak to the supervisor. A written statement from Registered Nurse Supervisor 4, dated March 2, 2025, revealed Resident 139 reported that Nurse Aide 2 came into his room, turned his bell off, and walked out of his room several times. He reported that she told him to, Stop ringing your bell, and You can do it yourself. He also reported that she was mean to him, he was afraid of her, and wished for her not to care for him again. He stated that she argued with him about his vision. He told her that he was partially blind due to his glaucoma and she told him, You're not blind, you can see just fine. He indicated he was fearful of retaliation. Facility investigation documents, dated March 2, 2025, revealed that Nurse Aide 2 went into Resident 139's room and turned his call bell off and walked out of his room several times. The last time she answered his bell he asked the nurse aide for help and she replied, Stop ringing your call bell. You can do it yourself. A call bell report was run, which indicated that the resident had rung his call bell several times in a short time frame. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement provided by Resident 139, dated March 7, 2025, indicated that Nurse Aide 2 refused to provide care for him saying we don't do that. For example, she will not make sure his private areas are clean and other areas like that. The resident stated this was not the first time this has happened with her, and that he gets the feeling she does not care. He also stated that he feels nervous when she answers his call bell, and that she sometimes just stands there and cocks her hips staring at him. Interview with the Assistant Director of Nursing 5 on June 12, 2025, at 2:03 p.m. confirmed that the facility substantiated neglect and mental abuse, and that Nurse Aide 2 was terminated. He further indicated that he would expect nursing staff to answer a resident's call bell and provide the care/assistance asked by the resident. An interview with the Nursing Home Administrator on June 12, 2025, at 16:50 p.m. confirmed that the facility substantiated abuse of Resident 139 by Nurse Aide 2. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(j) Resident Rights.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for one of 59 residents reviewed (Resident 169). Findings include: A facility policy regarding interdisciplinary care plans, dated July 1, 2024, indicated that each resident has an individualized interdisciplinary care plan. Proper documentation was required in the care plan for discontinued or added interventions, changes in problems, goals, and interventions. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 169, dated February 4, 2025, revealed that the resident was understood, could understand others, was moderately cognitively impaired, required supervision for showering and bathing, was independent with all other care needs, and had diagnoses that included heart failure and Alzheimer's disease. Nursing notes, dated February 16, 2025, indicated that Resident 169 fell at his daughter's home, was admitted to the hospital with a brain bleed, and had five sutures in the back of his head. A care plan regarding falls, dated May 5, 2024, indicated that the resident was at risk for falls related to antidepressant use. A care plan intervention for the resident, dated February 24, 2025, revealed that staff were to monitor staples to the head related to a fall while on a leave of absence. Staff were to notify the medical provider with worsening condition of the site. A nurse practitioner note for Resident 169, dated February 27, 2025, indicated that five staples were removed from the back of his head. Observations of Resident 169 on June 11, 2025, at 12:35 p.m. in the dining room revealed that he did not have any staples on the back of his head. Interview with Assistant Director of Nursing 6 on June 11, 2025, at 3:09 p.m. confirmed that Resident 169's care plan needed updated to discontinue staple care needs, as they were removed in February 2025. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to clarify physician's orders for one of 59 residents reviewed (Resident 140). Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 140, dated April 25, 2025, indicated that the resident was cognitively impaired and had diagnoses that included kidney failure and received dialysis. A care plan for nutritional status, dated January 26, 2024, revealed that the resident goes to dialysis at 6:00 a.m. on Tuesdays, Thursdays, and Saturdays. Physician's orders for Resident 140, dated January 26, 2024, included an order for the resident to receive at 9:00 a.m. 1 milligram (mg) of bumetanide (a medication to treat edema), 25 microgram (mcg) of vitamin D3, 2.5 mg of Eliquis (a blood thinner), one 50 mcg spray per nostril of Flonase (a medication to treat allergies), 0. 5 mg of lorazepam (a medication to treat anxiety), 10 mg of midodrine, 75 mg of Plavix (a medication to help prevent blood clots from forming), 10 mg of Protonix (a medication to treat acid reflux), 800 mg of renvela (a medication to treat high phosphorus levels), 25 mg Vistaril (a medication to treat anxiety and itchiness). A review of Resident 140's Medication Administration Records (MAR) for May and June 2025 revealed that the resident received his medications at 9:00 a.m. on Tuesdays, Thursdays, and Saturdays; however, a review of the resident's clinical record revealed that the resident was at dialysis on those dates and time, and was unavailable to receive his medication. There was no documented evidence to indicate that the physician was notified for clarification of the orders for Resident 140's dialysis days. Nursing notes for Resident 140 on dialysis days for the months of May and June 2025 revealed that the resident received his 9:00 a.m. medication by the third shift licensed practical nurse before leaving for dialysis at 6:00 a.m. on dialysis days. Interview with the Director of Nursing on July 7, 2025, at 11:37 a.m. confirmed that Resident 140's orders for his 9:00 a.m. medication on dialysis days should have been clarified with the physician. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for 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 and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that fall interventions were in place for one of 59 residents reviewed (Resident 9) who had a history of a fall from his bed, and failed to lock the wheels on a hoyer lift during use per manufacturer's instructions for one of 59 residents reviewed (Resident 186). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated March 25, 2025, revealed that the resident was cognitively intact, was dependent for most daily care needs including bed mobility, and had a diagnoses that included hemiplegia and hemiparesis (paralysis or weakness to one side of the body due to brain injury) of the left side following a stroke. The current fall care plan for Resident 9 revealed that the resident was at risk for falls. Interventions for Resident 9 included the use of a long positioning wedge to the left side at all times when in bed. Physician's orders for Resident 9, dated December 24, 2024, included an order for the resident to use a long positioning wedge to his left lateral side at all times when in bed. Observations on June 11, 2025, at 2:38 p.m. and June 12, 2025, at 11:16 a.m. revealed that Resident 9 was lying in bed and he did not have his long positioning wedge in place to his left lateral side. Interview with Licensed Practical Nurse 7 on June 12, 2025, at 11:24 a.m. indicated that she was not sure if Resident 9 was to have a wedge to his left side when in bed, but she would check with the nurse aide to see if she recalled him having one and where it was at. Licensed Practical Nurse 7 verified the orders and confirmed that the resident was to have the long positioning wedge to his left lateral side when in bed and it was not in place. Interview with Nurse Aide 8 on June 12, 2025, at 11:28 a.m. indicated that she did recall Resident 9 having a left lateral wedge in bed but could not locate it in his room. Interview with the resident at that time indicated that he had a wedge to his left side but did not know when he had it last. Interview with the Assistant Director of Nursing 6 on June 12, 2025, at 3:09 p.m. confirmed that Resident 9's long positioning wedge to his left lateral side should have been in place and it was not. The facility's policy for using a lifting machine, dated July 1, 2024, revealed that staff must be competent in the use of mechanical lifts per manufacturer's instructions. Manufacturer's instructions for the Vikking Hoyer lift revealed that the breaks were to be engaged when lifting a patient from the floor to decrease the risk of the lift moving into the patient. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 186, dated April 2, 2025, revealed that the resident was cognitively impaired and required extensive assistance with daily care needs including transfers. A fall care plan, dated May 21, 2025, revealed that the resident was to be transferred by two staff using a Hoyer mechanical lift with the model 350 size medium sling. Observations of Nurse Aide 9 and Registered Nurse 10 on June 9, 2025, at 1:21 p.m. using the mechanical lift to transfer Resident 186 from the floor to his bed revealed that the brakes on the lift were not engaged during the transfer causing the lift to roll slightly. Interview with Nurse Aide 9 and Registered Nurse 10 on June 9, 2025, at 1:30 p.m. confirmed that they should have had the brakes on while raising Resident 186 from the floor and lowering him into the bed. Interview with the Director of Nursing on June 10, 2025, at 2:13 p.m. confirmed that the brakes should have been engaged when using the mechanical lift to transfer Resident 186 from the floor to his bed. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to follow facility policy for the care and monitoring of residents receiving dialysis for one of 59 residents reviewed (Resident 140). Findings include: Review of the facility's current dialysis policy, dated July 1, 2024, revealed that when the resident returns from dialysis the resident will be assessed by a registered nurse with a complete set of vital signs and the dialysis access permacath (a catheter used for dialysis access) or fistula (a surgically created access point for dialysis) would be assessed for bleeding every 15 minutes for two hours. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 140, dated April 25, 2025, indicated that the resident was cognitively impaired, had a diagnosis of kidney failure, and received dialysis. The current care plan revealed that Resident 140 goes to dialysis early in the morning on Tuesdays, Thursdays, and Saturdays. A review of Resident 140's clinical record for April, May, and June 2025 revealed no documented evidence that a registered nurse assessed the dialysis site for bleeding every 15 minutes for two hours on April 15 and 17, 2025; May 1, 17, 31, 2025; and June 7, 2025; and no documented evidence that vital signs were completed upon return from dialysis on April 5, 8, 10, 12, 24, 26, 2025; May 6 , 15, 24, 27, 29, 2025; and June 5 and 7, 2025. Interview with the Director of Nursing on June 11, 2025, at 9:53 a.m. confirmed that there was no documented evidence that the facility's policy for after dialysis assessment, care and monitoring was completed for Resident 140 on the above dates. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain a complete and accurate accounting of controlled medications (medications with the potential to be abused) for one of 59 residents reviewed (Resident 53). Findings include: The facility's policy regarding medication administration, dated July 1, 2025, indicated that staff were to document that medication was given on the appropriate line of the resident's Medication Administration Record (MAR). Physician's orders for Resident 53, dated April 9, 2025, included an order for the resident to receive 10 milligrams (mg) of Oxycontin (a controlled narcotic pain medication) every four hours as needed. Resident 53's controlled drug records for May 2025 revealed that a 10 mg dose of Oxycontin was signed-out for administration once on May 1, 2025, at 12:42 p.m.; May 13, 2025, at 6:00 p.m.; May 24, 2025 at 5:22 p.m. ; and May 27, 2025 at 10:20 p.m. However, the resident's clinical record, including the MAR, contained no documented evidence that the Oxycontin was actually administered to the resident. Interview with Assistant Director of Nursing 6 on June 10 at 1:16 p.m. confirmed that there was no documented evidence that the dose of Oxycontin signed out by the nurse was actually administered to Resident 53 on the above dates and times. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly secured in the medication cart. Findings include: The facility's policy regarding medication storage, dated July 2, 2025, indicated that the nurse was to ensure the medication cart was securely locked at all times when out of the nurse's view. Observations on June 11, 2025, at 12:21 p.m. revealed that a medication cart in the hallway was unlocked and unattended by Licensed Practical Nurse 1 when she went to the nurse's station. Interview with Licensed Practical Nurse 1 on June 11, 2025, at 12:27 p.m. confirmed that her medication cart should have been locked when unattended. Interview with the Director of Nursing on June 11, 2025, at 2:06 p.m. confirmed that the medication cart should have been locked when unattended by Licensed Practical Nurse 1. 28 Pa. Code 211.9(a)(1)(k) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, it was determined that the facility failed to ensure that food was stored and prepared under sanitary conditions. Findings include: Observations in the main kitchen on June 9, 2025, at 9:20 a.m. revealed that the large plastic flour container, the large plastic sugar container, and the large plastic thickening powder container, located in the preparation area, was still in the original paper containers of flour, sugar, and powder thickener while stored inside each of the plastic containers. Interview with Dietary Manager on June 9, 2025, at 9:20 a.m. revealed that she was not aware of any reason that the original paper containers should not be inside the large plastic containers. 28 Pa. Code 211.6(f) Dietary Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to maintain clinical records that were accurately documented for three of 59 residents reviewed (Residents 53, 136, 171). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated March 26, 2025, indicated that the resident was cognitively intact, was independent for care, and received enteral feeding. Physician's orders, dated April 9, 2025, included an order for the resident to receive Isosource 1.5 (a tube feeding formula) at 250 milliters (ml) per hour over one hour three times a day, provide 85 ml flush before and after feeding, and document the amount of feed and flush administered. A review of Resident 53's Medication Administration Record (MAR), dated April, May, June 2025, indicated that staff were not correctly documenting the amount of feeds and flushes. On April 10, 2025, at 9:00 a.m. 100 ml was documented, and there was do documented evidence if the resident received pre and post-administration flushes; 250 ml was documented on April 11, at 9:00 a.m. and 1:00 p.m.; April 12, at 9:00 a.m. and 6:00 p.m.; April 13, at 9:00 a.m. and 1:00 p.m.; April 14, at 9:00 a.m.; April 17, at 6:00 p.m.; April 19, at 1:00 p.m.; April 21, at 6:00 p.m.; April 23, at 6:00 p.m.; April 24, at 9:00 a.m.; April 25, at 9:00 a.m. and 1:00 p.m.; April 30, at 1:00 p.m.; and no documented evidence of pre and post-administration flushes; 335 ml was documented as administered on April 15, at 9:00 a.m., 1:00 p.m. and 6:00 p.m.; April 16, at 9:00 a.m. and 1:00 p.m.; April 18, at 9:00 a.m. and 1:00 p.m.; April 19, at 6:00 p.m.; April 20, at 9:00 a.m., 1:00 p.m., and 6:00 p.m.; April 27, at 9:00 a.m., 1:00 p.m., and 6:00 p.m.; 250 ml feeding and 85 ml flush was documented for May 2, at 6:00 p.m.; 250 ml was documented as administered on May 3, at 1:00 p.m.; May 4, at 9:00 a.m.; May 7, at 6:00 p.m.; May 10, at 1:00 p.m.; May 17, at 9:00 a.m.; May 20, at 9:00 a.m.; May 22, at 1:00 p.m. and 6:00 p.m.; May 23, at 1:00 p.m. and 6:00 p.m.; May 24, at 1:00 p.m.; May 26, at 2:50 p. m.; May 29, at 1:00 p.m. and 6:00 p.m.; May 30, at 9:00 a.m., 1:00 p.m., and 6:00 p.m.; May 31, at 1:00 p.m.; 390 ml was documented as administered on May 17, at 6:00 p.m.; 240 ml was documented as administered on May 11, at 1:00 p.m.; 157 ml was documented as administered on May 20, at 6:00 p.m.; 500 ml was documented as administered on May 26, at 1:00 p.m.; 247 ml was documented as administered on May 27, at 1:00 p.m.; 370 ml was documented as administered on May 28, at 6:00 p.m.; and 380 ml was documented as administered on May 31, at 6:00 p.m. The documentation did not indicate how much was feeding and how much was pre and post-flushes. Interview with the Director of Nursing on June 12, 2025, at 1:16 p.m. confirmed that the nurses were to follow the physician's orders for Resident 53's enteral feeding to document the correct amount of flush and Isosource administered at the time of administration. A quarterly MDS assessment for Resident 136, dated March 4, 2025, revealed that the resident was cognitively impaired, was independent with most care needs, and had a diagnosis of Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event). (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	06/12/2025

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's progress note for Resident 136, dated April 23, 2025, at 1:41 p.m., indicated that the resident was seen for a 60-day assessment and had a diagnosis of ongoing chronic PTSD. Review of the resident's clinical records, including psychiatric progress notes, the resident's plan of care, and the trauma assessment revealed no documented evidence that the resident had a diagnosis of PTSD. Interview with the Social Service Director on June 12, 2025, at 2:20 p.m. indicated that she had reviewed Resident 136's clinical records dating back to his admission and that there was no prior documentation in the resident's clinical records that indicated he had a diagnosis of PTSD. She indicated that there was a psychiatric note that indicated he had no signs of PTSD, and she believed that the PTSD diagnoses may have been documented in error. She reached out to the Certified Registered Nurse Practitioner (CRNP) to clarify the PTSD diagnosis. She indicated that the resident was a civil war re-enactor and was care planned as such with no signs of PTSD. There was no active care plan for the resident related to PTSD. A physician's progress note for Resident 136, dated June 12, 2025, at 2:45 p.m., revealed that the resident's chart was reviewed secondary to his PTSD diagnosis. Upon review, there was no diagnosis of PTSD noted as per multiple psychiatrist documentation and follow up evaluations. The PTSD diagnosis was therefore not warranted based on their evaluations. Interview with the Social Service Director on June 12, 2025, at 3:07 p.m. confirmed that Resident 136 did not have a diagnosis of PTSD as confirmed by the CRNP per review of the resident's clinical record. A significant change MDS assessment for Resident 171, dated May 27, 2025, revealed that the resident was understood, could understand others, was independent with transfers, had a diagnosis of dementia, and had a history of falls. A nursing note for Resident 171, dated May 20, 2025, revealed that the resident had an unwitnessed fall. The resident sustained a 3 centimeter (cm) by 4 cm abrasion to the center of the neck. The CRNP was made aware and a new order was received to have the resident screened by speech therapy. A speech therapy note for Resident 171, dated May 20, 2025, indicated that the resident had a screening and it was recommended to have vocal rest due to recent trauma. Speech therapy would follow-up in a few days to assess voice further; however, there was no documented evidence in Resident 171's clinical record that speech therapy followed up as recommended. A late entry speech therapy note, recorded on June 11, 2025, for May 20, 2025, indicated that speech therapy followed up with Resident 171, who was improving, had a gargled voice, and recommended to continue with light vocal use and rest. Interview with the Speech Therapist on June 12, 2025, at 12:14 p.m. revealed that therapy screenings are documented in the medical record. She confirmed that she did follow up with Resident 171 but forgot to document it. She entered a late entry in the clinical record after she was made aware that there was no documentation. Interview with the Nursing Home Administrator on June 12, 2025, at 4:15 p.m. confirmed that Resident 171's clinic record should have been complete and accurate. (continued on next page)

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	39A437	A. Building B. Wing	06/12/2025

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plan of corrections for an annual survey ending July 18, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending June 12, 2025, identified repeated deficiencies related to a failure to protect the residents from abuse/neglect, failure to have accountability for controlled medications, failure to ensure that food was stored and served properly, and failure to ensure that medical records were complete and accurate. The facility's plan of correction for a deficiency regarding abuse/neglect, cited during the survey ending July 18, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F600, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident were free from abuse/neglect. The facility's plan of correction for a deficiency regarding accountability for controlled medications, cited during the survey ending July 18, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that controlled medications were accounted for. The facility's plan of correction for a deficiency regarding proper food storage/serving, cited during the survey ending July 18, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that food was stored and served properly. The facility's plan of correction for a deficiency regarding accurate medical records, cited during the survey ending July 18, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F842, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident records were complete and accurate. Refer to F600, F755, F812, F842. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.