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	06/11/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of facility policies, observations, and resident and staff interviews, it was determined that the facility failed to serve food that was palatable and at safe and appetizing temperatures. Findings include:The facility's policy regarding food temperatures, dated January 1, 2026, indicated that all hot foods were to be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit (F).Interview with a group of residents on June 10, 2026 at 2:00 p.m. revealed that the hot food is served warm or cold and that asking staff to reheat it in the microwave takes too much time. They stated that the residents that eat in their rooms are served first causing the food that sits in the dining room to cool down before the residents in the dining room are served. Interview with Resident 31 on June 8, 2026 at 12:14 p.m. revealed that the food is cold, the soup is always served cold, and that the plates are even cold. Interview with Resident 48 on June 8, 2026 at 12:19 p.m. revealed that the food is cold. She said that the food is barely warm when it reaches her and gets very cold before she has the chance to eat it. Interview with Resident 73 on June 8, 2026 at 12:10 p.m. revealed that the food is always cold. He stated that there are no plate warmers, no warm pallets for the plates to rest on, and no steam tables to keep the food warm. Interview with Resident 89 on June 8, 2026 at 12:15 p.m. revealed that the food is cold no matter if he eats in his room or in the dining room. He stated that he prefers to have hot food and especially hot soup. Observations in the North 1 dining room for the lunch meal service on June 10, 2026, at 11:53 a.m., revealed the lunch meal consisted of chicken tenders, mashed potatoes, corn, diced pears and a salad. The last resident to be served in the dining room was at 12:34 p.m. The test tray on June 10, 2026, at 12:35 p.m. revealed that the temperature of the chicken tenders was 141.0 degrees (F), mashed potatoes was 124.5 degrees (F) and the corn was 116.0 degrees (F). The mashed potatoes and corn were not hot and were not served at the appropriate temperatures. Interview with [NAME] 6 on June 10, 2026, at 12:45 p.m. confirmed that food should be served at a temperature of 140 degrees (F) or higher.28 Pa. Code 211.6(f) Dietary 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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food under sanitary conditions.Findings include:The facility's policy for food storage, dated January 1, 2026, revealed that all prepared items would be covered, labeled and dated clearly. Observations in the main kitchen on June 8, 2026, at 9:13 a.m. revealed that a stand up fan had a build up of black dust and debris on the cage and was blowing towards the food prep area; and at 9:33 a.m. in the walk-in freezer located in the basement, there were 11 birthday gobs that were not dated. Interviews with the Dietary Manager on June 8, 2026, at 9:13 a.m. and 9:33 a.m. confirmed that the dirty fan should not have been blowing towards the food prep area and needed cleaned, and the gobs should have been dated. 28 Pa. Code 211.6(f) Dietary Services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for one of 56 residents reviewed (Resident 5) who had a feeding tube.Findings include: A facility policy for feeding tubes, dated January 1, 2026, indicated that feeding tube use occurs based on current clinical standards of practice with the intent to maintain the resident's nutrition and hydration status within acceptable parameter and decrease the risk of complications from use. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated May 20, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care tasks, and had a feeding tube. Physician's orders for Resident 5, dated March 27, 2026, included orders for the resident to receive Novasource (a tube feeding formula) at 250 milliliters/hour as needed if the resident ate less than 50% for breakfast, lunch and dinner. Review of Resident 5's meal intakes for March, April, May and June 2026 revealed that the resident did not eat breakfast on March 27; did not eat breakfast on March 28, 29, 30, 31, April 1, 2, 3, 5, 7, 8, 9, 11, 12, 13, 14, ate 1-25% of lunch on April 15; did not eat breakfast on April 16, 17, 18, 21, 23, 25, 29, 30, May 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 14, 16, 17, 18, 19, 21, 22, 23, 26, 27, 28; ate 1-25 % of lunch on May 29; did not eat breakfast on May 30, June 2, 4; did not eat dinner on June 5; did not eat breakfast on June 6; did not eat dinner on June 8; did not eat lunch on June 9, 10; and did not eat breakfast on June 11, 2026. There was no documented evidence in the resident's clinical record that the resident refused or was offered the Novasource via feeding tube as ordered by the physician. Interview with Registered Dietitians 1 and 2 on June 10, 2026, at 2:07 p.m. confirmed that there was no documentation that the resident refused or was offered the Novasource via feeding tube as ordered by the physician. Interview with the Nursing Home Administrator on June 10, 2026, at 3:00 p.m. confirmed that there was no documentation that the resident refused or was offered the Novasource via feeding tube as ordered by the physician. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to administer a resident's continuous oxygen as ordered for one of 56 residents reviewed (Resident 174).Findings include:The facility's policy regarding oxygen therapy, dated January 1, 2026, indicated that supplemental oxygen therapy is provided and monitored for residents as per the provider's order, or in emergency situations, for the ease and comfort of respiratory effort and disease symptom management.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 174 dated June 4, 2026, indicated that the resident was cognitively intact, required supervision with daily care needs, received oxygen therapy, and had a diagnosis of chronic obstructive pulmonary disease (COPD- a disease that causes airflow blockage and breathing-related problems).Physician's orders for Resident 174, dated May 28, 2026, included an order for the resident to receive continuous oxygen at a flow rate of 5 liters per minute (LPM) via nasal cannula (tubes that deliver oxygen into the nostrils) every shift.Observations of Resident 174 on June 9, 2026, at 10:22 a.m. revealed that the resident was using his wheelchair to go back to his room from the dining room with an oxygen tank on the back of his wheelchair. The oxygen tank was set at 5 LPM and the tank was reading empty. An interview with Registered Nurse 3 on June 8, 2026, at 12:41 p.m. confirmed that the resident's oxygen tank was empty. Interview with the Nursing Home Administrator on June 8, 2026, at 3:00 p.m. confirmed that Resident 174's oxygen tank should have been checked and replaced.28 Pa. Code 211.12(d)(1)(3)(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 a review of the facility policies, as well as observations and staff interviews, it was determined that the facility failed to label medications with the appropriate instructions for administration for two of 56 residents reviewed (Resident 66, 83). Findings include: The facility's policy regarding medication administration and labeling, dated January 1, 2026, indicated that it is the purpose to provide guidance regarding medication administration to be in accordance with good nursing principles and practices and only by people legally authorized to do so. Labels for individual drug containers must include directions for use. Only the container in which a prescription drug or device is sold or dispensed to the ultimate consumer shall bear a label which shall be written in ink, typed or computer generated and shall contain full directions for the use of its contents. Manufacturer's directions for the use of Jardiance (used to manage diabetes) dated April 2026, revealed that Jardiance should not be split, broken or crushed, this may affect the medications absorption and stability. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 66, dated March 23, 2026, revealed that the resident was cognitively impaired, was dependent on staff for all his daily care needs, and had diagnoses that included diabetes. Physician's orders for Resident 66, dated July 24, 2025 included an order for the resident to receive 25 milligrams (mg) of Jardiance once a day. Observations of medication administration for Resident 66 on June 10, 2026, at 09:15 a.m. revealed that Licensed Practical Nurse 4 prepared the resident's medications, including Jardiance, by crushing it and then proceeded to administer the crushed medication to the resident. Interview with Licensed Practical Nurse 4 on June 10, 2026, at 11:20 a.m. revealed that she was unaware that she should not have crushed Jardiance, and that the medication package should have indicated do not crush if it was not supposed to be crushed and it did not. A quarterly MDS assessment for Resident 83, dated April 21, 2026, revealed that the resident was cognitively intact, required assistance with his daily care needs, and had diagnoses that included diabetes. Physician's orders for Resident 83, dated July 5, 2025, included an order for the resident to receive 10 mg Jardiance once a day. Observation of the [NAME] 2 medication cart June 10, 2026, at 11:20 a.m. revealed a medication card of 10 mg Jardiance for Resident 83. The medication card was not labeled with a do not crush label. Interview with Pharmacist 5 on June 11, 2026, at 2:08 p.m. confirmed that Jardiance should not be crushed and that that medication cards should contain a do not crush label to alert staff. Interview with the Nursing Home Administrator June 11, 2026, at 2:10 p.m. confirmed that the medication should not have been crushed and that medication cards should be labeled do not crush if the medication should not be crushed. 28 Pa. Code 211.9(a)(1) Pharmacy services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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 one of 56 residents reviewed (Resident 90).Findings include: CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that 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. For Enhanced Barrier Precautions, signage should clearly indicate the high-contact resident care activities that require the use of gown and gloves, and PPE, including gowns and gloves, and should be available immediately outside of the resident room. The facility's policy regarding EBP, dated January 1, 2026, indicated that EBP referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents, and an order for EBP will be obtained for residents with any of the following: Has a wound or indwelling medical device without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDR. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Clear signage would be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. Gowns and gloves would be available immediately outside of the resident's room. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 90, dated May 13, 2026, indicated that the resident was cognitively impaired, required assistance with care needs, had an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), and had a diagnosis of neurogenic bladder (bladder lacks control due to nerve or muscle problems) and obstructive uropathy (blockage in the urinary system). Physician's orders for Resident 90, dated February 4 and April 28, 2026, included an order for the resident to have EBP and a urinary (foley) catheter (an indwelling catheter). A care plan for Resident 90, dated May 21, 2026, revealed that the resident had an indwelling foley catheter and staff were to use PPE for EBP that included gowns and gloves while providing close contact care. Observations on June 10, 2026, at 9:18 a.m. revealed that Resident 90 was in bed and the wash basin that his urinary catheter bag was in was tipped on it's side, causing the urinary catheter bag to be in contact with the floor. There was no sign posted outside the resident's room to indicate the resident was on EBP and there was no PPE available outside of the resident's room. At 9:24 a.m. Nurse Aide 7 repositioned the resident's catheter and did not use proper PPE. An interview with Nurse Aide 7 at that time revealed that she thought Resident 90 was not on EBP. An interview with Licensed Practical Nurse 8 on June 10, 2026, at 9:29 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m. confirmed that Resident 90 was to be on EBP and that there was no sign posted or PPE available outside of his room. 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.