

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
STATE LICENSE NUMBER: 270102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0578	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and a complaint survey completed on February 12, 2025, it was determined that Heritage Ridge Senior Living was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0578		
SS=D				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0578 SS=D	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	The Director of Nursing provided resident 33 with information on how to formulate advance directives. Baseline audit was completed to identify residents without advanced directives and residents/resident representatives were provided with information on how to formulate advance directives. Advance directive status will be evaluated at the time of admission. Residents who do not have advance directives will be provided with information on formulating advance directives. Advance directive status will be reviewed quarterly. Monitoring will be captured through auditing advance directive status as follows up to 3 clinical records weekly for 4 weeks then up to 6 clinical records 2 times monthly for 2 months. The audits will be conducted by the Social Worker or designee.	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

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F 0578 SS=D	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578	Results of the audits will be provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 0578 SS=D	Continued from page 3 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or resident representative had an opportunity to develop an advance directive (instructions regarding the provision of health care when the resident is incapacitated) or assist in formulating an advance directive for one of 29 residents reviewed (Resident 33). Findings include: The facility policy regarding advance directives, dated January 20, 2025, indicated that upon admission, the resident or resident representative will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. If the resident or resident representative indicates that he or she has not established advance directives, the healthcare center staff will offer assistance in establishing advance	F 0578		

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F 0578 SS=D	Continued from page 4 directives. The resident or resident representative will be given the option to accept or decline the assistance, and care will not be contingent on either decision. Nursing staff will document in the medical record the offer to assist, and the resident's or resident representative's decision to accept or decline assistance. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 33, dated November 26, 2024, revealed that the resident was mildly cognitively impaired, required supervision to independent with care needs, had verbal behavioral symptoms expressed towards others occurring one to three days in the look-back period, and had diagnoses that included schizoaffective disorder (a mental health condition and mood disorder), bipolar disorder (a mood disorder), anxiety, depression and post-traumatic stress disorder (a mental and behavioral disorder that develops related to a	F 0578		

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F 0578 SS=D	Continued from page 5 terrifying event). Review of Resident 33's medical records indicated that they did not have advance directives. There was no documented evidence in the resident's clinical record that the resident and/or resident representative was given the opportunity to formulate an advance directive, and no documented evidence of the resident's and/or resident representative's decision regarding formulating advanced directives. Interview with the Director of Nursing on February 12, 2025, at 12:39 p.m. confirmed that there was no documented evidence in Resident 33's medical records that the resident and/or resident representative was given the opportunity to formulate an advance directive, and no documented evidence of the resident's and/or resident representative's decision regarding formulating advanced directives. 28 Pa. Code 201.29(a)(d) Resident Rights.	F 0578		

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F 0580 SS=D		F 0580		

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F 0580 SS=D	Continued from page 7 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	Resident 26 insulin orders were reviewed with the provider and adjustments were made to resident's insulin orders through collaboration with resident and provider. Baseline audit was completed on residents with insulin orders to identify other residents that are refusing insulin. The Director of Nursing provided education to licensed staff on notifying the provider when residents refuse insulin and documenting that the provider was notified. Monitoring will be captured through auditing insulin administration. Audits will be conducted on 4 resident records weekly for 4 weeks, then 8 resident records 2 times monthly for 2 months. The audits will be conducted by the Director of Nursing or designee. Results of the audits will be	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

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F 0580 SS=D	Continued from page 8 section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580	provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 0580 SS=D	Continued from page 9 Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's attending physician was notified about medication refusals of insulin and requests to speak to the physician for one of 29 residents reviewed (Resident 26). Findings include: An admission MDS assessment for Resident 26, dated January 14, 2025, revealed that the resident was cognitively intact, required assistance with personal care needs, and had diagnoses that included stroke and diabetes. Physician's orders for Resident 26, dated January 7, 2025, included an order for the resident to receive six units of insulin lispro (fast-acting insulin to treat high blood sugar) daily with lunch and dinner. Review of the MAR for January 2025 and February 2025 revealed that the resident refused her dinnertime dose on January 21, 27, and 30, and	F 0580		

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F 0580 SS=D	Continued from page 10 February 4 and 8, 2025. Physician's orders for Resident 26, dated January 8, 2025, included an order for the resident to receive 18 units of insulin lispro daily with breakfast. Review of the MAR, dated January 2025 and February 2025, revealed that the resident refused this dose on January 28 and February 1, 2, 7, and 11. Physician's orders for Resident 26, dated January 20, 2025, included an order for the resident to receive 48 units of insulin glargine (long-acting insulin used to treat high blood sugar) at bedtime. Review of the MAR, dated January 2025 and February 2025, revealed that the resident refused her bedtime insulin on January 30 and February 9. A nurse's note for Resident 26, dated February 1, 2025, at 1:49 p.m., revealed that the resident was refusing her insulins, stating that the amount of insulin was too high. The physician was aware and was to review insulin and medications on rounds Monday,	F 0580		

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F 0580 SS=D	Continued from page 11 February 3, 2025. A Medication Administration Note for Resident 26, dated February 2, 2025, at 8:24 a.m., revealed that the resident was refusing her morning insulin until she clarifies the dosage with the physician. A certified registered nurse practitioner (a registered nurse with advanced training and education) note for Resident 26, dated February 3, 2025, at 12:47 p.m., revealed that the resident reported concerns of insulin management, and the resident was encouraged to discuss that with the doctor. There was no documented evidence in Resident 26's clinical record as of February 11, 2025, that the physician was made aware that the resident's continued refusal of some of her ordered insulin doses until she clarified with her physician or that the insulin dosage was addressed by the physician as requested by the resident. Interview with the Director of Nursing on February	F 0580		

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F 0580 SS=D	Continued from page 12 12, 2025, at 3:00 p.m. confirmed that the physician was not notified of Resident 26's request for clarification of insulin doses and continued refusals and should have been.	F 0580		
F 0623 SS=D		F 0623		

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F 0623 SS=D	Continued from page 13 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	Residents 13, 23, 33, and 37 were provided with notice of transfer. Ombudsman was notified of transfers for the months of January and February Baseline audit was completed to identify residents that were transferred out of the facility during the months of January and February. A binder has been designated to maintain records of notice of transfer and Ombudsman notification. Education was provided to Social Worker and/or Designee on the process for maintaining records of notice of transfer and Ombudsman notification. Monitoring will be captured through auditing notice of transfer and Ombudsman notification of transfer. Up to 2 clinical records will be reviewed weekly for 4 weeks, then up to 4 clinical records 2 times monthly for 2 months. The audits will be conducted by the	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

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F 0623 SS=D	Continued from page 14 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i) (A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	Social Worker or designee. Results of the audits will be provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0623 SS=D	Continued from page 15 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0623 SS=D	Continued from page 16 Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident and/or resident's representative and the ombudsman in writing of the transfer and reason for hospitalization for four of 29 residents reviewed (Residents 13, 23, 33, 37). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated November 26, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnosis that included heart failure and diabetes. A nurse's note for Resident 13, dated May 13, 2024, at 6:30 p.m., revealed that the resident was observed lying on the floor in his room with bleeding observed from above his left eyebrow and above his left ear. The resident was transferred to the	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0623 SS=D	<p>Continued from page 17</p> <p>emergency room for evaluation and treatment.</p> <p>There was no documented evidence that a written notice of Resident 13's transfer to the hospital was provided to the resident and/or resident representative and the ombudsman regarding the reason for the transfer.</p> <p>A quarterly MDS assessment for Resident 23, dated January 14, 2025, revealed that the resident was cognitively intact, was dependent on staff for daily care needs, and had diagnosis that included metabolic encephalopathy (a change in how your brain works due to an underlying condition).</p> <p>A nurse's note for Resident 23, dated October 13, 2024, at 6:30 p.m., revealed that the resident was unable to answer orientation questions or hold a meaningful conversation and was transported to the emergency room for evaluation and treatment.</p> <p>There was no documented evidence that a written notice of Resident 23's transfer to the hospital was</p>	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0623 SS=D	<p>Continued from page 18</p> <p>provided to the resident and/or resident representative and the ombudsman regarding the reason for the transfer.</p> <p>A quarterly MDS assessment for Resident 33, dated November 26, 2024, revealed that the resident was mildly cognitively impaired, required supervision to independent with care needs, and had diagnoses that included schizoaffective disorder (a mental health condition and mood disorder), bipolar disorder (a mood disorder), and post-traumatic stress disorder (a mental and behavioral disorder that develops related to a terrifying event).</p> <p>A nursing note for Resident 33, dated October 14, 2024, at 1:07 p.m., revealed that a crisis representative arrived at the facility and spoke with resident. The resident was agreeable to be sent to the hospital for a mental health evaluation, and the resident was transported to the hospital.</p> <p>There was no documented evidence that a written notice of Resident 33's transfer to the hospital was</p>	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0623 SS=D	Continued from page 19 provided to the resident and/or resident representative and the ombudsman regarding the reason for the transfer. A quarterly MDS assessment for Resident 37, dated December 4, 2024, revealed that the resident was cognitively intact, required assistance with care needs, and had diagnoses that included diabetes, obstructive uropathy (blockage of the urinary tract), and renal insufficiency (kidneys lose the ability to remove waste and balance fluids). A nursing note for Resident 37, dated October 14, 2024, at 11:48 a.m., revealed that the resident had abnormal blood work and reports of intermittent nausea and vomiting. The certified registered nurse practioner was notified, and the resident was transferred to the hospital for further evaluation. A nursing note for Resident 37, dated November 17, 2024, at 5:25 a.m., revealed that the resident's left nephrostomy tube (thin flexible tube inserted into the kidney through the skin to drain urine directly	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
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F 0623 SS=D	<p>Continued from page 20</p> <p>into a collection bag) was dislodging. The physician was notified, and the resident was transferred to the hospital.</p> <p>A nursing note for Resident 37, dated January 18, 2025, at 12:44 p.m., revealed that the resident's nephrostomy tube was hanging out of the site several inches past the stitch that would have secured it to the skin. The physician was notified, and the resident was transferred to the hospital.</p> <p>There was no documented evidence that a written notice of Resident 37's transfers to the hospital were provided to the resident and/or resident representative and the ombudsman regarding the reason for the transfers.</p> <p>Interview with the Nursing Home Administrator on February 12, 2025, at 3:20 p.m. confirmed that the facility did not provide a written notice to the above residents and/or their representative and ombudsman regarding the reason for the transfer to the hospital on the above-mentioned dates.</p>	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0623 SS=D	Continued from page 21 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.	F 0623		
F 0625 SS=D		F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0625 SS=D	Continued from page 22 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	Residents 13, 23, 33 and 37 were provided with a copy of the bed hold notice. Baseline audit was completed to identify other residents who were transferred out of the facility for the months of January and February. A binder has been designated to maintain records of bed hold notifications. Education was provided to Admissions Director on the process for maintaining records of bed hold notification. Monitoring will be captured through auditing notice of transfer and Ombudsman notification of transfer. 2 clinical records will be reviewed weekly for 4 weeks, then 4 clinical records 2 times monthly for 2 months. Audits will be conducted by the Admissions Director or designee. Results of the audits will be	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0625 SS=D	Continued from page 23	F 0625	provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0625 SS=D	Continued from page 24 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to provide a written notice of the facility's bed-hold policy to the resident and/or the resident's representative at the time of a transfer for four of 29 residents reviewed (Residents 13, 23, 33, 37). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated November 26, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnosis that included heart failure and diabetes. A nurse's note for Resident 13, dated May 13, 2024, at 6:30 p.m., revealed that the resident was observed lying on the floor in his room with bleeding observed from above his left eyebrow and above his left ear. The resident was transferred to the emergency room for evaluation and treatment.	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0625 SS=D	Continued from page 25 There was no documented evidence that a bed-hold notice was provided to Resident 13 or his responsible party. A quarterly MDS assessment for Resident 23, dated January 14, 2025, revealed that the resident was cognitively intact, was dependent on staff for daily care needs, and had diagnosis that included metabolic encephalopathy (a change in how your brain works due to an underlying condition). A nurse's note for Resident 23, dated October 13, 2024, at 6:30 p.m., revealed that the resident was unable to answer orientation questions or hold a meaningful conversation and was transported to the emergency room for evaluation and treatment. There was no documented evidence that a bed-hold notice was provided to Resident 23 or his responsible party. A quarterly MDS assessment for Resident 33,	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0625 SS=D	Continued from page 26 dated November 26, 2024, revealed that the resident was mildly cognitively impaired, required supervision to independent with care needs, and had diagnoses that included schizoaffective disorder (a mental health condition and mood disorder), bipolar disorder (a mood disorder), and post-traumatic stress disorder (a mental and behavioral disorder that develops related to a terrifying event). A nursing note for Resident 33, dated October 14, 2024, at 1:07 p.m., revealed that a crisis representative arrived to facility and spoke with resident. He was agreeable to be sent to the hospital for a mental health evaluation and the resident was transported to the hospital. There was no documented evidence that a bed hold notice was provided to Resident 33 or his responsible party. A quarterly MDS assessment for Resident 37, dated December 4, 2024, revealed that the resident was cognitively intact, required assistance with care	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
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F 0625 SS=D	<p>Continued from page 27</p> <p>needs, and had diagnoses that included diabetes, obstructive uropathy (blockage of the urinary tract), and renal insufficiency (kidneys lose the ability to remove waste and balance fluids).</p> <p>A nursing note for Resident 37, dated October 14, 2024, at 11:48 a.m., revealed that the resident had abnormal blood work and reports of intermittent nausea and vomiting, and she was transferred to the hospital for further evaluation.</p> <p>A nursing note for Resident 37, dated November 17, 2024, at 5:25 a.m., revealed that the resident's left nephrostomy tube (thin flexible tube inserted into the kidney through the skin to drain urine directly into a collection bag) was dislodging. The physician was notified, and the resident was transferred to the hospital.</p> <p>A nursing note for Resident 37, dated January 18, 2025, at 12:44 p.m., revealed that the resident's nephrostomy tube was hanging out of the site several inches past the stitch that would have</p>	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0625 SS=D	Continued from page 28 secured it to the skin. The physician was notified, and the resident was transferred to the hospital. There was no documented evidence that a bed-hold notice was provided to Resident 37 or her responsible party. Interview with the Nursing Home Administrator on February 12, 2025, at 3:20 p.m. confirmed that the facility did not provide bed-hold notices to the above residents and/or their representative when the residents were transferred to the hospital. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(3) Management.	F 0625		
F 0641 SS=D		F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0641 SS=D	Continued from page 29 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Minimum Data Set (MDS) assessments were updated for residents #9, 17, 21, 26, 37, 42 and resubmitted. Residents who have a Minimal Data Set (MDS) completed and require coding related to care needs have the potential to be affected. Director of Nursing provided education to the Minimal Data Set (MDS) Coordinator on accuracy of assessments related to coding resident abilities and care needs via Resident Assessment Instrument (RAI) manual. Monitoring will be captured through auditing Minimal Data Set (MDS) assessments for care needs and coding. Review up to 2 clinical records weekly for 4 weeks, then 4 clinical records twice monthly for 2 months. The audits will be conducted by the Director of Nursing or designee.	Completion Date: 03/31/2025 Status: APPROVED Date: 03/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102	STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905
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F 0641 SS=D	Continued from page 30	F 0641	Results of the audits will be provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0641 SS=D	Continued from page 31 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for six of 29 residents reviewed (Residents 9, 17, 21, 26, 37, 42). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, revealed that N0415E anticoagulant (medications used as a blood thinner) was to be coded (1) is taking, if the resident received an anticoagulant medication during the seven-day assessment period. A quarterly MDS assessment for Resident 9, dated November 13, 2024, revealed that Section N0415E was not coded (1), which indicated that	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0641 SS=D	<p>Continued from page 32</p> <p>the resident did not receive an anticoagulant during the seven-day assessment period.</p> <p>Physician's order for Resident 9, dated June 22, 2024, included an order for the resident to receive 2.5 milligrams (mg) of apixaban (a blood thinner) two times a day for atrial fibrillation (an abnormal fluttering heart beat). Review of the Medication Administration Record (MAR) for Resident 9, dated November 2024, revealed that 2.5 mg of apixaban was administered twice a day during the seven-day assessment period.</p> <p>The Long-Term Care Facility RAI User's Manual, dated October 2024, revealed that O0110K1 hospice was to be coded (B) while a resident, when residents identified as being in a hospice program for terminally ill persons where an array of services was provided for the palliation and management of terminal illness and related conditions.</p> <p>Physician's order for Resident 17, dated August 5, 2024, included an order for the resident to be</p>	F 0641		

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F 0641 SS=D	<p>Continued from page 33</p> <p>admitted to hospice services. A care plan, dated July 31, 2024, indicated the resident had a terminal illness.</p> <p>A skin wound note, dated December 30, 2024, indicated that Resident 17 was currently on hospice care.</p> <p>A quarterly MDS assessment for Resident 17, dated January 1, 2024, revealed that Section O0110K1 was not coded (B), which indicated that the resident did not receive hospice services during the seven-day assessment period.</p> <p>Interview with the Registered Nurse Assessment Coordinator on February 12, 2025, at 3:44 p.m. confirmed that above-mentioned MDS assessments for Residents 9 and 17 were coded incorrectly.</p> <p>The Long-Term Care Facility RAI User's Manual, dated October 2024, revealed that Section N0415H Opioid (narcotic medications used to treat pain) was to be coded (1) if the resident received an</p>	F 0641		

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F 0641 SS=D	Continued from page 34 opioid medication during the seven-day assessment period. Physician's order for Resident 21, dated March 18, 2024, included for the resident to receive 5 milligrams (mg) of oxycodone (an opioid) two times a day. Review of the Medication Administration Record (MAR) for Resident 21, dated November 2024, revealed that 5 mg of oxycodone was administered twice a day during the seven-day assessment period. A quarterly MDS assessment for Resident 21, dated November 27, 2024, revealed that Section N0415H was not coded (1), which indicated that the resident did not receive an opioid during the seven-day assessment period. Physician's order for Resident 26, dated January 7, 2025, included an order for the resident to receive 25 mg of Tramadol (an opioid) every eight hours as needed for pain. Review of the MAR for Resident 26, dated January 2025, revealed that the resident was administered Tramadol daily on January 8 through January 14.	F 0641		

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F 0641 SS=D	Continued from page 35 An admission MDS assessment for Resident 26, dated January 14, 2025, revealed that Section N0415H was not coded (1), indicating that the resident did not receive an opioid during the seven-day assessment period. Interview with the Director of Nursing on February 12, 2025, at 12:39 p.m. confirmed that above-mentioned MDS assessments for Residents 21 and 26 should have indicated that the residents were receiving an opioid medication and did not. The Long-Term Care Facility RAI User's Manual, dated October 2024, revealed that Section H0100 was to be coded for each appliance that was used at any time in the past seven days. Select none of the above if none of the appliances A-D were used in the past seven days. Physician's orders for Resident 37, dated January 21, 2025, included an order for a left nephrostomy	F 0641		

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F 0641 SS=D	Continued from page 36 tube (thin flexible tube inserted into the kidney through the skin to drain urine directly into a collection bag). A care plan for Resident 37, dated June 25, 2024, revealed that the resident had a nephrostomy tube. A quarterly MDS assessment for Resident 37, dated January 28, 2025, revealed that Section H0100C was coded, indicating that the resident had an ostomy. Interview with the Director of Nursing on February 12, 2025, at 6:04 p.m. confirmed that Section H0100 was coded inaccurately for Resident 37, and that Section H0100A should have been coded indicating that the resident had a nephrostomy tube. An admission MDS assessment for Resident 42, dated December 27, 2024, revealed that Section N0415H was coded (1), indicating that the resident received an opioid during the seven-day assessment period.	F 0641		

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F 0641 SS=D	Continued from page 37 Review of the MAR for Resident 42, dated December 2024, revealed that there was no documented evidence that the resident received an opioid during the seven-day assessment period. Interview with the Director of Nursing on February 12, 2025, at 12:39 p.m. confirmed that above-mentioned MDS for Resident 42 was coded incorrectly, indicating that the resident received an opioid when he did not. 28 Pa. Code 211.5(f) Clinical Records.	F 0641		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 38 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Resident #7, 16, 33 care plans reviewed and revised to capture resident centered goals and interventions implemented. Residents who require a resident centered care plan have the potential to be affected. Director of Nursing provided education to interdisciplinary team as well as Minimum Data Set (MDS) coordinator on creating resident centered care plans. Monitoring will be captured through auditing specific care needs. Up to 4 clinical records will be reviewed weekly for 4 weeks, then up to 8 clinical records twice monthly for 2 months. The audits will be conducted by the Director of Nursing or designee. Results of the audits will be provided to the Administrator and be presented for review at the monthly Quality Assurance	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

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F 0656 SS=D	Continued from page 39 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting	

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F 0656 SS=D	Continued from page 40 Based on facility policies and clinical record reviews, as well as staff interviews, it was determined that the facility failed to ensure that resident-centered care plans were developed and implemented for three of 29 residents reviewed (Residents 7, 16, 33). Findings include: The facility's policy regarding care plans, dated January 20, 2025, indicated that the comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated November 13, 2024, revealed that the resident was cognitively	F 0656		

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F 0656 SS=D	Continued from page 41 intact, required assistance with care needs, received an antibiotic, anticoagulant (blood thinner), diuretic (a medication used to treat fluid build-up), and insulin, and had diagnoses that included coronary artery disease (CAD-a disease that limits blood flow to the heart caused by plaque buildup in the arteries), congestive heart failure (CHF-the heart cannot pump blood well enough to meet the body's needs), hypertension (HTN-high blood pressure), atrial fibrillation (irregular heart rhythm), diabetes, and presence of a cardiac pacemaker (a surgically-implanted, small battery-powered device to manage irregular heartbeats or heart failure). Physician's orders for Resident 7, dated May 29, 2024, included an order for the resident to receive six units of insulin Lispro subcutaneously with meals, 0.75 mg of Trulicity (a diabetic medication) subcutaneously daily every Thursday, and 2.5 mg of apixaban (an anticoagulant medication) twice daily. Physician's orders, dated August 5, 2024, included an order for the resident to have Accuchecks (blood sugar checks) three times daily with meals and to	F 0656		

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F 0656 SS=D	Continued from page 42 receive 1 mg of bumetanide (a diuretic medication) daily. Physician's orders, dated August 31, 2024, included an order for the resident to receive 500 milligrams (mg) of Cefadroxil (an antibiotic) daily for preventative. Physician's orders, dated January 8, 2025, included an order indicating that the resident had a dual chamber pacemaker to the left chest wall and follows with CPG cardiology. Physician's orders, dated January 20, 2025, included an order for the resident to receive 14 units of insulin Glargine subcutaneously at bedtime. Physician's orders, dated January 27, 2025, included an order for the resident to use a Dexcom G7 Sensor (Continuous Glucose System Sensor) subcutaneously (injected into the fat layer of the skin) every 10 days and Dexcom G7 Receiver Device (Continuous Glucose System Receiver to measure blood sugars) and ensure that the device is charged every shift. There was no documented evidence that care plans were developed to address Resident 7's diabetic needs including her use of the Dexcom and need for diabetic medications, cardiac needs including the	F 0656		

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F 0656 SS=D	<p>Continued from page 43</p> <p>presence of a cardiac pacemaker with her need to follow with a cardiologist, her need for diuretic and anticoagulant medications, or the need for long-term antibiotic therapy.</p> <p>Interview with the Registered Nurse Assessment Coordinator on February 12, 2025, at 2:51 p.m. confirmed that Resident 7 did not have a care plan in place to address her diabetic and cardiac needs, her diuretic and anticoagulant medications, or the need to address her long-term antibiotic therapy and should have.</p> <p>A quarterly MDS assessment for Resident 16, dated November 6, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, was receiving an anticonvulsant (medication used to prevent or control seizures), and had a diagnosis of epilepsy (a seizure disorder).</p> <p>Physician's orders for Resident 16, dated November 22, 2024, included an order for the resident to receive 0.5 mg of clonazepam (an</p>	F 0656		

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F 0656 SS=D	Continued from page 44 anticonvulsant) twice daily. There was no documented evidence that a care plan was developed to address Resident 16's seizure disorder and need for anticonvulsant medication. Interview with the Registered Nurse Assessment Coordinator on February 12, 2025, at 2:51 p.m. confirmed that Resident 16 did not have a care plan in place to address his seizure disorder and need for anticonvulsant medication. A quarterly MDS assessment for Resident 33, dated November 26, 2024, revealed that the resident was mildly cognitively impaired, required supervision to independent with care needs, had verbal behavioral symptoms expressed towards others occurring one to three days in the look-back period, and had diagnoses that included schizoaffective disorder (a mental health condition and mood disorder), bipolar disorder (a mood disorder), anxiety, depression, and post-traumatic stress disorder (PTSD - a mental and behavioral	F 0656		

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F 0656 SS=D	Continued from page 45 disorder that develops related to a terrifying event). Review of Resident 33's clinical records revealed that he was receiving routine psychological services for his diagnoses of depression, anxiety, bipolar disorder, schizoaffective disorder, and PTSD. A trauma assessment for Resident 33, completed October 15, 2024, identified triggers for reliving traumatic experience, physical and emotional symptoms of reliving trauma, and support and coping strategies/interventions. There was no documented evidence that a care plan was developed to address Resident 33's PTSD, his triggers, and his coping strategies/interventions. Interview with the Registered Nurse Assessment Coordinator on February 12, 2025, at 2:51 p.m. confirmed that Resident 33 did not have a care plan in place to address his PTSD, his triggers, and his coping strategies/interventions.	F 0656		

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F 0656 SS=D	Continued from page 46 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0656		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 47 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Resident #9 order was reviewed and had been followed. The care plan was reviewed and revised to capture the resident specific care needs. Resident #13 the care plan was reviewed and revised. Residents receiving specific care have the potential to be affected. Director of Nursing provided education to the Interdisciplinary team as well as the Minimum Data Set (MDS) coordinator on updating care plans to include specific care needs. Monitoring will be captured through auditing specific care needs. Review 3 clinical records will be reviewed weekly for 4 weeks, then 6 clinical records twice monthly for 2 months. The audits will be conducted by the Director of Nursing or designee. Results of the audits will be provided to the Administrator and	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102	STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905
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F 0657 SS=D	Continued from page 48	F 0657	be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 0657 SS=D	Continued from page 49 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 two of 29 residents reviewed (Residents 9, 13). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated November 18, 2024, revealed that the resident was understood, could understand others, had a Brief Interview for Mental Status (BIMS -a structured cognitive interview) of 15 indicating that the resident was cognitively intact, required substantial to max assistance for showering and bathing, and had diagnoses that included congestive heart failure (CHF) and a history of falls. A care plan for self care performance deficit, dated June 21, 2024, indicated that the resident prefers showers twice a week, but may refuse. A care plan for the resident,	F 0657		

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F 0657 SS=D	Continued from page 50 dated June 24, 2024, revealed that the resident had the potential for actual skin impairment due to ichthyosis vulgaris (a common, inherited skin disorder characterized by dry, scaly, and thickened skin). Physician orders for Resident 9, dated October 5, 2024, included an order for the resident's entire body to be lathered with Vaseline followed by Dove moisturizing lotion. A review of Resident 9's clinical record, including nurse aide tasks, revealed special instructions to provide the resident with a complete bed bath daily and no showers. Following the bed bath, staff were to apply white petrolatum external ointment head to toe, followed by Dove lotion. Interview with the Director of Nursing on February 11, 2025, at 4:01 p.m. confirmed that Resident 9's care plan needed updated to reflect her bed bath and skin care needs.	F 0657		

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F 0657 SS=D	Continued from page 51 A quarterly MDS assessment for Resident 13, dated November 26, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, had diagnoses that included heart failure and diabetes, and used a chair alarm daily. A care plan for Resident 13, dated May 16, 2024, indicated that the resident was an elopement risk, and a care plan, dated December 27, 2024, indicated that the resident required oxygen therapy. A review of elopement risk evaluations for Resident 13, dated September 9, 2024, and November 20, 2024, revealed that the resident had a score of zero and was not an elopement risk. Review of the clinical record also revealed no documented evidence that Resident 13 was receiving oxygen therapy. An interview with the Director of Nursing on February 11, 2025, at 10:54 a.m. and 12:30 p.m. revealed that Resident 13 was no longer an	F 0657		

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F 0657 SS=D	Continued from page 52 elopement risk and no longer received oxygen therapy, and his care plans should have been revised. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0657		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 53 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Resident 1 unable to retroactively address bowel movements, Medical Director (MD) notified. Resident 24 palm guard order was reviewed and updated to include documentation. MD notified Resident 26 unable to retroactively address hypoglycemic protocol administration documentation, MD notified. Resident 26 insulin orders were reviewed, and resident is receiving insulin as ordered. MD notified Resident 37 orders were reviewed and updated to include an order to record percutaneous drain output every shift. MD notified Resident 38 medication administration orders were reviewed and adjusted to dialysis times. MD notified Residents receiving medications and treatments have the potential to be	Completion Date: 03/31/2025 Status: APPROVED Date: 03/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0684 SS=E	Continued from page 54	F 0684	<p>affected.</p> <p>Licensed staff educated by the Director of Nursing on following physician orders for care and treatment. (e.g. order transcription, evaluation, parameters, documentation, physician notification)</p> <p>Code update in Electronic Medical Administration Record (EMAR) to document when glucose level does not require insulin coverage per sliding scale. Education was provided to licensed staff on the new EMAR code.</p> <p>Monitoring will be captured through auditing Medication administration. Audits will be completed as follows- 2 staff med pass observations will be conducted weekly for 4 weeks, then 4 staff med pass observations will be conducted 2 times monthly for 2 months.</p> <p>The med pass observations will be conducted by the Director of Nursing or designee.</p>	

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F 0684 SS=E	Continued from page 55	F 0684	Results of the med pass observations will be provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the	

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F 0684 SS=E	Continued from page 56 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to follow physician's orders for care and treatment for five of 29 residents reviewed (Resident 1, 24, 26, 37, 38). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 8, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, was frequently incontinent of bowel, and had a diagnosis of dementia. Physician's orders for Resident 1, dated July 6, 2024, included an order for the resident to receive 30 milliliters (ml) of Milk of Magnesia as needed for constipation if no bowel movements in three days, which as to be administered on the 7:00 a.m. to 3:00 p.m. shift on the first medication pass. Review of Resident 1's bowel record for February	F 0684		

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F 0684 SS=E	<p>Continued from page 57</p> <p>2025 revealed no documented evidence that the resident moved his bowels from February 1 through February 4, 2025, for a total of four days. Review of Resident 1's Medication Administration Record (MAR) for February 2025 revealed no documented evidence that he received Milk of Magnesia as ordered for constipation.</p> <p>Interview with the Director of Nursing on February 11, 2025, at 2:12 p.m. confirmed that there was no documented evidence that Resident 1 received Milk of Magnesia as ordered for constipation.</p> <p>A quarterly MDS assessment for Resident 24, dated November 7, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included Alzheimer's disease. Physician's orders for Resident 24, dated July 31, 2024, included orders for the resident to wear a left hand palm guard after evening care, removing for hygiene, skin checks, and exercise.</p>	F 0684		

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F 0684 SS=E	Continued from page 58 Review of Resident 24's clinical record, including nurse aide documentation, revealed no documented evidence that a left hand palm guard was applied to the resident as ordered. An interview with Resident 24 on February 12, 2025, at 8:43 a.m. revealed that she does have a palm guard that she is to wear at night; however, they do not always put it on her. She does not refuse to wear it; she thinks they forget to put it on. Interview with the Director of Nursing on February 12, 2025, at 10:10 a.m. confirmed that there was no documented evidence that Resident 24 had her palm guard applied as ordered and stated it was because the order was not transcribed correctly. An admission MDS assessment for Resident 26, dated January 14, 2025, revealed that the resident was cognitively intact, required assistance with personal care needs, and had diagnoses that included stroke and diabetes.	F 0684		

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F 0684 SS=E	Continued from page 59 Physician's orders for Resident 26, dated January 7, 2025, included an order to follow hypoglycemic protocol if the resident's blood sugar was less than 70 mg/dL, with or without symptoms, which included to administer 15 grams of glucose by mouth or carbohydrates found in any of the following: one-half cup of juice, one-half cup of applesauce, one cup milk, one tube glucose gel, or thee glucose tablets, wait 15 minutes and recheck the blood glucose level. Review of the blood glucose records for Resident 26 for February 2025 revealed that on February 8 at 5:00 p.m. the resident's blood sugar was 64 mg/dL. There was no documented evidence that hypoglycemic protocol was followed as ordered. Physician's orders for Resident 26, dated January 7, 2025, included an order for the resident to receive six units of insulin lispro (fast-acting insulin to treat high blood sugar) daily with lunch and dinner. Review of the MAR for January 2025 and February	F 0684		

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F 0684 SS=E	Continued from page 60 2025 revealed that the medication was not administered at lunch time on January 18, 20, 22, 23, 25, and 26, 2025. Physician's orders for Resident 26, dated January 8, 2025, included an order for the resident to receive 18 units of insulin lispro daily with breakfast. Review of the MAR, dated January 2025 and February 2025, revealed that the medication was not administered with breakfast on January 10, 14, and 19, 2025. Interview with the Director of Nursing on February 12, 2025, at 3:00 p.m. confirmed that hypoglycemic protocol was not followed as ordered for a low blood glucose and that insulin was not administered on the above dates and times as ordered and should have been. A quarterly MDS assessment for Resident 37, dated December 4, 2024, revealed that the resident was cognitively intact, required assistance with care	F 0684		

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F 0684 SS=E	Continued from page 61 needs, and had diagnoses that included diabetes, obstructive uropathy (blockage of the urinary tract), and renal insufficiency (kidneys lose the ability to remove waste and balance fluids). A care plan for Resident 37, dated June 25, 2024, revealed that the resident had a percutaneous drain (a small flexible tube inserted through the skin into a body cavity or organ to drain accumulated fluid) and the output needed to be monitored. Review of Resident 37's clinical record, including the resident's Treatment Administration Record (TARs), dated November and December 2024, and January and February 2025, revealed no documented evidence that staff monitored and documented the resident's percutaneous drain output. Interview with the Director of Nursing on February 11, 2025, at 2:12 p.m. confirmed that there was no documented evidence that staff monitored and documented Resident 37's percutaneous drain output as per the care plan.	F 0684		

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F 0684 SS=E	Continued from page 62 A significant change MDS for Resident 38, dated November 25, 2024, revealed that the resident was understood, could usually understand others, had a Brief Interview for Mental Status (BIMS -a structured cognitive interview) of 6 indicating that the resident was moderately cognitively impaired, required assistance for care needs, and had a diagnosis which included end-stage renal failure, hypertension (high blood pressure), Type I diabetes (unable to produce insulin to lower blood sugar), and received dialysis (procedure that filters waste products and excess fluid from the blood when the kidneys are no longer functioning properly). Physician's orders for Resident 38, dated December 11, 2024, included an order for the resident to receive 10 units of insulin Lantus (long acting insulin) daily in the morning. Review of the MAR, dated December 2024, January 2025, and February 2025, revealed that the medication was not administered on December 18, 2024; January 3, 6,	F 0684		

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F 0684 SS=E	Continued from page 63 8, 13, 15, 17, 20, 22, and 27, 2025; and February 3, 6, and 10, 2025. Physician's orders for Resident 38, dated December 25, 2024, included an order for the resident to receive 5 mg of amlodipine (medication used to treat high blood pressure) daily in the morning for hypertension (high blood pressure). Review of the MAR, dated December 2024, January 2025, and February 2025 revealed that the medication was not administered in the morning on December 27 and 29, 2024; January 3, 6, 8, 13, 15, 17, 20, 22, 27, and 31, 2025; and February 3, 6, and 10, 2025. Interview with the Director of Nursing on February 12, 2025, at 3:22 p.m. confirmed that Resident 38's orders were not transcribed correctly, and she did not receive her medication as the physician ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0684		

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F 0689 SS=D		F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0689 SS=D	Continued from page 65 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Resident 13 and 17 chair alarm is in place and functioning. Resident 24 transfer status reviewed and remains unchanged. Baseline audit was completed on residents that have assistive devices in place. Director of Nursing provided education to nursing staff related to checking placement of assistive devices (e.g. fall mats, alarms, transfer device) Monitoring will be captured through auditing assistive devices. Audits for assistive devices in place will be conducted as follows- 4 clinical records will be reviewed weekly for 4 weeks, then 10 clinical records will be reviewed 2 times monthly for 2 months. The audits will be conducted by the Director of Nursing or designee. Results of the audits will be	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0689 SS=D	Continued from page 66	F 0689	provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 0689 SS=D	Continued from page 67 Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure that assistance devices to prevent accidents or injury were in place for three of 29 residents reviewed (Residents 13, 17, 24) Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated November 26, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included heart failure and diabetes. Physician's orders for Resident 13, dated May 29, 2024, included an order for the resident to have a chair alarm to his wheelchair at all times. A nurse's note for Resident 13, dated July 20, 2024, at 2:00 p.m., revealed that the resident had fallen in his bathroom. The resident reported that he	F 0689		

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F 0689 SS=D	<p>Continued from page 68</p> <p>was trying to ambulate from his wheelchair to the bathroom. The chair pad alarm was not present on his wheelchair. A facility incident investigation, dated July 20, 2025, indicated that the resident's chair alarm was not in place.</p> <p>Interview with the Director of Nursing on February 11, 2025, at 10:54 a.m. confirmed that Resident 13 did not have a chair alarm on his wheelchair at the time of his fall on July 20, 2024, and should have.</p> <p>A quarterly MDS assessment for Resident 17, dated October 18, 2024, revealed that the resident was cognitively intact and had diagnoses that included dementia and a history of falls. A care plan for the resident, dated December 26, 2023, revealed that the resident was at high risk for falls due to deconditioning and gait balance problems.</p> <p>A fall investigation for Resident 17, dated October 5, 2024, indicated that the resident was trying to plug in his radio and slid off his wheelchair. The</p>	F 0689		

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F 0689 SS=D	Continued from page 69 chair alarm was not sounding at the time of the fall. An immediate intervention was to replace the chair alarm. Staff were provided education on checking the placement and function of the bed and chair alarms during routine rounds. A fall investigation for Resident 17, dated November 11 2024, indicated that the resident was found sitting on the floor in front of his closet with his back against the foot rests of the wheelchair. Resident 17's roommate alerted staff to the fall. The resident's ordered chair alarm was not sounding at the time of the fall. The resident had a 15 centimeter (cm) by 4 cm abrasion on his back that was bleeding. Interview with the Director of Nursing on February 12, 2025, at 4:56 p.m. confirmed that Resident 17 did not have a functional chair alarm on his wheelchair at the time of his fall on October 5, 2024, and November 11, 2024, and should have.	F 0689		

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F 0689 SS=D	Continued from page 70 A quarterly MDS assessment for Resident 24, dated November 7, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included Alzheimer's disease. Physician's orders for Resident 24, dated September 3, 2024, included an order for the resident to be transferred using a sit-to-stand lift. A nurse's note for Resident 24, dated June 11, 2024, at 5:37 p.m., revealed that the resident was being transferred to the toilet when she lost her balance due to her left foot getting caught, causing her to be off balance, and the resident slid down the wall and then to the floor. A facility incident investigation, dated June 11, 2024, revealed that the resident was not transferred with a sit-to-stand lift as ordered. Education was provided by the registered nurse on site for safe transfers. Interview with the Director of Nursing on February 12, 2025, at 2:04 p.m. revealed that the facility's incident report indicated that the resident was not	F 0689		

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F 0689 SS=D	Continued from page 71 transferred with a sit-to-stand lift as ordered at the time of her fall on June 11, 2024. The Director of Nursing revealed that the nurse aide reported using a sit-to-stand lift; however, a witness statement was not available and the incident report indicated that a sit-to-stand was not used. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0689		
F 0690 SS=D		F 0690		

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F 0690 SS=D	Continued from page 72 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	Resident 1: Indwelling urinary drainage bag and tubing were removed from the floor and catheter bag changed immediately. Unable to retroactively document catheter output. Resident 37: Unable to retroactively document Nephrostomy tube output An observation audit was completed to identify other residents with urinary catheters to validate catheter drainage bag and tubing were not in contact with the floor. Documentation audit completed related to obtaining catheter output. Nursing staff were educated by the Infection Control Nurse on keeping indwelling urinary catheter bag and tubing off the floor, Chain of Infection, and documentation. Monitoring will be captured through visual observation for placement of catheter bag and tubing. Complete 2 resident observations weekly for 4 weeks, then 4 resident observations	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

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F 0690 SS=D	Continued from page 73 This REQUIREMENT is not met as evidenced by:	F 0690	2 times monthly for 2 months. Monitoring will be captured through auditing charting of output on indwelling foley catheters. Audits will be conducted on 2 resident records weekly for 4 weeks, then 4 resident records 2 times monthly for 2 months. The audits will be conducted by the Infection Control Nurse or designee. Results of the audits will be provided to the Administrator by (DON) and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with the coordination of the Interdisciplinary team at QAPI Committee meeting.	

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F 0690 SS=D	Continued from page 74 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents received proper care for indwelling urinary catheters (a flexible catheter used to drain urine from the bladder into a drainage collection bag) and nephrostomy tubes (thin, flexible tube inserted into the kidney through the skin to drain urine directly into a collection bag) for two of 29 residents reviewed (Residents 1, 37). Findings include: A facility policy related to catheter care, dated January 20, 2025, indicated that the catheter tubing and drainage bag are kept off the floor and to observe urine level for noticeable increases or decrease. If the level stays the same, or increases rapidly, report it to the physician or supervisor. Follow the facility procedure for measuring and documenting input and output. A quarterly Minimum Data Set (MDS) assessment	F 0690		

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F 0690 SS=D	Continued from page 75 (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 8, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, had an indwelling urinary catheter, had diagnoses that included neurogenic bladder (bladder lacks control due to nerve or muscle problems), and had a urinary tract infection in the last 30 days. A care plan for the resident, dated June 25, 2024, revealed that the resident had an indwelling urinary catheter. Staff was to ensure that the catheter bag and tubing were secure and the tubing was not on the floor, and staff was to monitor and document intake and output as per facility policy. Physician's orders for Resident 1, dated December 30, 2024, included an order for an indwelling foley catheter to straight drainage. Staff were to ensure the catheter tubing and bag were secured to bed frame and not touching the floor and that the privacy bag was in place. Observations of Resident 1 on February 9, 2025, at	F 0690		

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F 0690 SS=D	Continued from page 76 2:31 p.m. revealed that the resident was lying in bed with his indwelling urinary catheter drainage bag and the catheter tubing was in direct contact with the floor. Interview with Nurse Aide 1, at the time of the observation, confirmed that the catheter bag and catheter tubing should not have been touching the floor. Interview with the Director of Nursing on February 9, 2025, at 3:20 p.m. confirmed that Resident 1's indwelling catheter drainage bag and tubing should not have been touching the floor. Review of the clinical record for Resident 1 for November and December 2024 and January and February 2025 revealed no documented evidence that his output was monitored and documented for the following days and shifts: November 14 and 21 on the night shift, November 25 on the evening shift, December 1 on the night shift, December 21, 25 and 30 on the evening shift, January 7 and 27 on the night shift, January 17 and 28 on the evening shift, and on February 1 on the night shift.	F 0690		

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F 0690 SS=D	Continued from page 77 Interview with the Director of Nursing on February 12, 2025, at 8:57 a.m. confirmed that there was no documented evidence that Resident 1's indwelling foley catheter output was monitored and documented on the above-mentioned dates/shifts as per the care plan and facility policy. A facility policy related to nephrostomy tube care, dated January 20, 2025, indicated to measure output initially every hour for four hours, then every four hours for 24 hours, then every eight hours. Empty drainage bag once per shift and as needed. A quarterly MDS assessment for Resident 37, dated December 4, 2024, revealed that the resident was cognitively intact, required assistance with care needs, and had diagnoses that included diabetes, obstructive uropathy (blockage of the urinary tract), and renal insufficiency (kidneys lose the ability to remove waste and balance fluids). Physician's orders for Resident 37, dated January	F 0690		

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F 0690 SS=D	Continued from page 78 21, 2025, included an order for a left nephrostomy tube. A care plan for Resident 37, dated June 25, 2024, revealed that the resident had a nephrostomy tube, and staff was to monitor and document intake and output as per facility policy. Review of the clinical record for Resident 37 for November and December 2024 and January and February 2025 revealed no documented evidence that staff monitored and documented the resident's nephrostomy tube output on the following dates and shifts: November 1 and 14 on the night shift, November 1 and 28 on the day shift, December 1, 6, and 23 on the night shift, December 25 on the evening shift, January 1, 9, 23 and 27 on the night shift, and February 1 on the night shift. Interview with the Director of Nursing on February 11, 2025, at 2:12 p.m. confirmed that there was no documented evidence that staff monitored and documented Resident 37's nephrostomy tube output on the above-mentioned dates/shifts as per the care plan and facility policy.	F 0690		

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F 0690 SS=D	Continued from page 79 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0690		
F 0755 SS=D		F 0755		

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F 0755 SS=D	Continued from page 80 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Resident 26 MAR was reviewed and reconciled. Residents with orders for controlled medication have the potential to be affected. Director of Nursing provided education to licensed nurses on documentation of controlled medication administration and controlled medication reconciliation. Monitoring will be captured through auditing Medication administration. Audits will be completed as follows- 2 staff med pass observations will be conducted weekly for 4 weeks, then 4 staff med pass observations will be conducted 2 times monthly for 2 months. Results of the med pass observations will be provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to	Completion Date: 03/31/2025 Status: APPROVED Date: 03/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102	STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0755 SS=D	Continued from page 81 This REQUIREMENT is not met as evidenced by:	F 0755	the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
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F 0755 SS=D	Continued from page 82 Based on review of 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 29 residents reviewed (Resident 26). Findings include: The facility's policy for medication administration, dated January 20, 2025, indicated that the individual administering the medication initials the resident's Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next one. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 26, dated January 14, 2025, revealed that the resident was cognitively intact, required assistance with personal care needs, and had diagnoses that included stroke	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0755 SS=D	Continued from page 83 and diabetes. Physician's orders for Resident 26, dated January 7, 2025; January 22, 2025; and February 5, 2025, included an order for the resident to receive 25 milligrams (mg) of Tramadol (a narcotic pain medication) every eight hours as needed for pain. Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 26, dated January and February 2025, revealed that a 25 mg Tramadol tablet was signed out on January 14, 2025, at 8:24 p.m.; January 21, 2025, at 10:00 a.m.; January 22, 2025, at 11:00 a.m.; January 29, 2025, at 10:00 a.m.; and February 5, 2025, at 10:00 a.m. and 7:37 p.m. However, there was no documented evidence in Resident 26's clinical record, including the Medication Administration Record (MAR), that the signed-out doses of controlled medications were administered to the resident on the above-mentioned dates and times.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
STATE LICENSE NUMBER: 270102				
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F 0755 SS=D	Continued from page 84 Interview with the Director of Nursing on February 12, 2025, at 3:56 p.m. confirmed that there was no documented evidence in Resident 26's clinical record to indicate that the signed-out doses of controlled medications mentioned above were administered. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0755		
F 0756 SS=E		F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0756 SS=E	Continued from page 85 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	Pharmacy medication reviews were completed for residents 16, 21, 23, 26, 33, 38, and 50 Residents who receive medications or treatments have the potential to be affected. Education was provided to the Director of Nursing on the process for maintaining records of pharmacy medication reviews. Staff educated on the process when pharmacy recommendations are received from pharmacy consultant: they are forwarded to attending provider. Once completed (approved, not approved) recommendations forms are kept in the resident record and a back-up copy in the pharmacy consultant binder. Monitoring will be captured through auditing pharmacy medication reviews. Audits will be conducted on 10 pharmacy recommendations monthly for 1 month then 5 pharmacy recommendations monthly	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0756 SS=E	Continued from page 86 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756	for 2 months. The audits will be conducted by the Director of Nursing or designee. Results of the audits will be provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
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F 0756 SS=E	Continued from page 87 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that monthly pharmacy medication reviews were completed for seven of 29 residents reviewed (Residents 16, 21, 23, 26, 33, 38, 50). Findings include: The facility policy regarding pharmacy services, dated January 20, 2025, indicated that the consultant pharmacist will provide a documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines; provide appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated; and provide the facility with written or electronic reports and recommendations	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0756 SS=E	Continued from page 88 related to all aspects of medication and pharmaceutical services review. Review of the clinical records for Residents 16, 21, 23, 26, 33, 38 and 50 revealed no documented evidence that monthly pharmacy medication reviews were completed from August 2024 through January 2025. Interview with the Director of Nursing on February 12, 2025, at 12:12 p.m. confirmed that there was no documented evidence that monthly pharmacy medication reviews were completed for the above-mentioned residents on the above-mentioned months reviewed. Interview with the Nursing Home Administrator on February 12, 2025, at 12:46 p.m. indicated that the facility had switched pharmacies in January 2024, and he thought the Director of Nursing was receiving the monthly pharmacy medication reviews. 28 Pa. Code 211.9(a)(1) Pharmacy Services.	F 0756		

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F 0756 SS=E	Continued from page 89 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0756		
F 0760 SS=D		F 0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
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F 0760 SS=D	Continued from page 90 483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 0760	Resident 29 Coumadin orders were reviewed resident is receiving Coumadin per physician orders. Residents who receive Coumadin have the potential to be affected. Baseline audit was completed on residents receiving Coumadin. Director of nursing completed education to licensed nurses on the process for obtaining Coumadin orders including transcription of order. Monitoring will be captured through auditing Coumadin orders. Audits will be conducted on up to 2 clinical records weekly for 4 weeks, then up to 2 clinical records twice monthly for 2 months. Audits will be conducted by the Director of Nursing. Results of the audits will be provided to the Administrator and be presented for review at the monthly Quality Assurance	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0760 SS=D	Continued from page 91	F 0760	Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
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F 0760 SS=D	Continued from page 92 Based on a review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to ensure that it was free from significant medication errors for one of 29 residents reviewed (Resident 21). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 21, dated November 27, 2024, indicated that the resident was cognitively intact, required assistance from staff for personal hygiene needs, and had diagnosis that included right femur (thigh bone) fracture. A nurse's note for Resident 21, dated October 2, 2024, at 9:42 p.m. revealed that orders were received to continue administering 2.5 milligrams (mg) of Coumadin (blood thinner) every Monday, Wednesday, and Friday, and 2 mg of Coumadin every Tuesday, Thursday, Saturday, and Sunday.	F 0760		

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F 0760 SS=D	Continued from page 93 Review of the Medication Administration Record (MAR) for Resident 21, dated October 2024, revealed no documented evidence that Coumadin was administered on October 2 through October 15, 2024. Interview with the Director of Nursing on February 12, 2025, at 8:58 a.m. confirmed that Coumadin should have been administered to Resident 21 on October 2 through October 15, but was not. 28 Pa Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0760		
F 0761 SS=D		F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0761 SS=D	Continued from page 94 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	The undated multi-use vial of Apisol was immediately disposed of, and another multi-use vial was replaced. Residents who have orders for Tuberculosis (TB) skin test have the potential to be affected. Baseline audit was completed to ensure that Apisol vials were dated for 28 days after opening. Licensed staff were educated by Staff Development Nurse on the process for dating prescribed items when opened and their recommended expiration date. Monitoring will be captured through auditing prescribed items for dating items when opened with their recommended expiration date. Audits will be conducted 2 times weekly for 4 weeks on 4 medications, then once monthly for 2 months on 4 medications. The audits will be conducted by the Staff Development Nurse or designee.	Completion Date: 03/31/2025 Status: APPROVED Date: 03/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0761 SS=D	Continued from page 95	F 0761	Results of the audits will be provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with the coordination of the Interdisciplinary team at QAPI Committee meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0761 SS=D	Continued from page 96 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly label a multi-use vial of Aplisol in one of one medication room reviewed. Findings include: The facility's policy regarding medication labeling and storage, dated January 20, 2025, indicated medications and biologicals are stored in a safe, secure, and orderly manner. Nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary method. Manufacturer's directions for use of Aplisol (tuberculin purified protein derivative), dated March 2016, indicated that the vials in use more than 30 days should be discarded due to possible oxidation and degradation, which may affect potency. Observations in the facility's medication room refrigerator in the main medication room on	F 0761		

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NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
STATE LICENSE NUMBER: 270102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 97 February 12, 2025, at 1:29 p.m. revealed one multi-use vial of Aplisol that was open and undated. Interview with Licenced Practical Nurse 2 at the time of the observation confirmed that the vial was not dated and should be discarded. An interview with the Director of Nursing on February 12, 2025, at 3:01 p.m. confirmed that the multi-use vial of Aplisol should have been dated when opened and discarded when expired. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.	F 0761		
F 0770 SS=D		F 0770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0770 SS=D	Continued from page 98 483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by:	F 0770	Resident 29- unable to retroactively address labs not obtained, MD notified. Residents who are ordered labs have the potential to be affected. Director of Nursing completed education to licensed nurses on the process for ordering labs included transcription to medication administration recorded/treatment administration and supplemental documentation (e.g. bowel movements). Monitoring will be captured through auditing lab orders. Audits will be conducted on 4 clinical records weekly for 4 weeks, then 10 clinical records twice monthly for 2 months. Audits will be conducted by the Director of Nursing. Results of the audits will be provided to the Administrator and be presented for review at the monthly Quality Assurance	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0770 SS=D	Continued from page 99	F 0770	Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
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F 0770 SS=D	Continued from page 100 Based on clinical record reviews and staff interviews, it was determined that the facility failed to obtain laboratory services as ordered by the physician for one of 29 residents reviewed (Resident 1). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 8, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, was frequently incontinent of bowel, and had a diagnosis of dementia. A nursing note for Resident 1, dated January 20, 2025, at 6:38 p.m., revealed that the resident had a large bowel movement with red staining noted to his sheets around the stool. Physician's orders for Resident 1, dated January 20,	F 0770		

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F 0770 SS=D	Continued from page 101 2025, included an order to obtain three stool samples for immuno-fecal occult (hidden) blood with instructions to record each collection in the resident's electronic health record and notify the physician if positive. A nursing note for Resident 1, dated January 21, 2025, at 9:29 a.m., revealed that the resident's first fecal occult blood specimen was negative. A nursing note for Resident 1, dated January 25, 2025, at 4:50 a.m., revealed that two stool samples were needed to be obtained. As of February 11, 2025, there was no documented evidence in Resident 1's clinical record that his remaining two stools were obtained and tested for occult blood. Interview with the Director of Nursing on February 11, 2025, at 2:12 p.m. confirmed that there was no documented evidence in Resident 1's clinical record that his remaining two stools were obtained and tested for occult blood. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0770		

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F 0770 SS=D	Continued from page 102	F 0770		
F 0804 SS=E		F 0804		

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F 0804 SS=E	Continued from page 103 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	Unable to retroactively correct the temperatures of the food. Residents receiving meals from Dining Services have the potential to be affected. Trays will be distributed within 15 minutes of the cart being delivered to the floor. Monitoring will be captured through auditing test trays. Audits will be conducted 6 trays weekly for 4 weeks, then 3 trays weekly for 2 months. The audits will be conducted by the Director of Dietary, the Dietitian or designee. Results of the audits will be provided to the Administrator by the Director of Dietary and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0804 SS=E	Continued from page 104	F 0804	implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 0804 SS=E	Continued from page 105 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to serve palatable food that was at appropriate temperatures. Findings include: The facility's policy regarding food temperatures and point of service, dated January 20, 2025, indicated that hot foods would be held at temperatures of 135 degrees or above. Best efforts would be made to present hot food hot and cold foods cold at point of service by using thermal lids and bases, heated or chilled plates, and thermal pellets as necessary. Observations of the kitchen's lunch meal tray line on February 10, 2025, revealed that it began at 12:01 p.m. and included barbecued ribs, homestyle baked beans, corn on the cob, and watermelon. The last tray was placed on the cart at 12:14 p.m. The cart left the kitchen and arrived on the unit at 12:17 p.m., and the last tray was removed from the cart and	F 0804		

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F 0804 SS=E	Continued from page 106 served at 12:27 p.m. The test tray was removed from the cart at 12:42 p.m. The barbecued rib was 114 degrees Fahrenheit (F) and tasted cold and was not palatable, the baked beans were 127 degrees F, the corn was 102 degrees F tasted cold and was not palatable, the watermelon was 53.1 degrees F, the pureed barbecued rib was 113.7 degrees F and was cold and not palatable, the pureed corn was 112 degrees F and was cold and not palatable, the pureed baked beans were 114.8 degrees F and were cold and not palatable. Interview with Director of Dietary on January 14, 2025, at 3:08 p.m. confirmed that the temperatures were not palatable because the tray line and tray passing was delayed. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.6(f) Dietary Services.	F 0804		

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F 0867 SS=D		F 0867		

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F 0867 SS=D	Continued from page 108 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	The center will continue to meet related to Quality Assurance Performance Improvement (QAPI) and if a plan is ineffective after reviewing the plan will be revised and with further auditing and surveillance initiated. Residents affected by previous deficiencies have the potential to be affected The administrator will provide education to the quality assurance performance improvement committee on the committee's role in improvement activities regarding federal regulations. Monitoring will be captured through auditing quality assurance performance improvement minutes monthly for 3 months. The audits will be conducted by the Administrator or designee. Results of the audits will be presented for review at the monthly	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

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F 0867 SS=D	Continued from page 109 the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867	Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0867 SS=D	Continued from page 110 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=D	Continued from page 111 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 0867		

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F 0867 SS=D	Continued from page 112 Based on review of the facility's plans of correction 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 plans of corrections for State Survey and Certification (Department of Health) survey ending February 29, 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 February 12, 2025, identified repeated deficiencies related to a failure to develop and implement comprehensive care plans, failure to update/revise care plans, failure to provide quality of care, failure to provide a safe environment that is	F 0867		

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F 0867 SS=D	Continued from page 113 free of accident hazards, failure to maintain compliance with the regulation regarding complete and accurate accounting of controlled medications, failure to store and label residents medications properly, and failure to ensure food was palatable and served at the proper temperature. The facility's plans of correction for deficiencies regarding developing and implementing comprehensive care plans, cited during the survey ending February 29, 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 F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the regulation regarding developing and implementing comprehensive care plans. The facility's plan of correction for a deficiency regarding a failure to update/revise residents' care plans, cited during the survey ending February 29, 2024, revealed that the facility developed a plan of	F 0867		

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F 0867 SS=D	Continued from page 114 correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding updating/revising residents' care plans. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending February 29, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care. The facility's plan of correction for deficiencies regarding a safe environment that is free of accident	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0867 SS=D	Continued from page 115 hazards, cited during the survey ending February 29, 2024, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding a safe environment that is free of accident hazards. The facility's plan of correction for a deficiency regarding pharmacy services accurate accounting of controlled medications, cited during the survey ending February 29, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding pharmacy services accurate accounting of controlled medications.	F 0867		

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NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
STATE LICENSE NUMBER: 270102				
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F 0867 SS=D	Continued from page 116 The facility's plan of correction for a deficiency regarding proper storage and/or labeling of medications, cited during the survey ending February 29, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding storing and labeling resident's medications properly. The facility's plans of correction for deficiencies regarding ensuring that food was palatable and at proper serving temperatures, cited during the survey ending on February 29, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F804, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding ensuring the	F 0867		

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F 0867 SS=D	Continued from page 117 food was palatable and had proper serving temperatures. Refer to F656, F657, F684, F689, F755, F761, F804. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0867		
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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F 0880 SS=D	Continued from page 118 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Nurse Aide 1 received one on one education regarding catheter bag care, hand hygiene and use of personal protective equipment. Residents who have an indwelling Foley catheter have the potential to be affected. Nursing staff were educated by the Infection Control Nurse on hand hygiene, standard precautions, providing catheter care and the Chain of Infection. Monitoring will be captured through staff observations for hand hygiene. Observations will be conducted on 20 staff weekly for 2 weeks, then 10 staff weekly for 2 weeks, then 10 staff twice monthly for 2 months. The audits will be conducted by the Infection Control Nurse or designee. Results of the audits will be provided to the Administrator and be presented for review at the monthly Quality Assurance	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0880 SS=D	Continued from page 119 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with the coordination of the Interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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F 0880 SS=D	Continued from page 120	F 0880		

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F 0880 SS=D	Continued from page 121 Based on observations and staff interviews, it was determined that the facility failed to use proper infection control practices to reduce the spread of infections and prevent cross-contamination for one of 29 residents reviewed (Resident 1). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 8, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, had an indwelling urinary catheter (a flexible catheter used to drain urine from the bladder into a drainage collection bag), had diagnoses that included neurogenic bladder (bladder lacks control due to nerve or muscle problems), and had a urinary tract infection in the last 30 days. A care plan for the resident, dated June 25, 2024, revealed that the resident had an indwelling urinary catheter. Physician's orders for Resident 1, dated December	F 0880		

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F 0880 SS=D	Continued from page 122 30, 2024, included an order for an indwelling foley catheter to straight drainage, ensure catheter tubing and bag are secured to bed frame and not touching the floor, and ensure privacy bag is in place. Observations of Resident 1 on February 9, 2025, at 2:31 p.m. revealed that the resident was lying in bed with his indwelling urinary catheter drainage bag and the catheter tubing in direct contact with the floor. Interview with Nurse Aide 1, at the time of the observation, confirmed that the catheter bag and catheter tubing should not have been touching the floor. She proceeded to pick the catheter bag and catheter tubing up off the floor with her bare, ungloved hands, then placed the catheter bag and tubing back on the floor, obtained a pair of gloves provided to her by another nurse aide, put the gloves on, and proceeded to place the catheter bag and tubing into the dignity bag. Interview with the Director of Nursing on February 9, 2025, at 3:20 p.m. confirmed that the nurse aide should have had gloves on when handling Resident	F 0880		

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F 0880 SS=D	Continued from page 123 1's catheter bag and tubing, and she should not have placed the catheter bag and tubing on the floor while donning her gloves. 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.	F 0880			

Pennsylvania Department of Health

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P 1020		P 1020		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
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P 1020	Continued from page 1 Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	Data previously collected for October 2024 through January 2025 will be retroactively entered to be captured into the Pennsylvania Patient Safety Reporting System (PA-PSRS). Residents with facility health care-associated infections reportable to the Pennsylvania Patient Safety Reporting System (PA-PSRS) as per the Act 52 Infection Control Plan have the potential to be affected. Education provided to the Infection Control Nurse by the Director of Nursing on the process for reporting health care-associated infections to the Pennsylvania Patient Safety Reporting System (PA-PSRS). Monitoring will be captured through auditing The Act 52 Infection Control Plan Pennsylvania Patient Safety Reporting System (PA-PSRS). Audits on PA-PSRS will be performed monthly for 3 months. The audits will be conducted by the	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 1020	Continued from page 2	P 1020	<p>Infection Control Nurse or designee.</p> <p>Results of the audits will be provided to the Administrator and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with the coordination of the interdisciplinary team at QAPI Committee meeting</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 1020	Continued from page 3 Based on staff interview and review of facility documentation, it was determined that the facility did not comply with all requirements of the Act 52 Infection Control Plan. Findings include: Review of ACT 52 of 2007, Chapter 4, health care-associated infections, section §1303.404 indicated that a nursing home shall electronically report health care-associated infection data to the department and the authority using nationally recognized standards based on CDC definitions, provided that the data is reported on a patient-specific basis in the form, with the time for reporting and format as determined by the department and the authority. In addition, section §1303.405 Patient Safety Authority jurisdiction, indicated that the occurrence of a health care-associated infection in a health care facility shall be deemed a serious event. Written notification of the serious event should be documented.	P 1020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 1020	Continued from page 4 As of February 11, 2025, the facility was unable to provide documented evidence that the facility reported health care-associated infections to the Pennsylvania Patient Safety Reporting System (PA-PSRS) and was unable to provide documented evidence that the facility sent written notification to the residents, or their responsible parties as required from October 2024 through January 2025 Interview with the Infection Preventionist/IP on February 11, 2025, at 12:14 p.m. revealed that she had only been the IP since October 23, 2024. She indicated that she was not reporting infections to PA-PSRS from the time she became the IP at the end of October through the end of January 2025. She indicated that she was not aware that she had to report health care-associated infections to PA-PSRS until recently.	P 1020		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 4920		P 4920		
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P 4920	Continued from page 6 Dietary Services. (a) Menus shall be planned and posted in the facility or distributed to residents at least 2 weeks in advance. Records of menus of foods actually served shall be retained for 30 days. When changes in the menu are necessary, substitutions shall provide equal nutritive value. This REGULATION is not met as evidenced by:	P 4920	Unable to retroactively correct the posting of the menus. Residents receiving meals from Dining Services have the potential to be affected. Menus will be posted in the dining room two weeks in advance. The menu will be posted on channel 2 two weeks in advance, which is available in resident rooms for viewing. Monitoring will be captured through auditing. The dining room will be checked to ensure the menus are posted. Channel 2 will be viewed to ensure menus are available. Audits will be done weekly for 4 weeks, then monthly for 2 months. The audits will be conducted by the Director of Dietary or designee. The results of the audits will be provided to the Administrator by Dietary Director and be presented for review at the monthly Quality	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

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P 4920	Continued from page 7	P 4920	Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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STATE LICENSE NUMBER: 270102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 4920	Continued from page 8 Based on observations and staff and resident interviews, it was determined that the facility failed to post menus in the facility or distribute menus to residents at least two weeks in advance. Findings include: An interview with a group of residents on February 10, 2025, at 10:00 a.m. revealed that they do not know what is being served at meals until it is delivered. The daily menu for the day is posted in the hallway, but they do not receive menus in advance or are they made aware of the meal. Observations during meal delivery on February 10, 2025, between 12:18 p.m. and 12:47 p.m. revealed that the current day's menu was the only menu posted in the hallway. There was no other menu available for residents. Interview with Director of Dietary on February 12, 2025, at 1:16 p.m. confirmed that the only menu	P 4920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 4920	Continued from page 9 posted was the current day's menu and that she would expect dietary services to post menus in the facility or distribute the menus to residents at least two weeks in advance, but it was not being done.	P 4920		
P 5520		P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 5520	Continued from page 10 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	Unable to retroactively correct staffing ratios for Certified Nurse Aides (CNAs) on dates noted. Residents who receive nursing care services have the potential to be affected. Recruitment and retention activities- 1.) Generous Sign on Bonus 2.) Flexible Scheduling 3.) Benefits Package for full-time employees 4.) Wage analysis completed 5.) "Kudos" recognition program 6.) Referral bonus 7.) Agency Contracts 8.) Administrative Coverage Monitoring will be captured through auditing staff schedules. Audit will be conducted daily for 12 weeks. The audits will be conducted by the Staffing Coordinator or designee. Results of the audits will be presented for review at the monthly	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 5520	Continued from page 11	P 5520	Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 5520	Continued from page 12 Based on review of nursing schedules, review of staffing information furnished by the facility, and staff interview, it was determined that the facility failed to provide one nurse aide (NA) per 10 residents on the day shift for 12 of 21 days, failed to provide one NA per 11 residents on the evening shift for 11 of 21 days, and failed to provide a minimum of one NA per 15 residents on the night shift for 14 of 21 days reviewed for January 19 through 25, 2025; January 26 through February 1, 2025; and February 5 through 11, 2025. Findings include: Review of facility census data revealed: On January 19, 2025, the facility census was 56, during the day shift, which required 5.60 NA's during the day shift. Review of the nursing time schedules revealed 5.30 NA's provided care on the day shift.	P 5520		

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NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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P 5520	<p>Continued from page 13</p> <p>On January 20, 2025, the facility census was 54, during the day shift, which required 5.40 NA's during the day shift. Review of the nursing time schedules revealed 4.57 NA's provided care on the day shift.</p> <p>On January 21, 2025, the facility census was 51, during the day shift, which required 5.10 NA's during the day shift. Review of the nursing time schedules revealed 4.43 NA's provided care on the day shift.</p> <p>On January 22, 2025, the facility census was 52, during the day shift, which required 5.20 NA's during the day shift. Review of the nursing time schedules revealed 4.63 NA's provided care on the day shift.</p> <p>On January 23, 2025, the facility census was 52, during the day shift, which required 5.20 NA's during the day shift. Review of the nursing time schedules revealed 4.33 NA's provided care on the day shift.</p>	P 5520		

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P 5520	Continued from page 14 On January 24, 2025, the facility census was 53, during the day shift, which required 5.30 NA's during the day shift. Review of the nursing time schedules revealed 4.43 NA's provided care on the day shift. On January 25, 2025, the facility census was 54, during the day shift, which required 5.40 NA's during the day shift. Review of the nursing time schedules revealed 5.10 NA's provided care on the day shift. On January 26, 2025, the facility census was 54, during the day shift, which required 5.40 NA's during the day shift. Review of the nursing time schedules revealed 4.67 NA's provided care on the day shift. On January 28, 2025, the facility census was 52, during the day shift, which required 5.20 NA's during the day shift. Review of the nursing time schedules revealed 4.33 NA's provided care on the	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 5520	Continued from page 15 day shift. On January 30, 2025, the facility census was 53, during the day shift, which required 5.30 NA's during the day shift. Review of the nursing time schedules revealed 5.27 NA's provided care on the day shift. On February 6, 2025, the facility census was 55, during the day shift, which required 5.50 NA's during the day shift. Review of the nursing time schedules revealed 4.63 NA's provided care on the day shift. On February 11, 2025, the facility census was 55, during the day shift, which required 5.50 NA's during the day shift. Review of the nursing time schedules revealed 4.30 NA's provided care on the day shift. On January 20, 2025, the facility census was 52, during the evening shift, which required 4.73 NA's during the evening shift. Review of the nursing time	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 5520	Continued from page 16 schedules revealed 3.73 NA's provided care on the evening shift. On January 21, 2025, the facility census was 52, during the evening shift, which required 4.73 NA's during the evening shift. Review of the nursing time schedules revealed 4.10 NA's provided care on the evening shift. On January 22, 2025, the facility census was 52, during the evening shift, which required 4.73 NA's during the evening shift. Review of the nursing time schedules revealed 4.70 NA's provided care on the evening shift. On January 25, 2025, the facility census was 54, during the evening shift, which required 4.91 NA's during the evening shift. Review of the nursing time schedules revealed 4.30 NA's provided care on the evening shift. On January 26, 2025, the facility census was 52, during the evening shift, which required 4.73 NA's	P 5520		

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P 5520	Continued from page 17 during the evening shift. Review of the nursing time schedules revealed 4.43 NA's provided care on the evening shift. On January 28, 2025, the facility census was 51, during the evening shift, which required 4.64 NA's during the evening shift. Review of the nursing time schedules revealed 4.63 NA's provided care on the evening shift. On January 29, 2025, the facility census was 53, during the evening shift, which required 4.82 NA's during the evening shift. Review of the nursing time schedules revealed 4.43 NA's provided care on the evening shift. On January 30, 2025, the facility census was 52, during the evening shift, which required 4.73 NA's during the evening shift. Review of the nursing time schedules revealed 4.60 NA's provided care on the evening shift. On February 5, 2025, the facility census was 55,	P 5520		

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P 5520	Continued from page 18 during the evening shift, which required 5.00 NA's during the evening shift. Review of the nursing time schedules revealed 4.87 NA's provided care on the evening shift. On February 8, 2025, the facility census was 55, during the evening shift, which required 5.00 NA's during the evening shift. Review of the nursing time schedules revealed 4.10 NA's provided care on the evening shift. On February 9, 2025, the facility census was 55, during the evening shift, which required 5.00 NA's during the evening shift. Review of the nursing time schedules revealed 4.80 NA's provided care on the evening shift. On January 19, 2025, the facility census was 54 during the night shift, which required 3.60 NA's during the night shift. Review of the nursing time schedules revealed that 3.20 NA's provided care during the night shift.	P 5520		

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P 5520	Continued from page 19 On January 20, 2025, the facility census was 51 during the night shift, which required 3.40 NA's during the night shift. Review of the nursing time schedules revealed that 2.77 NA's provided care during the night shift. On January 22, 2025, the facility census was 52 during the night shift, which required 3.47 NA's during the night shift. Review of the nursing time schedules revealed that 3.07 NA's provided care during the night shift. On January 23, 2025, the facility census was 53 during the night shift, which required 3.53 NA's during the night shift. Review of the nursing time schedules revealed that 2.97 NA's provided care during the night shift. On January 26, 2025, the facility census was 52 during the night shift, which required 3.47 NA's during the night shift. Review of the nursing time schedules revealed that 3.07 NA's provided care during the night shift.	P 5520		

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P 5520	Continued from page 20 On January 27, 2025, the facility census was 52 during the night shift, which required 3.47 NA's during the night shift. Review of the nursing time schedules revealed that 3.00 NA's provided care during the night shift. On January 28, 2025, the facility census was 51 during the night shift, which required 3.40 NA's during the night shift. Review of the nursing time schedules revealed that 3.20 NA's provided care during the night shift. On January 29, 2025, the facility census was 53 during the night shift, which required 3.53 NA's during the night shift. Review of the nursing time schedules revealed that 3.17 NA's provided care during the night shift. On January 30, 2025, the facility census was 51 during the night shift, which required 3.40 NA's during the night shift. Review of the nursing time schedules revealed that 3.13 NA's provided care	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 5520	Continued from page 21 during the night shift. On February 5, 2025, the facility census was 55 during the night shift, which required 3.67 NA's during the night shift. Review of the nursing time schedules revealed that 3.20 NA's provided care during the night shift. On February 6, 2025, the facility census was 55 during the night shift, which required 3.67 NA's during the night shift. Review of the nursing time schedules revealed that 3.63 NA's provided care during the night shift. On February 7, 2025, the facility census was 56 during the night shift, which required 3.73 NA's during the night shift. Review of the nursing time schedules revealed that 3.67 NA's provided care during the night shift. On February 8, 2025, the facility census was 55 during the night shift, which required 3.67 NA's during the night shift. Review of the nursing time	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 5520	Continued from page 22 schedules revealed that 2.93 NA's provided care during the night shift. On February 9, 2025, the facility census was 55 during the night shift, which required 3.67 NA's during the night shift. Review of the nursing time schedules revealed that 3.53 NA's provided care during the night shift. There were no additional excess higher-level staff available to compensate for these deficiencies. Interview with the Nursing Home Administrator on February 12, 2025, at 6:30 p.m. confirmed that the facility did not meet the required NA-to-resident staffing ratios for the days listed above.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 23 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	Unable to retroactively correct staffing ratios for Licensed Practical Nurses (LPNs on dates noted). Residents who receive nursing care services have the potential to be affected. Recruitment and retention activities- 1.) Generous Sign on Bonus 2.) Flexible Scheduling 3.) Benefits Package for full-time employees 4.) Competitive Wages 5.) "Kudos" employee recognition program 6.) Referral bonus 7.) Agency Contracts 8.) Administrative Coverage Monitoring will be captured through auditing staff schedules. Audit will be conducted daily for 12 weeks. The audits will be conducted by the Staffing Coordinator or designee. Results of the audits will be	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

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P 5530	Continued from page 24	P 5530	presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 5530	Continued from page 25 Based on review of nursing schedules, review of staffing information furnished by the facility, and staff interview, it was determined that the facility failed to provide a minimum of one licensed practical nurse (LPN) per 25 residents on the day shift for two of 21 days and failed to provide a minimum of one LPN per 40 residents on the overnight shifts for nine of 21 days reviewed for January 19 through 25, 2025; January 26 through February 1, 2025; and February 5 through 11, 2025. Findings include: Review of facility census data revealed: On January 19, 2025, the facility's census was 56 during the day shift, which required 2.24 LPN's on the day shift. Review of the nursing time schedules revealed that 2.20 LPN's provided care during the day shift. On February 8, 2025, the facility's census was 56	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
STATE LICENSE NUMBER: 270102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 26 during the day shift, which required 2.24 LPN's on the day shift. Review of the nursing time schedules revealed that 2.20 LPN's provided care during the day shift. On January 19, 2025, the facility's census was 54 during the night shift, which required 1.35 LPN's on the night shift. Review of the nursing time schedules revealed that 1.07 LPN's provided care during the night shift. On January 20, 2025, the facility's census was 51 during the night shift, which required 1.28 LPN's on the night shift. Review of the nursing time schedules revealed that 1.13 LPN's provided care during the night shift. On January 23, 2025, the facility's census was 53 during the night shift, which required 1.33 LPN's on the night shift. Review of the nursing time schedules revealed that 1.17 LPN's provided care during the night shift.	P 5530		

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P 5530	Continued from page 27 On January 25, 2025, the facility's census was 54 during the night shift, which required 1.35 LPN's on the night shift. Review of the nursing time schedules revealed that 1.27 LPN's provided care during the night shift. On January 30, 2025, the facility's census was 51 during the night shift, which required 1.28 LPN's on the night shift. Review of the nursing time schedules revealed that 1.27 LPN's provided care during the night shift. On January 31, 2025, the facility's census was 50 during the night shift, which required 1.25 LPN's on the night shift. Review of the nursing time schedules revealed that 1.17 LPN's provided care during the night shift. On February 1, 2025, the facility's census was 50 during the night shift, which required 1.25 LPN's on the night shift. Review of the nursing time schedules revealed that 1.23 LPN's provided care during the night shift.	P 5530		

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P 5530	Continued from page 28 On February 7, 2025, the facility's census was 56 during the night shift, which required 1.40 LPN's on the night shift. Review of the nursing time schedules revealed that 1.10 LPN's provided care during the night shift. On February 8, 2025, the facility's census was 55 during the night shift, which required 1.38 LPN's on the night shift. Review of the nursing time schedules revealed that 1.13 LPN's provided care during the night shift. There were no additional excess higher-level staff available to compensate for these deficiencies. Interview with the Nursing Home Administrator on February 12, 2025, at 6:30 p.m. confirmed that the facility did not meet the required LPN-to-resident staffing ratios for the days listed above.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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P 5640	Continued from page 29 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	Unable to retroactively correct the hours provided of direct resident care for dates noted. Residents who receive nursing care services have the potential to be affected. Recruitment and retention activities- 1.) Generous Sign on Bonus 2.) Flexible Scheduling 3.) Benefits Package for full-time employees 4.) Competitive Wages 5.) "Kudos" employee recognition program 6.) Wage analysis completed 7.) The facility is near public transportation. 8.) Referral bonus 9.) Agency Contracts 10.) Administrative Coverage Monitoring will be captured through auditing PPD. Audit will be conducted daily for 12 weeks. The audits will be conducted by the	Completion Date: 03/31/2025 Status: APPROVED Date: 03/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 5640	Continued from page 30	P 5640	Staffing Coordinator or designee. Results of the audits will be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/12/2025	
NAME OF PROVIDER OR SUPPLIER: HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN STATE LICENSE NUMBER: 270102		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 GOUCHER STREET JOHNSTOWN, PA 15905		
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P 5640	<p>Continued from page 31</p> <p>Based on review of nursing schedules and staff interviews, it was determined that the facility failed to provide 3.20 hours of direct resident care for each resident for seven of 21 days (24-hour periods) reviewed for January 19 through 25, 2025; January 26 through February 1, 2025; and February 5 through 11, 2025.</p> <p>Findings include:</p> <p>Review of the nursing time schedules provided by the facility revealed that the facility provided 3.03 hours of direct care for each resident on January 19; 2.89 hours of direct care for each resident on January 20; 3.06 hours of direct care for each resident on January 25; 2.88 hours of direct care for each resident on January 26; 3.15 hours of direct care for each resident on January 28; 3.09 hours of direct care for each resident on January 30; 2.95 hours of direct care for each resident on February 8.</p> <p>Interview with the Nursing Home Administrator on</p>	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395439	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 02/12/2025
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P 5640	Continued from page 32 February 12, 2025, at 6:30 p.m. confirmed that the facility did not meet the required daily hours of direct resident care for each resident on the days listed above.	P 5640			



Certified End Page

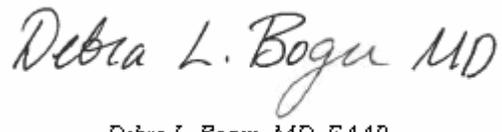
HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN

STATE LICENSE NUMBER: 270102

SURVEY EXIT DATE: 02/12/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY