

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395439</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/17/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>807 GOUCHER STREET JOHNSTOWN, PA 15905</b>		
STATE LICENSE NUMBER: <b>270102</b>				
(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 0610 SS=D	Based on a complaint survey completed on April 17, 2025, it was determined that Heritage Ridge Senior Living at Johnstown 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 0610		

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 0610  SS=D	Continued from page 1  483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by:	F 0610	Investigation and incident report completed for incident occurring on 03/20/2025 for resident #2.  Residents who receive care and services at the facility have the potential to be affected.  Director of Nursing was educated by the Administrator on the when to investigate and initiate an incident report in reference to family members/visitors and when police come into the facility to investigate an incident.  The Administrator or designee will audit and review incident reports to ensure the necessary investigation is completed.  Audits will be conducted as follows: 1.) Up to 5 records will be reviewed daily for 4 weeks. 2.) Then up to 10 records will be reviewed monthly for 2 months.  Results of the audits will be provided by the Administrator and	Completion Date: <b>05/19/2025</b> Status: <b>APPROVED</b> Date: <b>05/13/2025</b>

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F 0610  SS=D	Continued from page 2	F 0610	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 0610  SS=D	<p>Continued from page 3</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to complete a thorough investigation for an incident that occurred for one of four residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>A facility policy for incident and accident reports, dated January 20, 2025, revealed that the accidents or incidents involving residents, employees, visitors and vendors, occurring on our premises shall be investigated and reported to the administrator.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated March 3, 2025, revealed that the resident was cognitively intact, required extensive assistance with daily care needs, and had a diagnosis of dementia.</p> <p>Interview with the Social Worker on April 17,</p>	F 0610		

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F 0610  SS=D	Continued from page 4  2025, at 10:35 a.m. revealed an incident in March 2025 when Resident 2's spouse came to the facility, took Resident 2 out of the building, and attempted to put her in his vehicle to take her home. He made threats towards staff and the police were called.  A Social Service note for Resident 2, dated March 20, 2025, at 4:27 p.m., revealed that the social worker had a conversation with Resident 2's daughter to provide an update regarding the resident's spouse attempting to take the resident from the facility. The Social Worker explained that the resident was unable to stand to get herself into the car and spouse became extremely frustrated with Resident 2 and with facility staff while they were attempting to explain the concern for her safety. The situation was de-escalated with police presence; however, the police did have to contact crisis related to a comment made by the spouse to the officer. Crisis did talk with resident's spouse and felt that he was okay to go home once he calmed down. The social worker explained that resident was safe and remained at the facility. The	F 0610		

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F 0610  SS=D	Continued from page 5  daughter voiced understanding and stated that she felt that the safest place for the resident was to remain at the facility.  Interview with the Director of Nursing April 17, 2025, at 12:15 p.m. revealed that she was not aware that an investigation needed to be completed when a family member of a resident was involved.  Interview with the Nursing Home Administrator on April 17, 2025, at 12:30 p.m. revealed that he signed a document that Resident 2's spouse was no longer permitted on the property following the incident on March 20, 2025, and that he was not aware that an investigation needed to be completed.  28 Pa. Code 201.18(e)(1) Management.  28 Pa. Code 211.10(d) Resident Care Policies.  28 Pa. Code 211.12(d)(5) Nursing Services.	F 0610		

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Pennsylvania Department of Health

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P 1050		P 1050		

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P 1050	Continued from page 1  Responsibility of licensee.  [Reserved]  This REGULATION is not met as evidenced by:	P 1050	Unable to retroactively notify the Department of Health of incident that had the potential for harm to a resident.  Residents who receive care and services at the facility have the potential to be affected.  Director of Nursing was educated by the Administrator on reporting incidents that have the potential for harm to a resident to the Department of Health. The Director of Nursing will review questionable incidents with the Administrator to ensure compliance in reporting.  The Administrator or designee will audit and review incident reports to ensure the necessary reporting is completed.  Audits will be conducted as follows: 3.) Up to 5 records will be reviewed daily for 4 weeks. 4.) Then up to 10 records will be reviewed monthly for 2 months.	Completion Date: <b>05/19/2025</b> Status: <b>APPROVED</b> Date: <b>05/13/2025</b>

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P 1050	Continued from page 2	P 1050	Results of the audits will be provided by 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.	

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P 1050	Continued from page 3  Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to notify the Department of Health of an incident that had the potential for harm to a resident.  Findings include:  An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated March 3, 2025, revealed that the resident was cognitively intact and required extensive assistance with daily care needs and had a diagnosis of dementia.  Social services note for Resident 2, dated March 20, 2025, at 4:27 p.m. revealed that the social worker had a conversation with Resident 2's daughter to provide an update related to the resident's spouse attempting to take her from the facility. Social worker explained that the resident was unable to stand to get herself into the car and	P 1050		

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P 1050	Continued from page 4  spouse became extremely frustrated with Resident 2 and the staff when they attempted to explain their concern for her safety. Situation was de-escalated with police presence; however, the police did have to contact crisis related to a comment made by the spouse to the officer. Crisis did talk with resident's spouse and felt that he was okay to go home once he calmed down. The social worker explained that the resident was safe and remains at the facility. The daughter voiced understanding and stated that she felt that the safest place for the resident was to remain at the facility.  Interview with the Director of Nursing April 17, 2025, at 12:15 p.m. confirmed that the Department of Health was not notified of this incident.  Chapter 51.3(f) Notification.	P 1050		



# Certified End Page

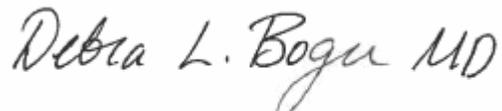
**HERITAGE RIDGE SENIOR LIVING AT JOHNSTOWN**

**STATE LICENSE NUMBER: 270102**

**SURVEY EXIT DATE: 04/17/2025**

**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