STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey completed on December 19, 2024, it was determined that Richland Nursing and Rehab 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 0000		
F 0558 SS=D		F 0558		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0558 SS=D	Continued from page 1 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	1. Resident number 2's call bell was placed within reach. 2. Staff rounded in facility to ensure resident call bells were within reach- if found, resident call bells were placed within reach. Education provided to nursing staff to ensure call bells are within resident's reach. 3. Director of Nursing or designee will complete audit to ensure resident's call bells are within reach weekly times two weeks and monthly times two months. 4. Results will be reviewed at the Quality Assurance Performance Improvement Meeting.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0558 SS=D	Continued from page 2 Based on review of facility policy and clinical record reviews, observations, and staff interviews, it was determined that the facility failed to provide reasonable accommodation of a resident's needs by failing to ensure that the call bell was within reach for one of 37 residents reviewed (Resident 2). Findings include: The facility's policy regarding call bells, dated November 21, 2024, revealed that the call bell should be within reach of the resident. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated November 6, 2024, indicated that the resident was understood and could understand, was cognitively impaired, and was dependent on staff for all care needs. The resident's current care plan indicated that the resident had decreased mobility and that staff were to ensure the call bell was within reach.	F 0558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0558 SS=D	Continued from page 3 Observations of Resident 2 on December 16, 2024, at 10:15 a.m. revealed that the resident was lying in bed and was asking for her call bell. The call bell was in her nightstand drawer and was not within her reach. Interview with Nurse Aide 1 at that time revealed that Resident 2 could use her call bell and that it should have been placed within her reach. Interview with Director of Nursing on December 16, 2024, at 3:20 p.m. confirmed that the call bell should have been within reach. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0558		
F 0623 SS=E		F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 4 483.15(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	1. Resident 9, 28, 36, 37, 43 and 62 were notified of transfer to out to hospital by phone, however they were not notified in writing. 2. Facility reviewed regulation for notice of requirements before transfer/discharge of a resident. Facility put in place utilizing a form to meet the regulation to accompany the bed hold notice. Business Office Manager and Registered Nurse Supervisor's were educated on sending written notice of resident transfer/discharge to responsible party. 3. Social Service director or designee will complete audit to ensure written transfer/discharge notice is sent for hospital transfer weekly times two weeks and monthly times two months. 4. Results will be reviewed at the Quality Assurance Performance Improvement Meeting.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 5 (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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 6 (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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 7 Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident and resident's representative in writing of the transfer and reason for hospitalization for six of 37 residents reviewed (Residents 9, 28, 36, 37, 43, 62). Findings include: A nursing note for Resident 9, dated August 11, 2024, at 12:17 p.m., revealed that the resident had a large emesis, had acute abdominal pain, and a history of bowel obstruction (partial or complete blockage of the small or large intestine). The physician was notified, and the resident was sent to the hospital for an evaluation. He was admitted with a urinary tract infection and small bowel obstruction. There was no documented evidence that a written notice of Resident 9's transfer to the hospital and reason for hospitalization was provided to the resident's representative.	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 8 A nursing note for Resident 28, dated October 22, 2024, at 8:06 p.m., revealed that the resident was transferred to the hospital and admitted with a heart attack. There was no documented evidence that a written notice of Resident 2's transfer to the hospital and reason for hospitalization was provided to the resident's representative. A nursing note for Resident 36, dated November 10, 2024, at 4:46 p.m., revealed that the resident was transferred to the hospital and admitted with a urinary tract infection. There was no documented evidence that a written notice of Resident 36's transfer to the hospital was provided to the resident's representative. A nursing note for Resident 37, dated June 29, 2024, at 3:00 a.m., revealed that the resident was transferred to the hospital and admitted with altered mental status. There was no documented evidence that a written notice of Resident 9's transfer to the hospital and reason for hospitalization was provided to the resident's representative.	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 9 A nursing note for Resident 43, dated September 7, 2024, at 5:19 a.m., revealed that the resident had a fall and complained of the left hip pain. The physician was notified and the resident was sent to the hospital for an evaluation and was admitted. There was no documented evidence that a written notice of Resident 43's transfer to the hospital and reason for hospitalization was provided to the resident's representative. A nursing note for Resident 62, dated November 9, 2024, at 9:26 p.m., revealed that the resident was transferred to the hospital and admitted with a diagnosis of status epilepticus (long-acting multiple seizures). There was no documented evidence that a written notice of Resident 62's transfer to the hospital was provided to the resident's representative. Interview with the Director of Nursing on December 18, 2024, at 10:33 a.m. confirmed that the facility did not provide a written notice to the above	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 10 residents and/or their representative when the residents were transferred to the hospital and/or the reason for hospitalization. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.	F 0623		
F 0625 SS=D	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	F 0625	Past noncompliance: no plan of correction required.	Completion Date: **01/08/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0625 SS=D	Continued from page 11 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0625 SS=D	Continued from page 12 Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure that the resident and/or responsible party was notified about the facility's bed-hold policy upon transfer to the hospital for three of 37 residents reviewed (Residents 9, 37, 43). This deficiency was cited as past noncompliance. Findings include: A nursing note for Resident 9, dated August 11, 2024, at 12:17 p.m., revealed that Resident 9 had a large emesis, had acute abdominal pain, and a history of bowel obstruction (partial or complete blockage of the small or large intestine). The physician was notified, and the resident was sent to the hospital for an evaluation. He was admitted with a urinary tract infection and small bowel obstruction. There was no documented evidence that Resident 9 and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfers to the hospital.	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0625 SS=D	Continued from page 13 A nursing note for Resident 37, dated June 29, 2024, at 3:00 a.m. revealed that Resident 37 was found lying on his floor mat between the wall and bed. No injuries were noted, and he was transferred to the hospital and admitted with altered mental status. There was no documented evidence that Resident 37 and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital. A nursing note for Resident 43, dated September 7, 2024, at 5:19 a.m. revealed that the resident had a fall and complained of the left hip pain. The physician was notified and wanted the resident sent to the hospital for an evaluation and was admitted. There was no documented evidence that Resident 43 and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfers to the hospital. Interview with the Director of Nursing (DON) on December 18, 2024, at 12:50 p.m. confirmed that	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0625 SS=D	Continued from page 14 there was no documented evidence that a bed-hold notice was issued to the above residents and/or their responsible party at the time of the transfers to the hospital. The DON also revealed that the new Business Office Manager had identified this as a concern on September 9, 2024. Following the identification on September 9, 2024, that they were not providing the bed-hold notices to the resident and/or the resident's representative when the resident was transferred to the hospital, the facility's corrective actions included: The new Business Office Manager will review the transfers daily with the interdisciplinary team and will call any resident representative regarding transfers to notify them of the bed-hold policy and inform them that they will be receiving a written notice in the mail. Audits were started on all residents that were transferred to the hospital. Utilization of a binder showing the date the bed-hold	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0625 SS=D	Continued from page 15 notification was made, and a copy of the returned, signed notification from the resident representative. The results of these audits will be brought to the Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F625 on September 18, 2024. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(a) Resident Rights.	F 0625		
F 0641 SS=D		F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 16 483.20(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	1. Resident 35, 36, 48 and 60's current Minimum Data Set (MDS) assessments are accurate. Facility was unable to correct past MDS due to them being closed. 2. Review of residents with nephrostomy tubes, antibiotic ointment, insulin injections and antipsychotic medications were reviewed for accuracy. Registered Nurse Assessment Coordinator was educated on ensuring accuracy of the MDS coding with current orders. 3. Registered Nurse Assessment Coordinator or designee will audit three residents with nephrostomy tube, antibiotic ointment, insulin injections or antipsychotic medications weekly times four weeks and monthly times two months. 4. Results will be reviewed at the Quality Assurance Performance Improvement Meeting.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 17 Based on 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 four of 37 residents reviewed (Residents 35, 36, 48, 60). Findings include: The Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, revealed that Section N0300 was to indicate if the resident received any type of injection during the last seven days and Section H0100A was to indicate if the resident had a nephrostomy tube (a tube inserted through the skin into the kidney that carries urine from the kidney to the bladder). Physician's orders for Resident 35, dated October	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 18 7, 2024, included an order for the resident's nephrostomy tube site be cleansed with normal saline solution and a dry dressing applied daily. A nursing note, dated November 10, 2024, revealed that the resident had a nephrostomy catheter. Treatment Administration Records (TAR's) for Resident 35, dated November 2024, revealed that staff cleaned the resident's nephrostomy site with normal saline solution and applied a dry dressing daily from November 1 to 30, 2024. A review of the Medication Administration Records (MAR's), dated November 2024, revealed no documented evidence that Resident 35 received any injections. However, Section N0300 of Resident 35's quarterly MDS assessment, dated November 13, 2024, was coded to indicate that the resident received injections on three days during the seven-day assessment period and Section H0100A was not coded to indicate that Resident 35 had a nephrostomy tube.	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 19 The RAI manual, dated October 2024, revealed that Section N0350A was to indicate that the resident received an insulin injection during the last seven days and Section N0415F (Antibiotic - medications) was to indicate any medications the resident was taking by pharmacological classification, during the last seven days, or since admission/entry or reentry if less than seven days. Physician's orders for Resident 36, dated November 16, 2024, included orders for the resident to receive 25 units of Novolog (rapid acting insulin) subcutaneously (beneath the skin) three times a day for diabetes. Medication Administration Record's (MAR's) for Resident 36, dated November 2024, revealed that the resident received Novolog insulin as ordered from November 16 to November 30, 2024. A review of the MAR, dated November 2024, revealed no documented evidence that Resident 36 received an antibiotic during the review period. Section N050A of Resident 36's quarterly MDS	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 20 assessment, dated November 21, 2024, was not coded to indicate that the resident received insulin injections during the seven days of the assessment period and Section N0415F was coded to indicate that Resident 36 received an antibiotic during the seven days of the assessment period. Physician's orders for Resident 48, dated October 24, 2024, included orders for 2 percent Mupirocin (antibiotic) ointment be applied daily to the resident's diabetic ulcer on his right foot. Treatment Administration Records for Resident 48, dated October and November 2024, revealed that staff applied Mupirocin to the resident's diabetic ulcer on October 27 and 28, and November 1 and 2, 2024. However, Section N0415F of Resident 48's quarterly MDS assessment, dated November 2, 2024, was coded to indicate that the resident did not receive an antibiotic during the seven days of the assessment period.	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 21 Interview with the Assistant Director of Nursing on December 18, 2024, at 8:42 a.m. confirmed that the MDS assessments for Residents 35, 36 and 48 were coded incorrectly. The RAI User's Manual, dated October 2024, indicated that the intent of Section N was to record the number of days, during the seven days of the assessment period, that any type of injection, insulin, and/or select medications were received by the resident. Section N0415A1 was to be checked if the resident was taking an antipsychotic medication (drugs that treat psychotic disorders) during the last seven days or since admission/entry or reentry if less than seven days, and Section N0450A was to be coded zero (0) No if antipsychotics were not received, and coded (1) Yes if the resident received an antipsychotic medication since admission/entry or reentry, or since the prior MDS assessment, whichever was more recent. Physician's orders for Resident 60, dated	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 22 September 27, 2024, included an order for the resident to receive one five milligram (mg) tablet of Abilify (an antipsychotic medication) daily for major depressive disorder (a serious mental illness that affects how people feel, think, and act). Medication Administration Records (MARs) for Resident 60, dated November 2024, revealed that staff administered Abilify to the resident November 1 through 15, 2024. A quarterly MDS assessment for Resident 60, dated November 15, 2024, revealed that Section N0415A1 indicated that the resident received an antipsychotic medication the last seven days during the assessment period. However, Section N0450A was coded as (0) No, indicating that the resident did not receive antipsychotic medication since admission/entry or re-entry, or since the prior MDS assessment. Interview with Registered Nurse Assessment Coordinator 2 (RNAC - a registered nurse who is	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0641 SS=D	Continued from page 23 responsible for the completion of MDS assessments) on December 18, 2024, at 3:35 p.m. confirmed that Section N0450A was coded inaccurately for Resident 60, who consistently received antipsychotic medication. 28 Pa. Code 211.5(f) Clinical Records.	F 0641		
F 0657 SS=D		F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 24 483.21(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	1. Resident 28, 33, 39 and 68's care plans were updated. 2. Review of residents with central venous catheter, resolution of contact isolation, resolution of enhanced barrier precautions due to skin breakdown and new pressure ulcers were reviewed to ensure care plans were accurate. Registered Nurse Assessment Coordinator's were educated on ensuring timely updating of resident care plans is being completed. 3. Registered Nurse Assessment Coordinator or designee will audit three residents care plan with a central venous catheter, resolution of contact isolation, resolution of enhanced barrier precautions due to skin breakdown and new pressure ulcers weekly times four weeks and monthly times two months. 4. Results will be reviewed at the Quality Assurance Performance Improvement Meeting.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 25 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for four of 37 residents reviewed (Residents 28, 33, 39, 68). Findings include: The facility's policy regarding care plans, dated November 21, 2024, indicated that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs).	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 26 A quarterly MDS assessment for Resident 28, dated September 26, 2024, revealed that the resident was cognitively impaired, was understood and able to understand others, required assistance with care needs, and had a diagnosis of end-stage kidney disease. A care plan for Resident 28, dated September 29, 2024, indicated that the resident was on dialysis and was to be assessed to ensure patency for his fistula (a surgically-created connection between an artery and a vein to provide access for dialysis) by feeling for a thrill (vibration or buzzing sensation that indicates blood is flowing through a fistula) or listening for a bruit (a whooshing sound that indicates high-pressure blood flow through a fistula). Physician's orders for Resident 28, dated September 29, 2024, included an order for the resident to receive dialysis on Monday, Wednesday, and Friday. Observations of Resident 28 on December 18, 2024, at 2:02 p.m. revealed a Central Venous	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 27 Catheter (a type of vascular access that allows blood to travel to and from a dialysis machine) in the left side of his chest, and that the resident did not have a fistula for dialysis. There was no documented evidence in Resident 28's clinical record to indicate that the care plan was updated to include the care and treatment of a central venous catheter for dialysis. Interview with the Director of Nursing on December 18, 2024, at 2:28 p.m. confirmed that Resident 28's care plan was not updated to include the care and treatment of a central venous catheter for dialysis and should have been. A quarterly MDS assessment for Resident 33, dated October 25, 2024, revealed that the resident was cognitively intact, was understood and able to understand others, was dependent on staff with care needs, and had a diagnosis of multi-drug resistant organisms. A care plan for Resident 33, dated October 27, 2024, indicated that the resident was	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 28 on contact precautions (an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use) secondary to ESBL - Escherichia coli (ESBL - E. coli) (a multi-drug resistant bacteria) in her urine causing a urinary tract infection (UTI). Physician's orders for Resident 33, dated November 2, 2024, included an order that the resident was no longer on contact precautions for ESBL- E. coli. Observations during the initial tour on December 16, 2024, at 10:35 a.m. revealed that Resident 33 did not have signage on the door to indicate that contact precautions were in place. As of December 17, 2024, there was no documented evidence that Resident 33's care plan was revised/updated to reflect that her UTI due to ESBL- E. coli was resolved, and that the resident was no longer on contact precautions. Interview with the Assistant Director of	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 29 Nursing/Infection Preventionist on December 18, 2024, at 8:24 a.m. confirmed that Resident 33's UTI due to ESBL - E. coli was resolved, and the resident was not on contact precautions, and the care plans for the contact precautions and UTI due to ESBL - E. coli should have been resolved and they were not. A quarterly MDS assessment for Resident 39, dated November 14, 2024, revealed that the resident was cognitively impaired, was understood and able to understand others, required assistance with care needs, and had no pressure injuries (a localized area of skin damage caused by prolonged pressure on the skin). A care plan for Resident 39, dated August 29, 2024, indicated that the resident was on Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) secondary to a chronic wound. A care plan for Resident 39, dated September 5, 2024, indicated that the resident had	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 30 actual skin breakdown related to a Stage 2 pressure ulcer (pressure wound with superficial skin loss) to her left elbow and left hip. Physician's orders for Resident 39, dated August 29, 2024, indicated that the resident was on EBP related to a chronic wound. A wound consult note from Healing Hands Certified Registered Nurse Practitioner (CRNP - a registered nurse who has additional education and training allowing them to work under a broader scope of practice), dated September 3, 2024, indicated that Resident 39's Stage 2 pressure areas to her left elbow and left hip were resolved. Observations during the initial tour on December 16, 2024, at 10:00 a.m. revealed that Resident 39 did not have signage on the door to indicate that EBP were in place. As of December 17, 2024, there was no documented evidence that Resident 39's care plan was revised/updated to reflect that her pressure ulcers were resolved, and the resident was not on EBP.	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 31 Interview with the Assistant Director of Nursing/Infection Preventionist on December 17, 2024, at 2:39 p.m. confirmed that Resident 39's pressure ulcers were resolved, the resident was not on EBP, and the care plans for the EBP and the actual skin impairments should have been resolved and they were not. A quarterly MDS assessment for Resident 68, dated November 2, 2024, revealed that the resident was sometimes understood, could sometimes understand others, and had no pressure injuries. A care plan for the resident, dated May 1, 2024, revealed that the resident was at risk for alteration in skin integrity related to impaired mobility. A nursing note for Resident 68, dated December 2, 2024, revealed that the nurse aide reported to the licensed practical nurse that a red open area was noted to the resident's left outer ankle, measuring one centimeter (cm) by two cm by 0.5 cm. The area was an old wound that reopened.	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 32 A CRNP note for Resident 68, dated December 11, 2024, revealed that she had been consulted to follow the resident for a reopened Stage 3 pressure injury (damage extends through all layers of the skin and into the underlying fatty tissue, but does not expose muscle, tendon, or bone) to left lateral malleolus (the bone on the outside of the ankle joint, at the end of the fibula bone). The area had been resolved since October 8, 2024. However, as of December 19, 2024, there was no documented evidence that Resident 68's care plan was revised/updated to include the reopened Stage 3 pressure injury to the resident's left lateral malleolus. Interview with the Director of Nursing on December 19, 2024, at 10:26 a.m. confirmed that Resident 68's care plan was not revised/updated to include the reopened Stage 3 pressure injury to the resident's left lateral malleolus.	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0657 SS=D	Continued from page 33 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0657		
F 0658 SS=E	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	1. Resident 19, 63, 76's orders were clarified with the medical director. 2. Review of residents with tube feed flush order, midodrine hold parameter and insulin hold parameter's were reviewed. Registered Nurse's were educated on clarification of flush orders when tube feeding is discontinued and clarification of hold parameters when therapeutic interchange is made and to review midodrine hold parameters for accuracy. 3. Assistant Director of Nursing or designee will audit three residents with tube feed flush order, midodrine order or insulin with hold parameters weekly times four weeks and monthly times two months. 4. Results will be reviewed at the Quality Assurance Performance Improvement Meeting.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=E	Continued from page 34 Based on review of the Pennsylvania's Nurse Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify a questionable physician's order for three of 37 residents reviewed (Residents 19, 63, 76). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. Physician's orders for Resident 19, dated October 11, 2024, included an order for staff to flush the resident's feeding tube (a medical device that provides nutrition, fluids, and medication to people	F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=E	Continued from page 35 who are unable to eat or drink safely by mouth) with 50 milliliters (ml) of water before and after administering medications and flush with 5 ml of water between each medication administered. A nutritional note for Resident 19, dated December 3, 2024, revealed that the resident was aware of his oral intake being improved. The resident made it known that he did not want the tube feeding to be restarted. He agreed to the use of oral supplementation if needed. A progress note for Resident 19, dated December 11, 2024, revealed that a care plan meeting was held that date indicating that the resident's tube feeding was recently discontinued. Interview with Licensed Practical Nurse 3 on December 18, 2024, at 9:10 a.m. revealed that Resident 19 still has the feeding tube in place, that she does not use it for administering his medications, and that she gives all of his medications by mouth.	F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=E	Continued from page 36 Interview with Resident 19, 2024, at 9:25 a.m. revealed that he takes everything by mouth now and that they do not use the feeding tube to administer any feedings and/or medications. He indicated that he is hoping that they soon get rid of the feeding tube. There was no documented evidence that Resident 19's physician was contacted to clarify how the resident's feeding tube was to be flushed, since he does not receive his medications by the feeding tube. Interview with the Director of Nursing December 18, 2024, at 12:30 p.m. confirmed that there was no documented evidence that Resident 19's physician was contacted to clarify how the resident's feeding tube was to be flushed, since he does not receive his medications by the feeding tube. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 63, dated November 14,	F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=E	Continued from page 37 2024, indicated that the resident was cognitively intact, could understand others and was understood, and had a diagnosis of diabetes. Physician's orders for Resident 63, dated November 14, 2024, included an order for the resident to receive 14 units of insulin lispro (a fast-acting medication to help regulate blood sugar levels in persons with diabetes) at 8:00 a.m., 12:00 p.m., and 5:15 p.m. Review of Resident 63's Medication Administration Record (MAR) for November and December 2024 revealed that the resident did not receive the 14 units of insulin lispro on November 14, 2024, at 5:15 p.m.; November 15, 2024, at 5:15 p.m.; November 20, 2024, at 8:00 a.m.; November 21, 2024, at 8:00 a.m.; November 22, 2024, at 8:00 a.m.; November 23 2024, at 8:00 a.m.; November 24, 2024, at 5:15 p.m.; November 25, 2024, at 8:00 a.m.; November 26, 2024, at 8:00 a.m.; November 29, 2024, at 8:00 a.m.; November 30, 2024, at 8:00 a.m.; and December 3, 2024, at 5:15	F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=E	Continued from page 38 p.m. Interview with Assistant Director of Nursing on December 19, 2024, at 11:11 a.m. confirmed that the insulin was not given to Resident 63 on the dates and times listed above, and that previously Resident 63 had orders to hold the insulin if the blood sugar was less than or equal to 150 mg/dl. The orders were recently changed by pharmacy and signed off by the site medical director and did not include holding the insulin. The new orders should have been clarified by the physician before holding the insulin. A quarterly MDS assessment for Resident 76, dated December 6, 2024, indicated that the resident was cognitively intact and had diagnoses that included heart failure and hypotension (low blood pressure). Physician's orders for Resident 76, dated November 18 and December 2, 2024, included orders for the resident to receive 5 milligrams (mg)	F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=E	Continued from page 39 of Midodrine (a medication used for low blood pressure) with meals three times on Mondays, Wednesdays, Fridays, and Sundays, and to be given if the resident's systolic blood pressure (pressure within heart when heart is pumping) was less than 90 mmHg and to hold if the resident's systolic blood pressure was greater than 120 mmHg or above. Resident 76's Medication Administration Records (MAR's) for November and December 2024 indicated that the resident's blood pressure at 5:30 a.m. was 101/66 mmHg on November 24, 104/52 mmHg on November 25, and 114/76 mmHg on November 27; at 12:30 p.m. was 104/60 mmHg on December 9, 116/70 mmHg on December 4, 110/60 mmHg on December 9, and 116/64 mmHg on December 16; at 5:30 p.m. was 118/60 mmHg on November 20, 107/63 mmHg on November 25, 100/56 mmHg on November 27, 118/78 mmHg on December 4, and 110/74 mmHg on December 6, 2024.	F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0658 SS=E	Continued from page 40 However, according to the MAR's, staff administered Midodrine on these days when the medication order should have been clarified for what to do when the resident's systolic blood pressure was between 90 and 120 mmHg. Interview with the Assistant Director of Nursing on December 18, 2024, at 2:39 p.m. confirmed that staff should have clarified the Midodrine order with the physician when the resident's systolic blood pressure was between 90 and 120 mmHg. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0658		
F 0684 SS=E		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 41 483.25 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	1. Resident 37 did not have documented neurological assessments (neurochecks) fully completed prior to transfer to hospital. Medication error completed on resident 76, hold parameter clarified, resident notified and Medical Director notified. There were no ill effects to resident 76. 2. Licensed Staff educated on completion of neurochecks and following hold parameters for midodrine. 3. Director of Nursing or designee will review neurochecks for completion weekly times four weeks and monthly times two months. Director of Nursing or designee will audit residents with midodrine hold parameters weekly times four weeks and monthly times two months. 4. Results will be reviewed at the Quality Assurance Performance Improvement Meeting.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 42 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to complete neurological checks per protocol following a fall for one of 37 residents reviewed (Resident 37) and failed to ensure that medications were provided as ordered by the physician for one of 37 residents reviewed (Resident 76). Findings include: The facility's examination and assessment policy, dated November 21, 2024, indicated that the purpose was to examine and assess the resident for any abnormalities in their health status, one way to do this was to use a neurological assessment flow sheet. The neurological assessment form indicated that neurological checks would be completed every 15 minutes for one hour, every hour for four hours, and every four hours for 19 hours. A quarterly Minimum Data Set (MDS) assessment	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 43 (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated October 9, 2024, indicated that the resident was moderately cognitively impaired and had diagnoses that included peripheral vascular disease (a slow, progressive disorder of the blood vessels) and atrial fibrillation (an irregular heartbeat). Nursing notes indicated that on June 28, 2024, at 3:30 a.m. Resident 37 was found lying on his floor mat between the wall and bed, assessments were done, and no injury was noted. Later that day the resident did not appear to be himself, spilling his pills all over himself, presenting with right-sided weakness and pain, mouth drooping, and the inability to tell staff where he was. A neurological assessment form was started as per the facility protocol and the resident examination and assessment policy. A review of the neurological assessment form check list for Resident 37's June 28, 2024, fall revealed that the assessments were not completed as per the	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 44 facility's protocol. The facility's medication administration policy, dated November 21, 2024, indicated that medications should be given as per physicians orders. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 76, dated December 6, 2024, indicated that the resident was cognitively intact and had diagnoses that included heart failure and hypotension (low blood pressure). Physician's orders for Resident 76, dated November 9 and December 2, 2024, included orders for the resident to receive 5 milligrams (mg) of Midodrine (a medication used for low blood pressure) with meals three times on Tuesdays, Thursdays and Saturdays and to hold if the resident's systolic blood pressure (pressure within the heart when the heart is pumping) was 120 millimeters of mercury (mmHg) or above.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0684 SS=E	Continued from page 45 Resident 76's Medication Administration Records (MAR's) for November and December 2024 indicated that the resident's blood pressure at 5:30 a.m. was 141/78 mmHg on November 28 and 122/70 mmHg on November 30; at 12:30 p.m. was 138/76 mmHg on December 3, 130/74 mmHg on December 7, and 136/88 mmHg on December 12; and at 5:30 p.m. was 126/58 mmHg on November 19, 2024. However, according to the MAR's, staff administered Midodrine on these days when the medication should have been held. Interview with the Assistant Director of Nursing on December 18, 2024, at 2:39 p.m. confirmed that staff should have completed the neurological assessments for Resident 37 as per facility protocol, and the Midodrine should have been held for Resident 76 when the resident's systolic blood pressure was more than 120 mmHg. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	1. Resident 19's treatment was properly completed per physician order. Licensed Practical Nurse was educated on following physician treatment orders. 2. Licensed Staff educated on following physician treatment orders. 3. Registered Nurse Assessment Coordinator or designee will audit three treatments weekly times four weeks and monthly times two months. 4. Results will be reviewed at the Quality Assurance Performance Improvement Meeting.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0686 SS=D	Continued from page 47 Based on clinical record reviews, as well as observations and staff interviews, it was determined that the facility failed to apply dressings to pressure ulcers as ordered by the physician for one of 37 residents reviewed (Resident 19). Findings include: A significant change in status Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated December 3, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included Stage 4 Pressure Ulcer (damage extends through all layers of skin, reaching the underlying muscle, tendon, or bone, often with exposed tissue) to his left heel, and a non-stageable pressure ulcer (unable to determine the depth of the wound) to another site. A care plan for the resident, dated November 6, 2024, revealed that the resident had an actual skin breakdown to his left great toe and staff was to administer the treatment per the	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0686 SS=D	Continued from page 48 physician's orders. Physician's orders for Resident 19, dated December 13, 2024, included an order for staff to cleanse the resident's left great toe with Acetic Acid 0.25 percent (a colorless, acidic liquid with a strong vinegar-like odor used to prevent the growth of bacteria), then apply medical grade honey (used in healing wounds) then apply Calcium Alginate (a highly absorptive, non-occlusive dressing) to the base of the wound, then secure with gauze and paper tape daily. Observations of Resident 19's wound care to his left toe on December 16, 2024, at 12:51 p.m. revealed that Licensed Practical Nurse 4 washed her hands then placed the Acetic Acid 0.25 percent into two different cups and then applied clean gloves. She removed the old bandage from the resident's left great toe, placed a 4" x 4" gauze pad into the Acetic Acid 0.25 percent, and then removed the 4" x 4" gauze and cleansed the resident's left great toe. She then removed her gloves and washed her hands.	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0686 SS=D	Continued from page 49 She donned new gloves and placed a 2" x 2" dressing in the other cup containing the Acetic Acid 0.25 percent. She removed the 2" x 2" dressing from the cup containing the Acetic Acid 0.25 percent and applied the dressing to the wound on the resident's left great toe. She then placed a dry gauze over the 2" x 2" soaked Acetic Acid 0.25 percent on the resident's left great toe and then secured the dressing with paper tape. Interview with Licensed Practical Nurse 4 on December 16, 2024, at 1:18 p.m. confirmed that she did not apply the medical grade honey and Calcium Alginate as ordered by the physician to Resident 19's left great toe wound. Interview with the Assistant Director of Nursing/Infection Control Preventionist on December 16, 2024, at 2:00 p.m. confirmed that Resident 19's wound treatment to his left great toe was not completed as ordered by the physician. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0686 SS=D	Continued from page 50	F 0686		
F 0694 SS=D	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0694	1. Resident 10's intravenous (IV) flush orders, before and after medications, were clarified with the Medical Director. Resident 10 had no ill effects. 2. Residents with IV flush orders were reviewed for accuracy. Registered Nurses were educated on clarifying before and after medication administration flush orders for IVs. 3. Director of Nursing or designee will audit residents with IV orders to ensure they include flush orders for before and after medication administration weekly times four and monthly times two months. 4. Results will be reviewed at the Quality Assurance Performance Improvement Meeting.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0694 SS=D	Continued from page 51 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that an intravenous line (a medical technique that administers fluids, medications, and nutrients directly into a person's vein) was flushed in accordance with facility policy for one of 37 residents reviewed (Resident 10). Findings include: The facility's policy regarding flushing midline (a thin, flexible tube that is inserted into a vein in the upper arm to deliver intravenous fluids or medicine) and central line (a long, flexible tube that is inserted into a large vein to provide access to the heart) intravenous catheters, dated November 21, 2024, revealed that midline and central line intravenous catheters will be flushed to maintain patency, to prevent mixing of incompatible medications and solutions, and to ensure entire dose of solution or medication is administered into the venous system. Flush catheters at regular intervals to maintain	F 0694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0694 SS=D	Continued from page 52 patency and before and after following administration of medication. Use the SASH method (saline, administer medication, saline, heparin) for intermittent treatments. Physician's orders for Resident 10, dated November 14, 2024, included an order for staff to flush the peripherally inserted central catheter (PICC - a long, flexible tube that is inserted into a vein in the arm, leg, or neck and threaded into a large vein near the heart) with 10 milliliters (ml) of 0.9 percent Normal Saline (a mixture of sodium chloride (salt) and water) every shift for intravenous line patency. Physician's orders for Resident 10, dated November 14, 2024, included an order for staff to administer one gram (gm) of Ertapenem Sodium (used alone or in combination with other antibiotics to treat infections caused by bacteria in many different parts of the body) intravenously one time a day for urinary tract infection (UTI). Resident 10's Medication Administration Records	F 0694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0694 SS=D	Continued from page 53 (MAR's) for November 2024 revealed that staff administered the one gm of Ertapenem Sodium every day at 9:00 a.m. from November 15 through 24, 2024. There was no documented evidence that the resident's intravenous catheter was flushed before or after medication administration per the facility's policy on those dates. Interview with the Director of Nursing and Assistant Director of Nursing on December 18, 2024, at 11:15 a.m. confirmed that there was no documented evidence that Resident 10's IV catheter was flushed according to the facility's policy. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0694		
F 0755 SS=E	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	F 0755	Past noncompliance: no plan of correction required.	Completion Date: **01/08/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 54 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. This REQUIREMENT is not met as evidenced by:	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 55 Based on review of clinical records and facility investigations, as well as staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications (drugs with the potential to be abused) for two of 37 residents reviewed (Residents 36, 59). This deficiency was cited as past non-compliance. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 36, dated November 21, 2024, revealed that the resident was cognitively intact, was understood and understands, required assistance with care needs, had occasional pain, received pain medication routinely and as needed, and received an opioid (a controlled pain medication). Physician's orders for Resident 36, dated April 16, 2024, included and order for the resident to receive 10 milligrams (mg) of Oxycodone every six hours as	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 56 needed for pain related to chronic pain syndrome. An investigation by the facility, dated June 7, 2024, revealed that during audits for drug diversion it was noted that 60 tablets of Oxycodone 10 mg were unable to be accounted for. There were two cards containing 60 tablets each delivered on May 23, 2024, and only one of those cards could be located. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 59, dated October 26, 2024, revealed that the resident was moderately cognitively impaired, was understood and understands, required assistance with care needs, had continuous pain, received pain medication three times a day, and received an opioid (a controlled pain medication). Physician's orders for Resident 59, dated March 26, 2024, included and order for the resident to receive 5 milligrams (mg) of Oxycodone every eight hours for pain related to polyneuropathy (disease of the	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 57 nervous system causing pain, numbness and weakness). An investigation by the facility, dated May 26, 2024, revealed that during audits for drug diversion it was noted that 60 tablets of Oxycodone 5 mg were unable to be accounted for. There were two cards containing a total of 88 tablets delivered on May 8, 2024, and only one of those cards could be located. Interview with the Director of Nursing on December 17, 2024, at 12:24 p.m. confirmed that the facility was unable to locate the missing cards of pain medications for Residents 36 and 59. Following the identification of missing narcotics, the facility's corrective actions included: The facility was unable to identify a perpetrator. Drug testing was completed on licensed practical nurses that were assigned to the B wing medication cart during the time of the missing narcotics.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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=E	Continued from page 58 New narcotic accountability forms were created and placed in the accountability binders for each medication cart. Education was completed on the new narcotic accountability sheets that were placed in the narcotic accountability binders. Narcotic accountability audits would be completed weekly for three weeks , then monthly for two months, or until compliance was met. A review of the facility's corrective actions revealed that they were in compliance with F755 on June 24, 2024. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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		F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 60 483.45(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	1. Resident 2's inhaler was discarded due to being opened without being dated. Resident 63's insulin pen was discarded due to being discontinued. Medication room fridge temperature was checked and marked to be within appropriate level at time of review. Medication carts were checked and loose pills removed. 2. Medication carts were checked for inhalers and insulin pens for date and active order. Licensed Staff educated on dating open inhalers, discarding discontinued insulin pens, completing daily medication room fridge temperature and removing loose pills from medication carts. 3. Admissions Director, who is a licensed staff member, or designee will audit medication carts for undated inhalers or discontinued insulin pens weekly times four weeks and monthly times two months. Admissions Director or designee will audit medication carts to ensure no	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/09/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 61	F 0761	loose pills in the cart weekly times four weeks and monthly times two months. Assistant Director of Nursing or designee will audit medication room fridge temperature log for completion weekly times four weeks and monthly times two months. 4. Results will be reviewed at the Quality Assurance Performance Improvement Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 62 Based on review of manufacturer's instructions, facility policies, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to label multi-dose containers of inhalers with the date they were opened in one of two medication carts reviewed (B-wing med cart), failed to discard a discontinued insulin pen in one of two medication carts reviewed (B-wing med cart), failed to obtain temperatures for the medication room refrigerator on the night shift, and failed to properly secure medications in the medication cart (C-wing med cart). Findings include: Manufacturer's directions for use of Fluticasone-Salmeterol (an inhaled medication used to help open the airways and make it easier to breathe), dated April 2008, indicated to discard Fluticasone-Salmeterol diskus one month after opening the foil tray or when the counter reads "0," whichever comes first. Write the "Pouch opened"	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 63 and "Use by" dates on the label on top of the diskus. The "Use by" date is one month from date of opening the pouch. Physician's orders for Resident 2, dated August 11, 2022, included an order for the resident to inhale one puff of Advair diskus (Fluticasone-Salmeterol) 100-50 micrograms (mcg) two times daily. Observations of the B-wing medication cart on December 18, 2024, at 2:33 p.m. revealed that Resident 2 had a box, dated August 3, 2024, that contained an opened, undated Fluticasone-Salmeterol diskus. Observations at that time revealed a second undated bag for Resident 2 that contained an opened, undated Fluticasone-Salmeterol diskus. Interview with Licensed Practical Nurse 5 at the time of observation confirmed that the opened containers of Resident 2's Fluticasone-Salmeterol diskus should have been labeled with the date they were opened and they were not.	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 64 Observations of the B-wing medication cart on December 18, 2024, at 2:33 p.m. revealed that Resident 63 had an insulin Lispro (Humalog) pen, dated November 11, 2024, that was in a bag labeled Novolog insulin with three other insulin pens labeled Novolog insulin. Review of Resident 63's clinical record revealed that the resident did not have a current order for insulin Lispro (Humalog). Interview with Licensed Practical Nurse 5 at the time of observation confirmed that Resident 63 did not have a current order for insulin Lispro (Humalog) and that the insulin Lispro (Humalog) pen should have been discarded and it was not. The facility's policy regarding medication labeling and storage, dated November 21, 2024, revealed that medications requiring refrigeration between 36 and 46 degrees Fahrenheit are kept in a refrigerator with a thermometer to allow daily temperature monitoring and documentation, and that medications should be properly secured in the medication cart at	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**
STATE LICENSE NUMBER: **440702**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 65 all times. Observations in the medication room on December 17, 2024, at 9:38 a.m. revealed that the medication refrigerator contained seven different types of insulins, with a total of approximately 68 insulin pens, 15 flu pens, 11 morphine pens, one Rocephin (antibiotic) intravenous infusion, and one bottle of eye drops. Observations of the December 2024 medication temperature log sheet, located on the door of the medication refrigerator, revealed that from December 1-17 the refrigerator temperature was taken a total of six times: December 4, 5, 6, 10, 13 and 15. Interview with Registered Nurse 6 on December 17, 2024, at 9:40 a.m. confirmed that the medications stored in the refrigerator required a temperature range between 36 and 46 degrees Fahrenheit, and that staff are to check it nightly and document the temperature on the log sheet, and they did not.	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 66 Observations of the C-wing medication cart on December 17, 2024, at 9:48 a.m. revealed that there were three loose medications found at the bottom of one medication drawer: one green oval; one round, bright orange; and one brown, oblong tablet. Interview with Licensed Practical Nurse 7 on December 18, 2024, at 9:50 p.m. indicated that she cleans the medication drawers on a regular basis and was surprised that there were three loose pills found. Interview with the Assistant Director Of Nursing on December 18, 2024, at 2:44 p.m. confirmed that multi-dose containers of inhalers should be labeled with the date they are opened, unused insulins should be discarded from the medication cart, the medication refrigerator required nightly documented temperature checks, and no loose medication tablets should be in the medication cart drawers. 28 Pa. Code 211.9(a)(1) Pharmacy Services.	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 67 28 Pa. Code 211.12(d)(1) Nursing Services.	F 0761		
F 0803 SS=F	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be	F 0803	1. There were no ill effects noted to residents in the facility due to menu change. 2. Dietary Manager educated on regulation of the notification to residents of menu changes. 3. Dietician or designee will audit to ensure lunch meal is accurate to communicated menu weekly times four weeks and monthly times two months. 4. Results will be reviewed at the Quality Assurance Performance Improvement Meeting.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0803 SS=F	Continued from page 68 construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 0803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0803 SS=F	Continued from page 69 Based on review of planned, written menus, and recipes, as well as observations and staff interviews, it was determined that the facility failed to follow their pre-approved planned menu and recipes. Findings included: Review of the posted menus for the lunch meal on Thursday, December 19, 2024, revealed that residents were to receive chicken vegetable stew, spaghetti noodles, dinner roll, pineapple tidbits with cream, two-percent milk, coffee/tea, and margarine. A facility recipe card for chicken and vegetable stew, dated September 6, 2015, indicated that the chicken and vegetable stew contained the following 19 ingredients: fully cooked 1/2-inch diced chicken that was 80 percent dark and 20 percent white, chopped ham, chicken broth, baby lima beans, corn, crushed tomatoes, diced celery, chopped onions, minced garlic, ketchup, red wine vinegar, sugar, Worcestershire sauce, paprika; marjoram,	F 0803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0803 SS=F	Continued from page 70 pepper, salt, hot sauce, and margarine. Observations on December 19, 2024, at 11:46 a.m. during the lunch tray delivery revealed that the residents received a bowl containing the spaghetti noodles and the chicken vegetable stew, and a small bowl containing the pineapple tidbits. However, there was no dinner roll or margarine placed on the residents' lunch tray. Observations during a test tray on December 19, 2024, at 12:00 p.m. revealed that the Chicken Vegetable Stew did not contain any chopped ham, lima beans, crushed tomatoes, diced celery, and minced garlic, the Pineapple Tidbits did not contain a cream, and there was no dinner roll on the tray. Interview with the Dietary Manager on December 19, 2024, at 12:04 p.m. confirmed that the dinner roll and margarine were not placed on the residents' trays, and that the pineapple tidbits did not contain the cream. He indicated that the cream was to be delivered today on the truck.	F 0803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0803 SS=F	Continued from page 71 Interview with Cook 8 on December 19, 2024, at 12:25 p.m. revealed that the supply truck had not arrived yet and that he tried to make the Chicken Vegetable Stew as hardy as possible with what he had available. There was no documented evidence that the change in the menu was discussed with the resident council president. 28 Pa. Code 211.6(a) Dietary Services.	F 0803		
F 0867 SS=D		F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0867 SS=D	Continued from page 72 483.75(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	1. The Quality Assurance and Performance Improvement committee reviewed current survey deficiencies and plan of correction including audits. 2. The Quality Assurance and Performance Improvement committee reviewed previous survey/complaint deficiencies to correct deficiencies and ensure that plans to effectively address recurring deficiencies. 3. The Quality Assurance and Performance Improvement committee was educated on the Quality Assurance and Performance Improvement Plan. 4. The Quality Assurance Performance Improvement committee will review previous survey/complaint deficiencies to ensure compliance.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0867 SS=D	Continued from page 73 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0867 SS=D	Continued from page 74 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0867 SS=D	Continued from page 75 (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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0867 SS=D	Continued from page 76 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plan of correction for the State Survey and Certification (Department of Health) survey ending January 11, 2024, revealed that the facility developed plans of corrections that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending December 19, 2024, identified repeated deficiencies related to quality of care/following physician's orders, treatment of pressure ulcers, medication storage and labeling, and following infection control practices.	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0867 SS=D	Continued from page 77 The facility's plan of correction for a deficiency regarding quality of care/failure to follow physician's orders, cited during the survey ending January 11, 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 F684, revealed that the facility's QAPI committee failed to maintain ongoing compliance with the regulation regarding quality of care/following physician's orders. The facility's plan of correction for a deficiency regarding treatment of pressure ulcers, cited during the survey ending January 11, 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 F686, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding the treatment of pressure ulcers.	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0867 SS=D	Continued from page 78 The facility's plan of correction for a deficiency regarding proper storage and/or labeling of medications, cited during the survey ending January 11, 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 of medications properly. The facility's plan of correction for a deficiency regarding following infection control practices, cited during the survey ending January 11, 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 F880, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding following infection control practices.	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0867 SS=D	Continued from page 79 Refer to F684, F686, F761, F880. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0867		
F 0880 SS=E		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 80 483.80(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	1. Residents 19, 45, 47, 62 and 76 had no ill effects. Resident 76's enhanced barrier precautions were added. 2. Review of residents with central venous catheters were reviewed to ensure enhanced barrier precautions were reviewed and ensured to have enhanced barrier precautions were in place. Licensed Staff educated on following enhanced barrier precautions, hand washing following a treatment and not touching medications with bare hands. 3. Assistant Director of Nursing or designee will audit residents with central venous catheters have enhanced barrier precautions in place weekly times four weeks and monthly times two months. Registered Nurse Assessment Coordinator or designee will audit that enhanced barrier precautions during wound care and hand washing following wound care is being completed weekly times four weeks and monthly times two	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 81 (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	months. Admissions Director or designee will audit to ensure medications are not being touched with bare hands weekly times four weeks and monthly times two weeks. 4. The Quality Assurance Performance Improvement committee will review previous survey/complaint deficiencies to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 82	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 83 Based on review of established infection control guidelines, facility policies, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to 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 for three of 37 residents reviewed (Residents 19, 62, 76). Findings include: CDC guidance on Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated July 12, 2022, indicated that multidrug-resistant organism (MDRO) transmission was common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 84 intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility's policy regarding EBP, dated November 21, 2024, indicated that EBP are used as an infection prevention and control intervention to reduce the spread of MDROs to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 85 entering the room); PPE is changed before caring for another resident, and face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include dressing; bathing/showering; transferring; providing hygiene, changing linens; changing briefs or assisting with toileting; device care, and wound care (any skin opening requiring a dressing). EBP's are indicated for residents with wounds and/or indwelling medical devices. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. A significant change in status Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated December 3, 2024, revealed that the resident was understood, could understand others, had a diagnosis which included Stage 4 Pressure Ulcer (damage extends through all layers of skin, reaching	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: 440702	349 VO TECH DRIVE JOHNSTOWN, PA 15904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 86 the underlying muscle, tendon, or bone, often with exposed tissue) to his left heel, and a non-stageable pressure ulcer (unable to determine the depth of the wound) to another site. A care plan for the resident, dated November 6, 2024, revealed that the resident had an actual skin breakdown to his left great toe. A care plan, dated September 22, 2024, revealed that the resident was on EBP, and staff was to use gown and gloves during high contact activities (e.g., dressing, hygiene, toileting, transferring, bathing/ showering, changing linens, device care, wound care, therapy). Physician's orders for Resident 19, dated October 29, 2024, included an order for the resident to be on EBPs. Observations of Resident 19's wound care to his left heel and left great toe on December 16, 2024, at 12:51 p.m. revealed that Licensed Practical Nurse 4 washed her hands then placed clean gloves on; however, she did not apply a gown. She then performed the wound treatment to the resident's left	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 87 heel and left great toe. Interview with Licensed Practical Nurse 4 on December 16, 2024, at 1:18 p.m. confirmed that she did not apply a gown prior to performing Resident 19's wound treatment. She indicated that the resident was no longer on EBP because his feeding tube was discontinued. Interview with the Assistant Director of Nursing/Infection Control Preventionist on December 16, 2024, at 2:00 p.m. confirmed that Licensed Practical Nurse 4 should have applied a gown prior to performing Resident 19's wound treatment. The facility's policy regarding wound care and hand washing/hand hygiene, dated November 21, 2024, revealed that staff were to provide wound care in a manner to decrease potential for infection and/or cross-contamination. In addition, gloves should be removed and hand hygiene done prior to moving from a dirty to clean task.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 88 A significant change in status Minimum Data Set (MDS) assessment for Resident 62, dated November 24, 2024, indicated that the resident was cognitively intact, required extensive assistance from staff for care tasks, had diagnoses that included chronic obstructive pulmonary disease and stroke, and had an alteration of skin integrity related to immobility and incontinence. Physician's orders, dated December 9, 2024, included an order to cleanse the bilateral buttocks twice a day with soap and water, apply Dermagran (a vitamin enriched wound dressing), and cover with an abdominal pad. Observations of Resident 62's wound care on December 17, 2024, at 10:26 a.m. revealed that Licensed Practical Nurse 4 washed her hands and put on gloves prior to cleaning the area on the resident's right and left buttocks with a wash cloth and soap and water, she then patted the area dry with a dry wash cloth, removed her gloves, washed her hands, donned new gloves, applied Dermagran to her gloved hands, rubbed her hands together,	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 89 applied the Dermagran to the bilateral buttocks area, and covered the area with an abdominal pad. Licensed Practical Nurse 4 then turned off the resident's oxygen, adjusted her pillow, and covered her up with the sheet. She then removed her gloves and sanitized her hands. Licensed Practical Nurse 4 did not remove her gloves and wash her hands after providing wound care and before turning off the oxygen and adjusting the resident's pillow and sheets. Interview with Licensed Practical Nurse 4 on December 17, 2024, at 10:38 a.m. confirmed that she did not remove her gloves and wash her hands after Resident 62's wound care and prior to turning off the oxygen and adjusting the resident's pillow and sheets. Interview with the Assistant Director of Nursing on December 17, 2024, at 12:38 p.m. confirmed that Licensed Practical Nurse 4 should have removed her gloves and washed her hands after Resident 62's wound care, and prior to turning off the oxygen and	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 90 adjusting the resident's pillow and sheets. The facility's policy regarding medication administration, dated November 21, 2024, indicated that gloves should be worn whenever dosage forms are handled. Physician's orders for Resident 45, dated April 13, 2023, included an order for the resident to receive 81 milligrams (mg) of aspirin daily. Physician's orders for Resident 45, dated April 13, 2023, included an order for the resident to receive 50 micrograms (mcg) of cholecalciferol (vitamin D3) daily. Physician's orders for Resident 45, dated October 15, 2023, included an order for the resident to receive 8.6-50 mg of Senna-s (a laxative) twice daily. Observations during medication administration on December 17, 2024, at 7:39 a.m. revealed that Licensed Practical Nurse 9 removed the medications listed above for Resident 45 from individual bottles into his bare hands. He then	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: 440702	349 VO TECH DRIVE JOHNSTOWN, PA 15904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 91 placed them into a medication cup with Resident 45's other medications and administered them to the resident. Physician's orders for Resident 47, dated November 15, 2024, included an order for the resident to receive 1,000 mcg of vitamin B12 daily. Observations during medication administration on December 17, 2024, at 7:39 a.m. revealed that Licensed Practical Nurse 9 poured a vitamin B12 tablet for Resident 47 from a bottle into his bare hands. He then placed the medication into a medication cup with Resident 47's other medication and administered it to the resident. He returned to the medication cart and proceeded to prepare medications for Resident 45 without performing hand hygiene. Interview with Licensed Practical Nurse 9 on December 17, 2024, at 7:52 a.m. confirmed that he should have performed hand hygiene after administering medications to Resident 47 and before	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 92 preparing medications for Resident 45 and confirmed that he should not have poured the medications for Residents 45 and 47 into his bare hands. Interview with the Director of Nursing on December 17, 2024, at 11:58 a.m. confirmed that nurses should perform hand hygiene between residents when administering medications and should not place medications in ungloved, bare hands. A quarterly MDS assessment for Resident 76, dated December 6, 2024, revealed that the resident was cognitively intact, received dialysis, and had diagnoses that included renal failure. A nursing note for Resident 76, dated December 2, 2024, at 9:30 p.m. revealed that the resident was re-admitted from the hospital and had a dialysis port to her right side. A physician's order for the resident, dated December 2, 2024, included an order for staff to cover the resident's dialysis catheter with plastic wrap prior to showers. A	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0880 SS=E	Continued from page 93 physician's order, dated December 17, 2024, included an order for EBP. Observations of Resident 76 on December 16, 2024, at 9:13 a.m. revealed that the resident had no signage at the entrance to her room or in her room to indicate infection control measures for EBP were in place related to her dialysis catheter. Interview with the Assistant Director of Nursing/Infection Preventionist on December 19, 2024, at 10:27 a.m. confirmed that Resident 76 did not have EBP in place related to her dialysis catheter until December 17, 2024. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5520		P 5520		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5520	Continued from page 1 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	1. The facility will continue to take measures to adequately provide staff to ensure the needs of the residents are met. 2. The facility will continue to take measures to adequately provide staff to meet the required Certified Nursing Assistant to resident ratios. When total certified nursing assistant to resident ratios is unable to be met, the facility will reevaluate the scheduling of new admissions. The Nursing Home Administrator or designee will provide education on minimum staffing ratios to the Registered Nurse Supervisor and Scheduler who are responsible to maintain adequate staffing and staffing ratios. 3. The Nursing Home Administrator or designee will audit daily schedules to ensure minimum number of staff are scheduled to meet the needs of the residents weekly times two weeks and monthly times two months.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5520	Continued from page 2	P 5520	4. The results will be reviewed at Quality Assurance Performance Improvement meetings until substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5520	Continued from page 3 Based on review of nursing schedules and staffing information furnished by the facility, as well as staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 10 residents on the day shift for seven of 21 days reviewed for November 17 through 23, December 1 through 7, and December 12 through 18, 2024; to ensure a minimum of one NA per 11 residents on the evening shift for six of 21 days for November 17 through 23, December 1 through 7, and December 12 through 18, 2024; and failed to ensure a minimum of one NA per 15 residents on the overnight shift for 14 of 21 days for November 17 through 23, December 1 through 7, and December 12 through 18, 2024. Findings include: Review of facility census data indicated that on November 17, 2024, the facility census was 80, which required 8.00 NA's during the day shift. Review of the nursing time schedules revealed 7.45	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5520	Continued from page 4 NA's provided care on the day shift on November 17, 2024. Review of facility census data indicated that on November 22, 2024, the facility census was 80, which required 8.00 NA's during the day shift. Review of the nursing time schedules revealed 6.84 NA's provided care on the day shift on November 22, 2024. Review of facility census data indicated that on December 1, 2024, the facility census was 76, which required 7.60 NA's during the day shift. Review of the nursing time schedules revealed 7.56 NA's provided care on the day shift on December 1, 2024. Review of facility census data indicated that on December 3, 2024, the facility census was 74, which required 7.40 NA's during the day shift. Review of the nursing time schedules revealed 7.22 NA's provided care on the day shift on December 3, 2024. Review of facility census data indicated that on December 13, 2024, the facility census was 80, which required 8.00 NA's during the day shift. Review of the nursing time schedules revealed 7.91 NA's provided care on the day shift on December 13, 2024. Review of facility census data indicated that on December 17, 2024, the facility census was	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5520	Continued from page 5 82, which required 8.20 NA's during the day shift. Review of the nursing time schedules revealed 8.10 NA's provided care on the day shift on December 17, 2024. Review of facility census data indicated that on December 18, 2024, the facility census was 81, which required 8.10 NA's during the day shift. Review of the nursing time schedules revealed 8.04 NA's provided care on the day shift on December 18, 2024. Review of facility census data indicated that on November 18, 2024, the facility census was 81, which required 7.36 NA's during the evening shift. Review of the nursing time schedules revealed 6.91 NA's provided care on the evening shift on November 18, 2024. Review of facility census data indicated that on November 23, 2024, the facility census was 81, which required 7.18 NA's during the evening shift. Review of the nursing time schedules revealed 6.97 NA's provided care on the evening shift on November 23, 2024. Review of facility census data indicated that on December 2, 2024, the facility census was 75, which required	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5520	Continued from page 6 6.82 NA's during the evening shift. Review of the nursing time schedules revealed 6.47 NA's provided care on the evening shift on December 2, 2024. Review of facility census data indicated that on December 4, 2024, the facility census was 74, which required 6.73 NA's during the evening shift. Review of the nursing time schedules revealed 6.72 NA's provided care on the evening shift on December 4, 2024. Review of facility census data indicated that on December 7, 2024, the facility census was 76, which required 6.91 NA's during the evening shift. Review of the nursing time schedules revealed 6.78 NA's provided care on the evening shift on December 7, 2024. Review of facility census data indicated that on December 15, 2024, the facility census was 81, which required 7.36 NA's during the evening shift. Review of the nursing time schedules revealed 6.96 NA's provided care on the evening shift on December 15, 2024. Review of facility census data indicated that on November 17, 2024, the facility census was 80, which required 5.33 NA's during the overnight shift.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5520	Continued from page 7 Review of the nursing time schedules revealed 5.31 NA's provided care on the overnight on November 17, 2024. Review of facility census data indicated that on November 18, 2024, the facility census was 81, which required 5.40 NA's during the overnight shift. Review of the nursing time schedules revealed 5.19 NA's provided care on the overnight on November 18, 2024. Review of facility census data indicated that on November 20, 2024, the facility census was 81, which required 5.40 NA's during the overnight shift. Review of the nursing time schedules revealed 5.25 NA's provided care on the overnight on November 20, 2024. Review of facility census data indicated that on November 23, 2024, the facility census was 79, which required 5.27 NA's during the overnight shift. Review of the nursing time schedules revealed 4.28 NA's provided care on the overnight on November 23, 2024. Review of facility census data indicated that on December 1, 2024, the facility census was 76, which required 5.07 NA's during the overnight shift. Review of the nursing time schedules revealed 3.94 NA's provided care on the overnight on December	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5520	Continued from page 8 1, 2024. Review of facility census data indicated that on December 2, 2024, the facility census was 75, which required 5.00 NA's during the overnight shift. Review of the nursing time schedules revealed 3.81 NA's provided care on the overnight on December 2, 2024. Review of facility census data indicated that on December 3, 2024, the facility census was 74, which required 4.93 NA's during the overnight shift. Review of the nursing time schedules revealed 3.47 NA's provided care on the overnight on December 3, 2024. Review of facility census data indicated that on December 4, 2024, the facility census was 74, which required 4.93 NA's during the overnight shift. Review of the nursing time schedules revealed 3.88 NA's provided care on the overnight on December 4, 2024. Review of facility census data indicated that on December 5, 2024, the facility census was 75, which required 5.00 NA's during the overnight shift. Review of the nursing time schedules revealed 3.81 NA's provided care on the overnight on December 5, 2024. Review of facility census data indicated that on December 6, 2024, the facility census was	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5520	Continued from page 9 75, which required 5.00 NA's during the overnight shift. Review of the nursing time schedules revealed 4.56 NA's provided care on the overnight on December 6, 2024. Review of facility census data indicated that on December 7, 2024, the facility census was 76, which required 5.07 NA's during the overnight shift. Review of the nursing time schedules revealed 4.84 NA's provided care on the overnight on December 7, 2024. No additional excess higher-level staff were available to compensate for these deficiencies. Interview with the Nursing Home Administrator on December 19, 2024, at 1:55 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 10 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	1. The facility will continue to take measures to adequately provide staff to ensure the needs of the residents are met. 2. The facility will continue to take measures to adequately provide staff to meet the required Licensed Practical Nurses to resident ratios on all shifts. When total Licensed Practical Nurses to resident ratios is unable to be met, the facility will reevaluate the scheduling of new admissions. The Nursing Home Administrator or designee will provide education on minimum staffing ratios to the Registered Nurse Supervisor and Scheduler who are responsible to maintain adequate staffing and staffing ratios. 3. The Nursing Home Administrator or designee will audit daily schedules to ensure minimum number of staff are scheduled to meet the needs of the residents weekly times two weeks and monthly times two months.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 11	P 5530	4. The results will be reviewed at Quality Assurance Performance Improvement meetings until substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 12 Based on review of nursing schedules and staffing information furnished by the facility, as well as staff interview, it was determined that the facility failed to ensure a minimum of one Licensed Practical Nurse (LPN) per 25 residents on the day shift for two of seven days for November 17 through 23, 2024, and failed to ensure a minimum of one LPN per 40 residents on the overnight shift for two of seven days for December 12 through 18, 2024. Findings include: Review of facility census data indicated that on November 17, 2024, the facility census was 80, which required 2.00 LPN's during the day shift. Review of the nursing time schedules revealed 1.91 LPN's provided care on the day shift on November 17, 2024. Review of facility census data indicated that on November 23, 2024, the facility census was 79, which required 1.98 LPN's during the day shift. Review of the nursing time schedules revealed 1.47 LPN's provided care on the day shift on November	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395610	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RICHLAND NURSING AND REHAB STATE LICENSE NUMBER: **440702**	**349 VO TECH DRIVE** **JOHNSTOWN, PA 15904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 13 23, 2024. Review of facility census data indicated that on December 17, 2024, the facility census was 82, which required 2.05 LPN's during the overnight shift. Review of the nursing time schedules revealed 2.03 LPN's provided care on the overnight shift on December 17, 2024. Review of facility census data indicated that on December 18, 2024, the facility census was 81, which required 2.03 LPN's during the overnight shift. Review of the nursing time schedules revealed 2.00 LPN's provided care on the overnight shift on December 18, 2024. No additional excess higher-level staff were available to compensate for these deficiencies. Interview with the Nursing Home Administrator on December 19, 2024, at 1:55 p.m. confirmed that the facility did not meet the required LPN-to-resident staffing ratios for the days listed above.	P 5530		

Certified End Page

RICHLAND NURSING AND REHAB

STATE LICENSE NUMBER: 440702

SURVEY EXIT DATE: 12/19/2024

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
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