

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395812	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024
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NAME OF PROVIDER OR SUPPLIER: HILLTOP HEIGHTS HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WOODMONT ROAD JOHNSTOWN, PA 15905
STATE LICENSE NUMBER: 380502	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0550 SS=D	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and a complaint survey completed on December 12, 2024, it was determined that Hilltop Heights Health and Rehab Center 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 0550		

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

TITLE:

(X6) DATE:

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

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

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F 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	1. Unable to retroactively correct form of clothing for resident 97. 2. Baseline audit completed of residents to ensure dignity. 3. Non-clinical rounds to be completed by facility managers to make sure resident rights are met including dignity during ambulation. The Administrator/Designee will educate facility staff including therapy and agency on resident rights which includes dignity. 4. The Administrator or designee will complete dignity audits of 5 residents weekly for four weeks then monthly times one month. Identified issues will be address when found. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550		

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F 0550 SS=D	Continued from page 3 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to maintain the dignity of one of 79 residents reviewed (Resident 97). Findings include: Resident 97 was admitted to the facility on November 29, 2024, and the admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) was not completed as of December 9, 2024. An admission nursing note for Resident 97, dated November 26, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had a diagnosis of chronic ureteropelvic junction obstruction (a blockage causing loss of kidney function), and had a nephrostomy tube (a small tube inserted into the kidney through the skin in the lower back to drain urine into a drainage bag).	F 0550		

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F 0550 SS=D	Continued from page 4 Observations of Resident 97 on December 9, 2024, at 11:05 a.m. revealed that the resident was being assisted with ambulation to the therapy department by Therapy Assistant 1. While assisting Resident 97, Therapy Assistant 1 was holding on to the back of the resident's gown while the back of his brief, his legs, and drainage bag were exposed and visible. Interview with Director of Therapy on December 9, 2024, at 2:18 p.m. confirmed that Resident 97 should be wearing a form of clothing to maintain dignity while being assisted with ambulation to the therapy department. Interview with the Director of Nursing on December 9, 2024, at 2:30 p.m. confirmed that Resident 97 should have had clothing on that covered him to maintain his dignity. 28 Pa. Code 201.29(c) Resident Rights.	F 0550		
F 0610 SS=D		F 0610		

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F 0610 SS=D	Continued from page 5 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	1. Resident 39 who is understood and understands. Upon return demonstration resident 39 indicated to license nursing staff he was sliding from chair and nursing assistant attempted to prevent fall. Resident 39 signed statement indicating he was sliding from chair and nursing assistant was attempting to prevent a fall. 2. A review of incident reports for past two weeks will be reviewed to ensure a thorough investigation was completed. 3. The Interdisciplinary team will review with report of falls during morning clinical meeting to determine if further information is needed to complete fall investigation. The Director of Nursing/designee will re-educate licensed nursing staff including agency nurses on the fall management process including completion of report/investigation at time of fall. 4. To maintain and monitor compliance, a weekly audit will be	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0610 SS=D	Continued from page 6	F 0610	conducted by the Director of Nursing or designee for four weeks to make sure the incidents of falls have incident report or investigation. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	

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F 0610 SS=D	Continued from page 7 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to complete a thorough investigation of a fall to rule out neglect and/or abuse for one of 79 residents reviewed (Resident 39). Findings include: The facility's policy for protection from abuse, neglect, or exploitation, dated October 24, 2024, indicated that the facility will report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property, following federal and state regulations. There was to be immediate notification, but no later than two hours, to the facility's administrator, the Department of Health - Division of Nursing Care Facilities, Area Agency on Aging, and Protective Services if the events that caused the allegation involved abuse or resulted in serious bodily injury, and notification within 24 hours if the events that caused the	F 0610		

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F 0610 SS=D	Continued from page 8 allegation did not involve abuse and did not result in serious bodily injury. A facility policy for fall management, dated October 24, 2024, indicated that a fall is defined as unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming force. Falls will be reviewed by an interdisciplinary team and any new interventions identified will be implemented and the care plan updated as necessary. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 39, dated September 17, 2024, revealed that the resident was understood and able to understand others, was dependent on staff for chair/bed-to-chair transfers, and had diagnoses that included flaccid hemiplegia affecting his left dominant side (condition where a person has a complete lack of voluntary movement in one side of their body).	F 0610		

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F 0610 SS=D	Continued from page 9 A nurse's note for Resident 39, dated December 5, 2024, at 4:41 a.m., revealed that at 7:45 p.m. the resident was observed on the floor in his room between his bed and the window wall. There was no documented evidence that an investigation was initiated at the time of the fall to rule out abuse or neglect as a cause. Interview with the Director of Nursing on December 12, 2024, at 8:57 a.m. confirmed that she was unable to find an incident report or investigation for Resident 39's fall that occurred on December 5, 2024. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.10(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0610		
F 0623 SS=B		F 0623		

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F 0623 SS=B	Continued from page 10 483.15(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. The facility cannot retroactively address the transfer to the hospital. Resident 24 returned to the facility after their hospitalization. No residents have been refused re-admission to the facility. 2. The Interdisciplinary team will review hospital transfers during morning clinical meeting to make sure the resident/responsible party received written notice that includes the reason for transfer. The Social Service Director or designee will complete missed forms upon discovery. 3. RN Supervisors including agency, Social Services and Case Manager will be educated on the facility's policy for written notification that includes the reason for the transfer at the time of transfer. 4. The Administrator or designee will audit hospital transfers weekly for four weeks then monthly for two months for documentation providing written notifications with the reason for hospitalization. Identified issues will be address when found. Results	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0623 SS=B	Continued from page 11 (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	of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	

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F 0623 SS=B	Continued from page 12 (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		

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F 0623 SS=B	Continued from page 13 Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident, responsible party, and Ombudsman, in writing, regarding the reason for hospitalization for one of 79 residents reviewed (Resident 24). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated October 21, 2024, indicated that the resident was cognitively intact and required assistance from staff for daily care needs. A nursing note for Resident 24, dated October 12, 2024, at 5:50 a.m., revealed that the resident had a large, liquid and brown emesis (ejection of stomach contents through the mouth). The physician was notified, and the resident was transferred to the hospital.	F 0623		

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F 0623 SS=B	Continued from page 14 There was no documented evidence that a written notice of Resident 24's transfer to the hospital was provided to the resident's responsible party and the Ombudsman regarding the reason for transfer. Interview with the Director of Nursing on December 10, 2024, at 2:15 p.m. confirmed that the facility did not provide a written notice to the resident, the resident's responsible party, or Ombudsman when a resident was transferred to the hospital. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.	F 0623		
F 0625 SS=B		F 0625		

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F 0625 SS=B	Continued from page 15 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	1. Unable to retroactively provide bed hold for Resident 24. 2. The Interdisciplinary team will review hospital transfers during morning clinical meeting to determine if the bed hold policy was communicated for residents transferred to the hospital. The Social Service Director or designee will complete missed forms upon discovery along with re-education to appropriate staff member. The Director of Nursing/designee will re-educate the Registered Nurse Supervisors including agency, Social Services and Case Manager on the facility's bed hold policy. 3. To maintain and monitor compliance, a weekly audit will be conducted by the Nursing Home Administrator or designee for four weeks and monthly for 2 months on residents transferred to the hospital to determine if the bed hold policy was communicated and documented. 4. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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NAME OF PROVIDER OR SUPPLIER: HILLTOP HEIGHTS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WOODMONT ROAD JOHNSTOWN, PA 15905		
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F 0625 SS=B	Continued from page 16	F 0625	necessary.	

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F 0625 SS=B	Continued from page 17 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that appropriate parties were notified about the facility's bed-hold policy upon transfer to the hospital for one of 79 residents reviewed (Resident 24). Findings include: A facility policy for Bed Holds, dated October 24, 2024, included that the facility will track Medicaid bed hold days and notify appropriate parties via Medicaid bed hold letter for hospitalizations or therapeutic leave. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated October 21, 2024, revealed that the resident was cognitively intact and required assistance from staff for daily care needs. A nursing note for Resident 24, dated October 12,	F 0625		

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F 0625 SS=B	Continued from page 18 2024, at 5:50 a.m., revealed that the resident had a large, liquid and brown emesis (ejection of stomach contents through the mouth). The physician was notified, and the resident was transferred to the hospital. There was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfers to the hospital for Resident 24. Interview with the Director of Nursing on December 10, 2024, at 2:15 p.m. confirmed that there was no documented evidence that a bed hold notice was issued to Resident 24 or his responsible party and that it should have been. 28 Pa. Code 201.29(d) Resident Rights. 28 Pa. Code 211.5(f) Clinical Records.	F 0625		
F 0636 SS=E		F 0636		

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F 0636 SS=E	Continued from page 19 483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 0636	1. A comprehensive Minimum Data Set (MDS) assessment was completed for all residents who were identified. The completion dates for the assessments cannot be modified. 2.The facility's Registered Nurse Assessment Coordinator, or a designee, will audit the assessment reference dates of the required next annual MDS assessment or admission MDS assessment for the in-house residents. She will ensure that the Interdisciplinary Team staff involved in the assessment process are provided with the audit information to assure compliance with subsequent completion dates. 3.The members of the Interdisciplinary Team involved in the assessment process will be re-trained on the requirements and procedures for conducting comprehensive assessments by the Regional Clinical Reimbursement Specialist or a designee. 4.The Regional Clinical	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0636 SS=E	Continued from page 20 (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b) (2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 0636	Reimbursement Specialist, or a designee, will conduct audits of five random residents' annual and admission MDS assessments to ensure compliance with F636 requirements related to completion timing twice weekly times two, weekly times two and monthly times two. 5. The audit results will be reviewed in the monthly quality assurance meetings to address any identified issues promptly	

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F 0636 SS=E	Continued from page 21 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 ensure that comprehensive annual Minimum Data Set assessments were completed in the required time frame for 35 of 79 residents reviewed (Residents 4, 6, 8, 11, 14, 16, 17, 22, 23, 24, 27, 29, 32, 34, 35, 36, 42, 43, 44, 47, 58, 60, 61, 65, 66, 68, 70, 71, 74, 75, 83, 84, 85, 86, 93). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that an annual MDS assessment was to be completed no later than the assessment reference date (ARD - the last day of the assessment's look-back period) plus 14 calendar days.	F 0636		

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F 0636 SS=E	Continued from page 22 An annual MDS assessment for Resident 4, with an ARD of October 18, 2024, was due to be completed by October 31, 2024, but was not signed as completed until November 11, 2024, which was 25 days from the ARD until completion. An annual MDS assessment for Resident 6, with an ARD of November 3, 2024, was due to be completed by November 16, but was not signed as completed until November 26, 2024, which was 24 days from the ARD until completion. An admission MDS assessment for Resident 8, with an ARD of November 2, 2024, was due to be completed by November 15, but was not signed as completed until November 25, 2024, which was 24 days from the ARD until completion. An admission MDS assessment for Resident 11, with an ARD of October 10, 2024, was due to be completed by October 23, 2024, but was not signed as completed until October 25, 2024, which	F 0636		

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F 0636 SS=E	Continued from page 23 was 16 days from the ARD until completion. An admission MDS assessment for Resident 14, with an ARD of September 15, 2024, was due to be completed by September 28, 2024, but was not signed as completed until October 8, 2024, which was 24 days from the ARD until completion. An admission MDS assessment for Resident 16, with an ARD of September 23, 2024, was due to be completed by October 6, 2024, but was not signed as completed until October 7, 2024, which was 15 days from the ARD until completion. An admission MDS assessment for Resident 17, with an ARD of October 18, 2024, was due to be completed by October 31, 2024, but was not signed as completed until November 14, 2024, which was 28 days from the ARD until completion. An admission MDS assessment for Resident 22, with an ARD of October 10, 2024, was due to be completed by October 23, 2024, but was not	F 0636		

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F 0636 SS=E	Continued from page 24 signed as completed until October 25, 2024, which was 16 days from the ARD until completion. An admission MDS assessment for Resident 23, with an ARD of October 9, 2024, was due to be completed by October 22, 2024, but was not signed as completed until October 24, 2024, which was 16 days from the ARD until completion. An admission MDS assessment for Resident 24, with an ARD of September 9, 2024, was due to be completed by September 22, 2024, but was not signed as completed until September 24, 2024, which was 16 days from the ARD until completion. An admission MDS assessment for Resident 27, with an ARD of October 21, 2024, was due to be completed by November 3, 2024, but was not signed as completed until November 17, 2024, which was 28 days from the ARD until completion. An admission MDS assessment for Resident 29, with an ARD of October 24, 2024, was due to be	F 0636		

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F 0636 SS=E	Continued from page 25 completed by November 11, 2024, but was not signed as completed until November 12, 2024, which was 15 days from the ARD until completion. An admission MDS assessment for Resident 32, with an ARD of November 2, 2024, was due to be completed by November 15, 2024, but was not signed as completed until December 1, 2024, which was 30 days from the ARD until completion. An admission MDS assessment for Resident 34, with an ARD of November 6, 2024, was due to be completed by November 19, 2024, but was not signed as completed until December 2, 2024, which was 27 days from the ARD until completion. An admission MDS assessment for Resident 35, with an ARD of October 14, 2024, was due to be completed by October 27, 2024, but was not signed as completed until November 31, 2024, which was 18 days from the ARD until completion. An admission MDS assessment for Resident 36,	F 0636		

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F 0636 SS=E	Continued from page 26 with an ARD of September 10, 2024, was due to be completed by September 23, 2024, but was not signed as completed until September 25, 2024, which was 16 days from the ARD until completion. An admission MDS assessment for Resident 42, with an ARD of September 11, 2024, was due to be completed by September 24, 2024, but was not signed as completed until September 30, 2024, which was 20 days from the ARD until completion. An admission MDS assessment for Resident 43, with an ARD of October 31, 2024, was due to be completed by November 13, 2024, but was not signed as completed until December 1, 2024, which was 32 days from the ARD until completion. An admission MDS assessment for Resident 44, with an ARD of September 16, 2024, was due to be completed by September 29, 2024, but was not signed as completed until October 1, 2024, which was 16 days from the ARD until completion.	F 0636		

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F 0636 SS=E	<p>Continued from page 27</p> <p>An annual MDS assessment for Resident 47, with an ARD of November 4, 2024, was due to be completed by November 17, 2024, but was not signed as completed until November 27, 2024, which was 24 days from the ARD until completion.</p> <p>An admission MDS assessment for Resident 58, with an ARD of October 18, 2024, was due to be completed by October 31, 2024, but was not signed as completed until November 6, 2024, which was 20 days from the ARD until completion.</p> <p>An admission MDS assessment for Resident 60, with an ARD of September 25, 2024, was due to be completed by October 8, 2024, but was not signed as completed until October 9, 2024, which was 15 days from the ARD until completion.</p> <p>An admission MDS assessment for Resident 61, with an ARD of November 13, 2024, was due to be completed by November 26, 2024, but was not signed as completed until December 3, 2024, which was 21 days from the ARD until completion.</p>	F 0636		

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F 0636 SS=E	Continued from page 28 An admission MDS assessment for Resident 65, with an ARD of September 30, 2024, was due to be completed by October 13, 2024, but was not signed as completed until October 15, 2024, which was 16 days from the ARD until completion. An admission MDS assessment for Resident 66, with an ARD of October 23, 2024, was due to be completed by November 5, 2024, but was not signed as completed until November 16, 2024, which was 25 days from the ARD until completion. An annual MDS assessment for Resident 68, with an ARD of November 2, 2024, was due to be completed by November 15, 2024, but was not signed as completed until November 25, 2024, which was 24 days from the ARD until completion. An admission MDS assessment for Resident 70, with an ARD of November 5, 2024, was due to be completed by November 18, 2024, but was not signed as completed until December 2, 2024, which	F 0636		

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F 0636 SS=E	<p>Continued from page 29</p> <p>was 28 days from the ARD until completion.</p> <p>An admission MDS assessment for Resident 71, with an ARD of October 15, 2024, was due to be completed by October 28, 2024, but was not signed as completed until November 6, 2024, which was 25 days from the ARD until completion.</p> <p>An admission MDS assessment for Resident 74, with an ARD of October 29, 2024, was due to be completed by November 11, 2024, but was not signed as completed until November 19, 2024, which was 22 days from the ARD until completion.</p> <p>An admission MDS assessment for Resident 75, with an ARD of October 24, 2024, was due to be completed by November 6, 2024, but was not signed as completed until November 19, 2024, which was 27 days from the ARD until completion.</p> <p>An admission MDS assessment for Resident 83, with an ARD of November 15, 2024, was due to be completed by November 28, 2024, but was not</p>	F 0636		

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F 0636 SS=E	Continued from page 30 signed as completed until December 3, 2024, which was 19 days from the ARD until completion. An admission MDS assessment for Resident 84, with an ARD of November 8, 2024, was due to be completed by November 21, 2024, but was not signed as completed until December 2, 2024, which was 25 days from the ARD until completion. An admission MDS assessment for Resident 85, with an ARD of October 4, 2024, was due to be completed by October 17, 2024, but was not signed as completed until October 18, 2024, which was 15 days from the ARD until completion. An admission MDS assessment for Resident 86, with an ARD of September 21, 2024, was due to be completed by October 4, 2024, but was not signed as completed until October 14, 2024, which was 25 days from the ARD until completion. An admission MDS assessment for Resident 93, with an ARD of September 13, 2024, was due to	F 0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395812	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024
NAME OF PROVIDER OR SUPPLIER: HILLTOP HEIGHTS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WOODMONT ROAD JOHNSTOWN, PA 15905		
STATE LICENSE NUMBER: 380502				
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F 0636 SS=E	Continued from page 31 be completed by September 26, 2024, but was not signed as completed until September 29, 2024, which was 17 days from the ARD until completion. An interview with the Registered Nurse Assessment Coordinator (RNAC - registered nurse in charge of the MDS assessments) and the Director of Nursing on December 12, 2024, at 1:34 p.m. confirmed that the above-listed comprehensive MDS assessments were not completed within the required timeframe. 28 Pa. Code 211.5(f) Clinical Records.	F 0636		
F 0638 SS=E		F 0638		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395812	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024
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F 0638 SS=E	Continued from page 32 483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by:	F 0638	1.A quarterly Minimum Data Set (MDS) assessment was completed for all residents who were identified. The completion dates for the assessments cannot be modified. 2.The facility's Registered Nurse Assessment Coordinator, or a designee, will audit the assessment reference dates of the required next quarterly MDS assessment for the in-house residents. She will ensure that the Interdisciplinary Team staff involved in the assessment process are provided with the audit information to assure compliance with subsequent completion dates. 3.The members of the Interdisciplinary Team involved in the assessment process will be re-trained on the requirements and procedures for conducting quarterly assessments by the Regional Clinical Reimbursement Specialist or a designee. 4.The Regional Clinical Reimbursement Specialist, or a	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0638 SS=E	Continued from page 33	F 0638	designee, will conduct audits of residents' quarterly MDS assessments to ensure compliance with F638 requirements related to completion timing twice weekly times two, weekly times two and monthly times two. 5.The audit results will be reviewed in the monthly quality assurance meetings to address any identified issues promptly.	

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F 0638 SS=E	Continued from page 34 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 ensure that Quarterly Minimum Data Set assessments were completed within the required timeframe for 37 of 79 residents reviewed (Residents 1, 2, 3, 5, 9, 12, 13, 15, 18, 20, 21, 27, 28, 31, 33, 36, 37, 38, 39, 40, 45, 48, 51, 52, 54, 55, 56, 57, 59, 67, 68, 72, 73, 76, 78, 82, 85). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of residents' abilities and care needs), dated October 2024, indicated that the completion date for a quarterly assessment is the Assessment Reference Date (ARD - the last day of an assessment's look-back period) plus 14 days. A quarterly assessment is due every 92 days (ARD of	F 0638		

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F 0638 SS=E	Continued from page 35 most recent assessment + 92 days). A quarterly MDS assessment for Resident 1, with an ARD of November 2, 2024, was due to be completed on November 15, 2024; however, it was not completed until November 25, 2024, which was 10 days late. A quarterly MDS assessment for Resident 2, with an ARD of August 15, 2024, was due to be completed on August 28, 2024; however, it was not completed until September 5, 2024, which was seven days late. A quarterly MDS assessment for Resident 2, with an ARD of November 1, 2024, was due to be completed on November 14, 2024; however, it was not completed until November 20, 2024, which was six days late. A quarterly MDS assessment for Resident 3, with an ARD of August 21, 2024, was due to be completed on September 4, 2024; however, it was not completed until September 9, 2024, which was five days late.	F 0638		

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F 0638 SS=E	Continued from page 36 A quarterly MDS assessment for Resident 5, with an ARD of August 14, 2024, was due to be completed on August 27, 2024; however, it was not completed until August 30, 2024, which was three days late. A quarterly MDS assessment for Resident 5, with an ARD of October 28, 2024, was due to be completed on November 11, 2024; however, it was not completed until November 19, 2024, which was eight days late. A quarterly MDS assessment for Resident 9, with an ARD of October 18, 2024, was due to be completed on October 1, 2024; however, it was not completed until October 10, 2024, which was nine days late. A quarterly MDS assessment for Resident 12, with an ARD of September 19, 2024, was due to be completed on October 2, 2024; however, it was not completed until October 7, 2024, which was five days late.	F 0638		

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F 0638 SS=E	Continued from page 37 A quarterly MDS assessment for Resident 13, with an ARD of October 20, 2024, was due to be completed on November 2, 2024; however, it was not completed until November 12, 2024, which was 10 days late. A quarterly MDS assessment for Resident 15, with an ARD of October 1, 2024, was due to be completed on October 14, 2024; however, it was not completed until October 16, 2024, which was two days late. A quarterly MDS assessment for Resident 18, with an ARD of October 18, 2024, was due to be completed on October 31, 2024; however, it was not completed until November 11, 2024, which was 11 days late. A quarterly MDS assessment for Resident 20, with an ARD of October 25, 2024, was due to be completed on November 7, 2024; however, it was not completed until November 15, 2024, which was eight days late.	F 0638		

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F 0638 SS=E	Continued from page 38 A quarterly MDS assessment for Resident 21, with an ARD of September 25, 2024, was due to be completed on October 8, 2024; however, it was not completed until October 14, 2024, which was six days late. A quarterly MDS assessment for Resident 27, with an ARD of September 26, 2024, was due to be completed on October 9, 2024; however, it was not completed until October 15, 2024, which was six days late. A quarterly MDS assessment for Resident 28, with an ARD of September 20, 2024, was due to be completed on October 3, 2024; however, it was not completed until October 8, 2024, which was five days late. A quarterly MDS assessment for Resident 31, with an ARD of September 25, 2024, was due to be completed on October 8, 2024; however, it was not completed until October 14, 2024, which was six	F 0638		

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F 0638 SS=E	Continued from page 39 days late. A quarterly MDS assessment for Resident 31, with an ARD of October 18, 2024, was due to be completed on October 31, 2024; however, it was not completed until November 11, 2024, which was 11 days late. A quarterly MDS assessment for Resident 33, with an ARD of October 19, 2024, was due to be completed on November 1, 2024; however, it was not completed until November 11, 2024, which was 10 days late. A quarterly MDS assessment for Resident 36, with an ARD of October 5, 2024, was due to be completed on October 18, 2024; however, it was not completed until October 21, 2024, which was three days late. A quarterly MDS assessment for Resident 37, with an ARD of October 23, 2024, was due to be completed on November 6, 2024; however, it was not completed until November 14, 2024, which was eight days late.	F 0638		

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F 0638 SS=E	Continued from page 40 A quarterly MDS assessment for Resident 38, with an ARD of September 18, 2024, was due to be completed on October 1, 2024; however, it was not completed until October 7, 2024, which was six days late. A quarterly MDS assessment for Resident 39, with an ARD of September 17, 2024, was due to be completed on September 30, 2024; however, it was not completed until October 7, 2024, which was seven days late. A quarterly MDS assessment for Resident 40, with an ARD of November 6, 2024, was due to be completed on November 19, 2024; however, it was not completed until November 27, 2024, which was eight days late. A quarterly MDS assessment for Resident 45, with an ARD of November 3, 2024, was due to be completed on November 16, 2024; however, it was not completed until November 26, 2024, which was	F 0638		

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F 0638 SS=E	Continued from page 41 10 days late. A quarterly MDS assessment for Resident 48, with an ARD of September 26, 2024, was due to be completed on October 9, 2024; however, it was not completed until October 14, 2024, which was five days late. A quarterly MDS assessment for Resident 51, with an ARD of August 22, 2024, was due to be completed on September 4, 2024; however, it was not completed until September 8, 2024, which was four days late. A quarterly MDS assessment for Resident 51, with an ARD of September 25, 2024, was due to be completed on October 8, 2024; however, it was not completed until October 14, 2024, which was six days late. A quarterly MDS assessment for Resident 51, with an ARD of October 28, 2024, was due to be completed on November 10, 2024; however, it was not completed until November 18, 2024, which was eight days late.	F 0638		

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F 0638 SS=E	Continued from page 42 A quarterly MDS assessment for Resident 52, with an ARD of October 24, 2024, was due to be completed on November 6, 2024; however, it was not completed until November 15, 2024, which was nine days late. A quarterly MDS assessment for Resident 54, with an ARD of August 16, 2024, was due to be completed on August 29, 2024; however, it was not completed until September 5, 2024, which was seven days late. A quarterly MDS assessment for Resident 55, with an ARD of August 16, 2024, was due to be completed on August 29, 2024; however, it was not completed until September 5, 2024, which was seven days late. A quarterly MDS assessment for Resident 56, with an ARD of August 20, 2024, was due to be completed on September 2, 2024; however, it was not completed until September 6, 2024, which was four days late.	F 0638		

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F 0638 SS=E	Continued from page 43 A quarterly MDS assessment for Resident 57, with an ARD of November 2, 2024, was due to be completed on November 15, 2024; however, it was not completed until November 25, 2024, which was 10 days late. A quarterly MDS assessment for Resident 59, with an ARD of August 23, 2024, was due to be completed on September 5, 2024; however, it was not completed until September 9, 2024, which was four days late. A quarterly MDS assessment for Resident 67, with an ARD of November 1, 2024, was due to be completed on November 14, 2024; however, it was not completed until November 20, 2024, which was six days late. A quarterly MDS assessment for Resident 68, with an ARD of August 22, 2024, was due to be completed on September 4, 2024; however, it was not completed until September 9, 2024, which was	F 0638		

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F 0638 SS=E	Continued from page 44 five days late. A quarterly MDS assessment for Resident 72, with an ARD of August 18, 2024, was due to be completed on August 31, 2024; however, it was not completed until September 6, 2024, which was six days late. A quarterly MDS assessment for Resident 72, with an ARD of November 3, 2024, was due to be completed on November 16, 2024; however, it was not completed until November 26, 2024, which was 10 days late. A quarterly MDS assessment for Resident 73, with an ARD of August 27, 2024, was due to be completed on September 9, 2024; however, it was not completed until September 11, 2024, which was two days late. A quarterly MDS assessment for Resident 76, with an ARD of November 5, 2024, was due to be completed on November 18, 2024; however, it was not completed until November 27, 2024, which was nine days late.	F 0638		

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F 0638 SS=E	Continued from page 45 A quarterly MDS assessment for Resident 78, with an ARD of September 13, 2024, was due to be completed on September 26, 2024; however, it was not completed until September 30, 2024, which was four days late. A quarterly MDS assessment for Resident 82, with an ARD of September 13, 2024, was due to be completed on September 26, 2024; however, it was not completed until September 30, 2024, which was four days late. A quarterly MDS assessment for Resident 85, with an ARD of October 27, 2024, was due to be completed on November 9, 2024; however, it was not completed until November 19, 2024, which was 10 days late. An interview with the Registered Nurse Assessment Coordinator (RNAC - registered nurse in charge of the MDS assessments) and the Director of Nursing on December 12, 2024, at 1:34 p.m. confirmed that	F 0638		

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F 0638 SS=E	Continued from page 46 the above-listed quarterly MDS assessments were not completed within the required timeframe. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0638		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 47 483.20(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.The Minimum Data Set assessment for Resident 7 was modified to reflect the use of the pain medication. A Brief Interview for Mental Status (BIMS) observation was not completed during the look back period for Residents 33, 39 and 49. Thus, modifications of the MDS assessments could not be completed. The Minimum Data Set assessment for Resident 88 was modified to reflect the actual discharge location. 2.The facility's Registered Nurse Assessment Coordinator, or a designee, will audit the opening of the BIMS observation form associated with the assessment reference dates of the next 14 days of quarterly MDS assessments. She will ensure that the designated Interdisciplinary Team staff involved in the BIMS process are provided with the audit information to assure compliance of the observations. 3.The applicable members of the Interdisciplinary Team involved in	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395812	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024
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F 0641 SS=D	Continued from page 48	F 0641	<p>the assessment process will be re-trained on the Resident Assessment Instrument (RAI) manual coding guidance for Section A discharge location, Section C BIMS and Section J pain management by the Regional Clinical Reimbursement Specialist or a designee.</p> <p>4.The Regional Clinical Reimbursement Specialist, or a designee, will conduct audits of five random residents' MDS assessments to ensure compliance with the coding of MDS Section A discharge location, Section C BIMS and Section J pain management twice weekly times two, weekly times two and monthly times two.</p> <p>5.The audit results will be reviewed in the monthly quality assurance meetings to address any identified issues promptly.</p>	

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F 0641 SS=D	Continued from page 49 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 five of 79 residents reviewed (Residents 7, 33, 39, 49, 88). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that Section J0100B was to be checked yes if the resident was administered any as needed pain medications during the seven-day assessment period. An annual MDS assessment for Resident 7, dated November 7, 2024, indicated that the resident did not receive "as needed" pain medication during the	F 0641		

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F 0641 SS=D	<p>Continued from page 50</p> <p>seven-day assessment period. Physician's orders for Resident 7, dated September 17, 2024, included an order for the resident to receive 0.5 milliliters (ml) of morphine concentrate every two hours as needed for pain or respiratory distress.</p> <p>Review of the Medication Administration Record (MAR) for Resident 7, dated November 2024, revealed that the resident was administered 0.5 ml of morphine concentrate on November 1 at 1:20 p.m. for pain, November 5 at 5:33 a.m. for pain, and on November 6 at 4:01 p.m. for pain.</p> <p>The RAI User's Manual, dated October 2024, revealed that the intent of Section C0100 was to determine if a Brief Interview for Mental Status (BIMS) should be conducted and the intent of Section D0100 was to determine if a mood interview should be conducted. Both assessments should be conducted unless the resident is rarely or never understood.</p> <p>A quarterly MDS for Resident 33, dated October</p>	F 0641		

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F 0641 SS=D	Continued from page 51 10, 2024, indicated that the resident was able to make herself understood, had the ability to understand others, and that a BIMS and a mood interview should be conducted; however, a BIMS and mood interview were not completed on the MDS assessment. A quarterly MDS for Resident 39, dated September 17, 2024, indicated that the resident was able to make himself understood, had the ability to understand others, and that a BIMS and a mood interview should be conducted; however, a BIMS and mood interview were not completed on the MDS assessment. A quarterly MDS for Resident 49, dated October 12, 2024, indicated that the resident was usually able to make herself understood, sometimes had the ability to understand others, and that a BIMS and a mood interview should be conducted; however, a BIMS and mood interview were not completed on the MDS assessment.	F 0641		

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F 0641 SS=D	Continued from page 52 Interview with the Director of Nursing on December 12, 2024, at 11:06 a.m. confirmed that the above-mentioned MDS assessments were coded incorrectly. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that Section A2105 discharge status: The resident's discharge was to be coded the two-digit code that corresponds to the resident's discharge status. A discharge MDS for Resident 88, dated September 13, 2024, indicated that section A2105 was coded 04 short-term general hospital; however, a nursing note for Resident 88, dated September 13, 2024, indicated that resident was discharged home by transport service. All of his medication and belonging were sent with his mother.	F 0641		

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F 0641 SS=D	Continued from page 53 Interview with the Director of Nursing on December 12, 2024, at 1:35 p.m. confirmed that Resident 88 was discharged home with home health services and not to the hospital. 28 Pa. Code 211.5(f) Clinical Records.	F 0641		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 54 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	1. Resident 62 was discharged. The care plan for Resident 68 was updated. 2. The facility's Registered Nurse Assessment Coordinator and Social Worker, or designees, will audit the care plans of the in-house residents with diagnoses of post-traumatic stress disorder, dementia and Parkinson's Disease to assure they address these conditions. 3. The members of the Interdisciplinary Team involved in care planning will be re-trained on the care planning process by the Regional Clinical Reimbursement Specialist or a designee. 4. The Director of Nursing, or a designee, will conduct audits of five random residents' care plans related to the above diagnoses twice weekly times two, weekly times two and monthly times two. 5. The audit results will be reviewed in the monthly quality assurance	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0656 SS=D	Continued from page 55 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	meetings to address any identified issues promptly.	

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F 0656 SS=D	Continued from page 56 Based on clinical record reviews, as well as resident and staff interviews, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized preferences regarding Post Traumatic Stress Disorder (PTSD), Parkinson's Disease, or dementia for two of 79 residents reviewed (Residents 62, 68). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated August 7, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnosis that included Parkinson's disease. Discharge instructions for Resident 62, dated September 2, 2024, revealed that the resident was diagnosed with vascular dementia. Physician's orders for Resident 62, dated	F 0656		

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F 0656 SS=D	<p>Continued from page 57</p> <p>September 2, 2024, included an order for the resident to receive 25-250 milligrams (mg) carbidopa-levodopa three times per day (used to treat Parkinson's disease) and 5 mg donepezil nightly (for dementia).</p> <p>There was no evidence that Resident 62 had a care plan developed to address the care and treatment needs associated with his Parkinson's disease or his dementia.</p> <p>A comprehensive MDS assessment for Resident 68, dated November 2, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnosis that included PTSD.</p> <p>Admission assessment for Resident 68, dated November 1, 2023, revealed that the resident suffered from PTSD and had identified triggers.</p> <p>As of December 12, 2024, there was no care plan</p>	F 0656		

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F 0656 SS=D	Continued from page 58 developed that identified Resident 68's PTSD or his triggers. An interview with the Director of Nursing on December 12, 2024, at 9:35 a.m. confirmed that there was no care plan developed regarding Resident 62's Parkinson's disease or dementia, or Resident 68's PTSD, and there should have been. 28 Pa. Code 201.24(e)(4) Admission Policy.	F 0656		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 59 483.21(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.The care plans for the in-house cited residents were updated. 2.The facility's Interdisciplinary Team staff responsible for care planning will audit the care plans of the in-house residents against the residents' current physician order sets The care plans will be updated accordingly. 3.The members of the Interdisciplinary Team involved in care planning will be re-trained on the care planning process by the Regional Clinical Reimbursement Specialist or a designee. 4.The Director of Nursing, or a designee, will conduct audits of five random residents' care plans related to order changes twice weekly times two, weekly times two and monthly times two. 5.The audit results will be reviewed in the monthly quality assurance meetings to address any identified issues promptly.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0657 SS=D	Continued from page 60 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for three of 79 residents reviewed (Residents 7, 39, 72). Findings include: A facility policy for comprehensive care planning, dated October 24, 2024, indicated that the care planning coordinator will add minor changes in the resident's status to the existing care plan on a daily basis. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated November 7, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, was receiving hospice care, and had diagnoses that included stroke.	F 0657		

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F 0657 SS=D	Continued from page 61 A care plan for Resident 7, dated December 25, 2023, indicated that the resident was receiving antidepressant medication. A care plan, dated November 1, 2023, indicated that the resident was receiving antianxiety medication. Review of the Medication Administration Record (MAR) for Resident 7, dated December 2024, revealed no documented evidence that the resident was receiving antidepressant or antianxiety medication. Interview with The Director of Nursing on December 11, 2024, at 12:44 p.m. revealed that the resident should not have had a care plan for antidepressant and antianxiety medication because she was not receiving either. A quarterly MDS assessment for Resident 39, dated September 17, 2024, revealed that the resident was understood and able to understand others, was dependent on staff for personal care	F 0657		

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F 0657 SS=D	<p>Continued from page 62</p> <p>needs, and had diagnoses that included flaccid hemiplegia affecting his left dominant side (condition where a person has a complete lack of voluntary movement in one side of their body).</p> <p>A care plan for Resident 39, dated August 31, 2023, indicated that the resident had a self-care performance deficit. An active intervention in his care plan, dated September 14, 2023, indicated that the resident was to be transferred using a mechanical lift. An active intervention in his care plan, dated March 17, 2024, indicated that the resident preferred bed baths. An active care plan, dated August 9, 2023, revealed that the resident was receiving antipsychotic medication.</p> <p>Physician's orders for Resident 39, dated October 8, 2024, included an order that the resident be transferred with the assist of two staff.</p> <p>A nurse's note, dated April 17, 2024, at 10:30 a.m., revealed that the resident requested to have showers once a week in the evening and that he was added</p>	F 0657		

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F 0657 SS=D	Continued from page 63 to the shower schedule. Review of the MAR for Resident 39, dated December 2024, revealed no documented evidence that the resident was receiving antipsychotic medication. Interview with the Director of Nursing on December 11, 2024, at 12:26 p.m. revealed that Resident 39's care plan was not updated to reflect his current transfer status and shower preferences and should not have had a care plan for antipsychotic medication because he was not receiving any. A quarterly MDS assessment for Resident 72, dated November 3, 2024, indicated that the resident was cognitively intact, required assistance from staff for personal care needs, and had diagnoses that included diabetes and seizure disorder. A care plan for Resident 72, dated November 5, 2023, indicated that the resident had sacral,	F 0657		

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NAME OF PROVIDER OR SUPPLIER: HILLTOP HEIGHTS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WOODMONT ROAD JOHNSTOWN, PA 15905		
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F 0657 SS=D	Continued from page 64 abdominal, and right leg incision. An active intervention, dated September 13, 2024, indicated that the resident was to have wound vac (a medical treatment that uses negative pressure to promote wound healing) dressing changes completed as ordered. A nurse's note for Resident 72, dated September 23, 2024, at 2:16 p.m., indicated that the resident had new wound care orders that included discontinuing the wound vac. Interview with The Director of Nursing on December 12, 2024, at 12:10 p.m. revealed that Resident 72's care plan was not updated when his wound vac was discontinued as it should have been. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0657		

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F 0677 SS=E	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	1. Resident 62 offered shower and refused. 2. Residents were interviewed to identify shower preferences. 3. The Interdisciplinary team will review shower schedule during morning clinical meeting to determine if showers were provided or refused and documented. The Director of Nursing/designee will educate nursing staff including agency on the process of providing showers including documentation in the electronic medical record. 4. To maintain and monitor compliance, an audit of residents' showers will be completed by the Director of Nursing or designee weekly times four weeks then monthly for two month to ensure showers have been provided.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0677 SS=E	Continued from page 66 Based on clinical record reviews, resident interviews, and staff interviews, it was determined that the facility failed to ensure that dependent residents were provided with the necessary services to maintain personal hygiene, by failing to provide showers as scheduled for one of nine residents reviewed (Resident 5). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated August 7, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, required extensive assistance from staff for personal hygiene, was dependent on staff for bathing, and had diagnoses that included Parkinson's disease. The resident's current shower schedule indicated that he was to receive a shower weekly on Mondays. However, the resident's bathing records for August, September, October,	F 0677		

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F 0677 SS=E	Continued from page 67 November, and December 2024 revealed that the resident received only three showers since August 1, 2024. Interview with Resident 62 on December 9, 2024, at 11:20 a.m. revealed that he has not been getting a shower, despite asking for one. He stated that he has not been showered at least once a week and that he would like to be. Interview with the Director of Nursing on December 11, 2024, at 3:07 p.m. confirmed that there was no documented evidence regarding why Resident 62 was not getting his showers and that she talked to him and he would like to be showered at least weekly. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0677		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 68 483.25 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. Immediate intervention completed. Medication and treatment time updated to reflect specific times of administration and completion. 2. The Interdisciplinary team will review pain medications with specific times as it relates to treatment/wound care. 3. Pain medications with specific times related to a treatment will be reviewed during morning clinical meeting to determine if the physician needs contacted related to the timing of order. The Director of Nursing/designee will educate licensed nursing staff including agency on pain medication and treatments related to residents with specific times of orders. Will discuss with physician as needed. 4. To maintain and monitor compliance, a weekly audit will be conducted by the Director of Nursing or designee for four weeks then monthly for two months to ensure that physician orders are completed as ordered. Results of this audit will be reviewed by the	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0684 SS=D	Continued from page 69	F 0684	Quality Assurance and Improvement Committee for additional recommendations if necessary.	

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F 0684 SS=D	Continued from page 70 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice by failing to ensure that physician's orders were followed for one of 79 residents reviewed (Resident 7). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated November 7, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, was receiving hospice care, and had diagnoses that included stroke. Physician's orders for Resident 7, dated August 28, 2024, included an order for the resident to have her right dorsal (top) foot and right mid planter (bottom) foot cleansed with wound cleaner, swabbed with betadine (solution used to prevent infections), and secured with nonwoven gauze daily. Physician's orders,	F 0684		

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F 0684 SS=D	Continued from page 71 dated November 14, 2024, included orders for the resident to receive 15 milligrams (mg) of immediate release morphine (pain medication) 30 minutes prior to wound care every day. Review of the Medication Administration Record (MAR) for Resident 7 indicated that the morphine was scheduled for administration at 8:00 a.m. daily. However, the resident's wound care was scheduled to be completed between 6:00 a.m. and 6:00 p.m. daily. Review of Resident 7's MAR on December 11, 2024, at 8:38 a.m. revealed that the resident's morphine that was to be given prior to wound care at 8:00 a.m. was documented as administered. Observations of Resident 7 on December 11, 2024, at 10:22 a.m. revealed that staff was providing wound care to the resident's right foot. There was no documented evidence that morphine was provided 30 minutes prior to the wound care.	F 0684		

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F 0684 SS=D	Continued from page 72 Interview with Resident 7 on December 10, 2024, at 2:20 p.m. revealed that her wound care was completed at different times each day, depending on how busy the staff was. Interview with the Director of Nursing on December 11, 2024, at 3:19 p.m. confirmed that there was no documented evidence that Resident 7 received pain medication 30 minutes prior to her wound care as ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0684		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 73 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. The facility cannot retroactively address the incident. Resident 7 was not injured. 2. Residents reviewed to confirm their transfer status. The Interdisciplinary team will review changes in transfer status during morning clinical meeting to make sure the information is updated in the care plan. 3. The Director of Nursing or designee will educate the Nursing staff including agency will be educated on resident transfer status and asking for assistance if needed. 4. To maintain and monitor compliance, a weekly audit will be conducted by the Director of Nursing or designee for four weeks then monthly for two months on residents transfers to determine if the transfer status is being followed per order. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0689 SS=D	Continued from page 74 Based on a review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to safely transfer one of 79 residents reviewed (Resident 39) who required assistance from staff for transfers. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 39, dated September 17, 2024, revealed that the resident was understood and able to understand others, was dependent on staff for chair/bed-to-chair transfers, and had diagnoses that included flaccid hemiplegia affecting his left dominant side (condition where a person has a complete lack of voluntary movement in one side of their body). Physician's orders for Resident 39, dated October 8, 2024, included that the resident be transferred with the assist of two staff.	F 0689		

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F 0689 SS=D	<p>Continued from page 75</p> <p>A nurse's note for Resident 39, dated December 5, at 4:41 a.m., revealed that on December 4, 2024, at around 7:45 p.m. the resident was observed to be on the floor in his room between the bed and the window wall. He was assessed, had no injuries, and was assisted back to bed with the use of a mechanical lift.</p> <p>An undated witness statement provided by Nurse Aide 2, revealed "when I walked in the room, he was at the tip of his chair about to fall off, I attempted to put him in his bed, but his pants got stuck on the break. He had my arms so I couldn't unhook him. I then lowered him to the ground with his back against the wall."</p> <p>Interview with Resident 39 on December 11, 2024, at 8:53 a.m. revealed that he fell last week trying to get into bed. One nurse aide was helping him. He did not get hurt. Resident 39 reported that he is sometimes transferred with one staff member and sometimes transferred with two staff members and</p>	F 0689		

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F 0689 SS=D	Continued from page 76 prefers to be transferred by two staff because he feels more comfortable with two staff helping. Interview with the Director of Nursing on December 12, 2024, at 8:57 a.m. revealed that a fall re-enactment and interview with Nurse Aide 2 completed on December 11, 2024, by the facility revealed that the resident was not transferred with two staff members as ordered by the physician because Nurse Aide 2 felt the resident would have fallen out of his chair if she had not tried to transfer him to his bed. She was unable to reposition him in his chair and attempted to transfer him to his bed rather than lower him to the floor. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0689		
F 0692 SS=E		F 0692		

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F 0692 SS=E	Continued from page 77 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	1. The facility cannot retroactively address the findings. 2. Weights completed. Those with significant changes to have completion of nutrition assessment with MD and responsible party notification. 3. Director of Nursing or Designee to educate nursing staff including agency regarding weights and implementation of follow through documentation and notification. 4. Director of Nursing or Designee to complete weekly weight audits to ensure follow through of significant weight changes as well as the completion of interventions or re-evaluation of weights. Audits to be completed weekly for 4 weeks then monthly for 2 months. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0692 SS=E	Continued from page 78 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a resident's weight was obtained and documented as per facility policy for a resident with tube feedings for one of 79 residents reviewed (Resident 1) and failed to ensure that residents maintained acceptable parameters of nutritional status, by failing to ensure timely intervention for weight loss for one of 79 residents reviewed (Resident 62). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 2, 2024, indicated that the resident was rarely/never understood, was dependent on staff for all care, was receiving tube feedings (delivers liquid nutrition through a flexible tube that goes directly into your stomach), and had diagnoses that included traumatic brain injury (disruption of normal function of the brain caused by an outside force). A facility policy for residents' weights revealed that	F 0692		

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F 0692 SS=E	Continued from page 79 weights are to be obtained routinely in order to monitor nutritional health over time. Residents will be weighed monthly unless ordered otherwise by a provider. Weights will be recorded in the electronic health record. A care plan for Resident 1, dated July 14, 2023, indicated that the resident was receiving nothing by mouth, required tube feedings, and had a goal that the resident will be free of significant weight changes every month per weight reports. Review of Resident 1's weight record revealed no documented evidence that the resident's weight was obtained in January, March, May, or June 2024. Interview with the Director of Nursing on December 12, 2024, at 8:54 a.m. confirmed that Resident 1 should have been weighed monthly but was not weighed in January, March, May, or June 2024. An admission Minimum Data Set (MDS)	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395812	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0692 SS=E	Continued from page 80 assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated August 7, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnosis that included Parkinson's disease. The resident's weight records revealed that he experienced a 117.9-pound weight loss in four months when his weight dropped from 310.7 pounds on August 1, 2024, to 192.8 pounds on October 6, 2024. According to Resident 62's weight record for August 2024 through October 2024, the resident weighed 310.7 pounds on August 1, 2024; 311.5 pounds on August 6, 2024; 309.5 pounds on August 13, 2024; 202.4 pounds on August 22, 2024; 208.7 pounds on August 28, 2024; 204 pounds on September 1, 2024; 194.4 pounds on September 10, 2024; 192.9 pounds on September 17, 2024; 192.6 pounds on September 24, 2024; 192.8 pounds on October 1, 2024; and 192.8 pounds on October 6, 2024.	F 0692		

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F 0692 SS=E	<p>Continued from page 81</p> <p>A dietary note, dated August 26, 2024, indicated that the resident's weights from August 1, August 6, August 13, and August 22 were not accurate and that he would be reassessed.</p> <p>A dietary note, dated September 25, 2024, indicated that the resident had a 7.6 percent weight loss in 30 days; however, the accuracy of the weights that were obtained was questionable. There was no documented evidence that the resident's weight loss was addressed at that time.</p> <p>There was no documented evidence that any interventions were developed and implemented to prevent further unplanned weight loss for Resident 62, or that the physician was notified regarding his 117.9-pound weight loss. As of December 12, 2024, there were no further weights obtained after October 6, 2024, to assess the accuracy of previous weights obtained or to address the weight loss.</p> <p>Interview with the Director of Nursing on December</p>	F 0692		

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F 0692 SS=E	Continued from page 82 12, 2024, at 10:19 a.m. confirmed that there was no documented evidence that Resident 62's weight loss was addressed by the dietician or the physician and that it should have been. 28 Pa. Code 211.12(d)(3) Nursing Services.	F 0692		
F 0693 SS=D		F 0693		

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F 0693 SS=D	Continued from page 83 483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 0693	1. The facility cannot retroactively address the findings. 2. Weights completed. Those with significant changes to have completion of nutrition assessment with MD and responsible party notification. 3. Director of Nursing or Designee to educate nursing staff regarding weights and implementation of follow through documentation and notification. 4. Director of Nursing or Designee to complete weekly weight audits to ensure follow through of significant weight changes as well as the completion of interventions or re-evaluation of weights. Audits to be completed weekly for 4 weeks then monthly for 2 months. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0693 SS=D	Continued from page 84 Based on a review of clinical record reviews and staff interviews, it was determined that the facility failed to ensure that there was timely physician notification and intervention for a significant weight loss for residents with a tube feed (surgically implanted tube for artificial feeding) for two of 79 residents reviewed (Residents 66, 78). Findings include: The facility's policy regarding tube feeds, dated October 24, 2024, revealed that staff would maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. A quarterly Minimum Data Set (MDS a mandated assessment of a resident's abilities and care needs) assessment for Resident 66, dated November 5, 2024, revealed that the resident is severely	F 0693		

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F 0693 SS=D	<p>Continued from page 85</p> <p>cognitively impaired, requires extensive assistance from staff for all daily care needs, had diagnoses that included stroke, and had a feeding tube (tube surgically inserted into the stomach for artificial feeding). The resident's weight records, dated November 2024, revealed that he experienced a 14-pound weight loss in 15 days. On November 12, 2024, Resident 66 weighed 145 pounds and on November 27, 2024, the resident weighed 131 pounds, indicating a 14-pound weight loss in 15 days.</p> <p>There was no documented evidence that any interventions were developed and implemented to prevent further unplanned weight loss for Resident 66, or that the physician was notified regarding his 14-pound weight loss in 15 days.</p> <p>Interview with the Director of Nursing on December 12, 2024, at 10:19 a.m. confirmed that as of December 12, 2024, Resident 66's weight loss had not been addressed by the dietician or physician.</p>	F 0693		

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F 0693 SS=D	<p>Continued from page 86</p> <p>A quarterly MDS assessment for Resident 78, dated September 13, 2024, revealed that the resident is cognitively intact and required assistance from staff for all daily care needs, had diagnoses that included stroke, and had a feeding tube (tube surgically inserted into the stomach for artificial feeding). The resident's weight records, dated August 22, 2024, revealed that he experienced a 13-pound weight loss in 17 days. On August 5, 2024, Resident 78 weighed 149 pounds and on August 22, 2024, the resident weighed 136 pounds, indicating a 13-pound weight loss in 17 days.</p> <p>There was no documented evidence that any interventions were developed and implemented to prevent further unplanned weight loss for Resident 78, or that the physician was notified regarding his 13-pound weight loss in 17 days.</p> <p>Interview with the Director of Nursing on December 12, 2024, at 11:30 a.m. confirmed that as of December 12, 2024, Resident 78's weight loss had not been addressed by the dietician or physician.</p>	F 0693		

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F 0693 SS=D	Continued from page 87 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0693		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 88 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. An order for oxygen was obtained for resident 5. 2. The Interdisciplinary team will review progress notes and orders during morning clinical meeting to determine if the oxygen orders were obtained on those residents that are using oxygen. An audit was completed 12/29 to make sure those residents using oxygen have physician order. 3. Licensed Nursing staff educated on the process of monitoring those residents on oxygen have physician order in electronic record. 4. To maintain and monitor compliance, a weekly audit will be conducted by the Director of Nursing or designee for four weeks then monthly for two months on residents rounds to make sure residents on oxygen have appropriate order. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0695 SS=D	Continued from page 89 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to obtain a physician's order for oxygen therapy for one of 79 residents reviewed (Resident 5). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated October 28, 2024, revealed that the resident had moderate cognitive impairment, required assistance from staff for care needs, and had diagnoses that included chronic respiratory failure. A care plan for Resident 5, dated July 26, 2024, indicated that the resident required oxygen therapy for chronic respiratory failure, and that staff were to explain the importance of keeping the oxygen at the prescribed setting, stressing more oxygen may not be better.	F 0695		

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F 0695 SS=D	Continued from page 90 Observations of Resident 5 on December 9, 2024, at 10:50 a.m. and December 12, 2024, at 12:59 p.m. revealed that the resident was sitting in her wheelchair in the hallway with oxygen being administered at four liters per minute. Observations on December 11, 2024, at 8:42 a.m. revealed that the resident was lying in bed with oxygen being administered at four liters per minute. Review of clinical records for Resident 5, including physicians' orders and treatment administration records, revealed no documented evidence that physician's orders were obtained for the resident's oxygen therapy. Interview with Director of Nursing on December 12, 2024, at 1:12 p.m. confirmed that there was no documented evidence that a physician's order was obtained for Resident 5's use of oxygen. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0695		

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F 0697 SS=D	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0697	<ol style="list-style-type: none"> The Director of Nursing contacted the pharmacy regarding resident 62 and the Butrans patch were delivered the same day. Baseline audit of pain medication completed. The Interdisciplinary team will review administration of pain medications during morning clinical meeting to determine pain medication effectiveness or need for further evaluation of treatment. The Director of Nursing /designee will educate licensed nursing staff including agency on the process for medication availability during a medication pass. To maintain and monitor compliance, a weekly audit will be conducted by the Director of Nursing or designee for four weeks, then monthly for two months, to ensure resident's pain medications are available or the physician has been notified to obtain further recommendations. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary. 	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0697 SS=D	Continued from page 92 Based on review of policies, a pharmacy delivery schedule, a list of emergency medications kept at the facility, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to provide pain management for one of 22 residents reviewed (Resident 62). Findings include: The facility's policy regarding pain management, dated January 14, 2019, indicated that staff would implement the pain management program, including evaluation/re-evaluation for residents experiencing either acute or chronic pain. The policy also indicated that "pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does." Staff were to obtain information from the evaluation process to determine what level of pain will interfere with the resident's quality of life and prohibit him/her from carrying out normal life activities.	F 0697		

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F 0697 SS=D	<p>Continued from page 93</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated August 7, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, required extensive assistance from staff for personal hygiene, had moderate pain occasionally, and had diagnoses that included Parkinson's disease. Current physician's order for Resident 62 included an order for 10 micrograms/hour (mcg/hr) Butran's patch (pain patch), change every seven days for pain.</p> <p>Resident 62's Medication Administration Record (MAR), dated December 2024, revealed that the Butran's patch was not available on December 4 or December 11, 2024; therefore, the resident had not had a pain patch on since November 27, 2024.</p> <p>An interview with Resident 62 on December 9, 2024, at 11:32 a.m. revealed that he has pain frequently and does not get relief from his current medications. He stated that the last two weeks he</p>	F 0697		

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F 0697 SS=D	Continued from page 94 had more pain than usual. There was no documented evidence that nursing staff made efforts to provide effective pain management for Resident 62 when his pain patches were not available. Interview with the Director of Nursing on December 12, 2024, at 10:21 a.m. revealed that she called the pharmacy and there was a problem with Resident 62's insurance. They stated that the Butran's patches would be sent to the facility that evening for the resident. She stated there was no evidence that the staff offered the resident any other pain medication for relief. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0697		
F 0730 SS=D		F 0730		

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F 0730 SS=D	Continued from page 95 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	1. Performance evaluation completed on Nurse Aide 3, Nurse Aide 4 and Nurse Aide 5. 2. An audit was done to monitor the completion of Nurse Aide evaluations. Hire dates will be reviewed monthly by the Director of Nursing. 3. The Nursing Home Administrator will educate RN Supervisors and the Director of Nursing on the evaluation process for Nurse Aides. 4. To maintain and monitor compliance, a weekly audit will be conducted by the Nursing Home Administrator or designee for four weeks then monthly for two months on the completion of Nurse Aide performance evaluation. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0730 SS=D	<p>Continued from page 96</p> <p>Based on review of personnel files, as well as staff interviews, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed annually, based on hire dates, for three of three nurse aides reviewed (Nurse Aide 3, Nurse Aide 4, Nurse Aide 5).</p> <p>Findings include:</p> <p>A list of nurse aides provided by the facility revealed that based on their months and days of hire, an annual performance evaluation for Nurse Aide 3 was due July 1, 2024. As of December 12, 2024, there was no documented evidence that the annual performance evaluation was completed as required for Nurse Aide 3.</p> <p>A list of nurse aides provided by the facility revealed that based on their months and days of hire, an annual performance evaluation for Nurse Aide 4 was due July 1, 2024. As of December 12, 2024, there was no documented evidence that the annual performance evaluation was completed as required</p>	F 0730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395812	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024	
NAME OF PROVIDER OR SUPPLIER: HILLTOP HEIGHTS HEALTH & REHAB CENTER STATE LICENSE NUMBER: 380502		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WOODMONT ROAD JOHNSTOWN, PA 15905		
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F 0730 SS=D	Continued from page 97 for Nurse Aide 4. A list of nurse aides provided by the facility revealed that based on their months and days of hire, an annual performance evaluation for Nurse Aide 5 was due July 1, 2024. As of December 12, 2024, there was no documented evidence that the annual performance evaluation was completed as required for Nurse Aide 5. Interview with the Nursing Home Administrator on December 12, 2024, at 12:45 p.m. confirmed that there was no evidence that the annual performance evaluation for Nurse Aide 3, Nurse Aide 4, and Nurse Aide 5 was completed as required. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 201.20(a)(c) Staff Development.	F 0730		

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F 0755 SS=D	<p>483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records</p> <p>§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§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.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0755	<ol style="list-style-type: none"> The Pharmacy confirmed Lorazepam was not sent for Resident 76. No medication disposition for destruction would be indicated for a medication not received by facility. A baseline audit was completed to make sure accountability for controlled medications is complete. The Director of Nursing/designee will educate nursing staff including agency on the process of maintaining accountability for controlled medications with corresponding documentation. To maintain and monitor compliance, a weekly audit will be conducted by the Director of Nursing or designee for four weeks then monthly for two months to make sure accountability is maintained for controlled medications. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary. 	<p>Completion Date: 01/14/2025</p> <p>Status: APPROVED</p> <p>Date: 01/03/2025</p>

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F 0755 SS=D	Continued from page 99	F 0755		

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F 0755 SS=D	Continued from page 100 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 76 residents reviewed (Resident 89). Findings include: The facility's policy regarding controlled substance disposal, dated October 24, 2024, indicated that the destroying/disposal of controlled drugs should be conducted according to federal and state regulations. Destruction of controlled medications should be documented on the controlled medication count sheet and signed by the registered nurse and a witnessing licensed professional. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 89, dated October 27, 2024, revealed that the resident was cognitively impaired, received an antianxiety medication, and had diagnoses that included Metabolic	F 0755		

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F 0755 SS=D	<p>Continued from page 101</p> <p>Encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood the affects the brain).</p> <p>Physician's orders for Resident 89, dated October 28, 2024, included an order for the resident to receive 1 milligram (mg) of Lorazepam (an antianxiety medication) every four hours as needed for anxiety and restlessness.</p> <p>The Medication Administration Record (MAR) for Resident 89, dated October 2024, revealed that there was no documentation to indicate that the resident received any doses of Lorazepam. As of December 12, 2024, there was no controlled drug count record (tracks each dose of a controlled medication). Resident 89 ceased to breath on October 29, 2024, and there was no documentation that Lorazepam was destroyed or disposed of per facility policy.</p> <p>Interview with the Director of Nursing on December 12, 2024, at 11:30 a.m. confirmed that there was no</p>	F 0755		

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F 0755 SS=D	Continued from page 102 documentation the Lorazepam was destroyed or disposed of and there should have been. 28 Pa. Code 211.9(a)(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0755		
F 0756 SS=D		F 0756		

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F 0756 SS=D	Continued from page 103 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	<ol style="list-style-type: none"> 1. Physician to review medication recommendation with resident. 2. A baseline audit was completed for pharmacy recommendations. 3. The Director of Nursing/designee will educate nursing staff including agency on the process of following through with pharmacy recommendations. 4. To maintain and monitor compliance, a weekly audit will be conducted by the Director of Nursing or designee for four weeks then monthly for two months to ensure follow through of pharmacy recommendations. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary. 	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0756 SS=D	Continued from page 104 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

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F 0756 SS=D	Continued from page 105 Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to respond timely to a pharmacy recommendation for one of 79 residents reviewed (Resident 72). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 72, dated November 3, 2024, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, received routine and as needed pain medication, and had diagnosis that included diabetes. Review of a pharmacy Medication Regimen Review (MRR) recommendation for Resident 5, dated July 7, 2024, recommended that the physician consider ordering Senna (stimulant laxative to treat constipation) once daily at bedtime, while continuing to monitor for signs and symptoms of constipation.	F 0756		

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F 0756 SS=D	Continued from page 106 There was no documented evidence that the pharmacy recommendation was reviewed by the physician. Interview with the Director of Nursing on December 12, 2024, at 1:38 p.m. confirmed that there was no documented evidence that the physician addressed the pharmacy MRR for Resident 72 and should have. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0756		
F 0803 SS=E		F 0803		

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F 0803 SS=E	Continued from page 107 483.60(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 construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 0803	1. The facility cannot retroactively address the findings. 2. Baseline audit of menus completed. 3. Dietary manager to educate dietary staff on menus, production sheets and recipes. Nursing staff to be educated on resident menus. 4. Weekly audits completed by contract Certified Dietary Manager or designee for 4 weeks then monthly for 2 months to ensure menus, spreadsheets and recipes are followed. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0803 SS=E	Continued from page 108	F 0803		

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F 0803 SS=E	<p>Continued from page 109</p> <p>Based on review of the facility's written menus, as well as observations and staff interviews, it was determined that the facility failed to follow their planned menu.</p> <p>Findings include:</p> <p>The facility's policies regarding menu planning, as well as sanitization, dated October 24, 2024, indicated that regular and therapeutic menus will be written to provide a variety of foods served on different days of the week, adjusted for seasonal changes, and in adequate amounts at each meal to satisfy recommended daily allowances.</p> <p>The facility's written and posted weekly menu for the lunch meal on December 8, 2024, revealed that the residents were to receive baked fish. The recipe of baked cod, undated, indicated that the cod filets were to be baked with margarine, salt, and white pepper.</p> <p>A test tray completed on November 11, 2024, at</p>	F 0803		

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F 0803 SS=E	Continued from page 110 12:12 p.m. revealed that the pureed baked fish was snow white in color when compared to the regular diet portion of baked fish, and there were no seasonings added to the pureed fish. The regular diet portion of baked fish had visible seasonings and margarine added. The pureed baked cod was bland tasting and was not as flavorful. Interview with the Corporate Dietary Director on December 11, 2024, at 2:20 p.m. confirmed that the pureed baked cod should have been prepared with the same ingredients, and that seasoning may not have been added to the pureed fish, as it appeared to be whiter in color compared to the regular portion of baked fish. 28 Pa. Code 211.6(a) Dietary Services. 28 Pa. Code 201.29(j) Resident Rights.	F 0803		
F 0804 SS=E		F 0804		

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F 0804 SS=E	Continued from page 111 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	1. The facility cannot retroactively address the findings. 2. Baseline audit completed regarding temperature and palatability. 3. Dietary Manager to educate dietary staff on serving meals at proper temperature. Nursing staff educated on the timing of meal service. 4. Contract Contracted Dietary Manager/designee to complete food temperature audits/test during tray line weekly x 4 weeks, then monthly for 2 months. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0804 SS=E	Continued from page 112 Based on observations, as well as resident and staff interviews, it was determined that the facility failed to serve food items that were palatable. Findings include: Interview with a group of residents on December 10, 2024, at 11:15 a.m. revealed that the food delivered to the resident rooms was served cold. Observations in the kitchen for the lunch meal service on December 11, 2024, at 11:58 a.m. revealed that a test tray left the kitchen and arrived on the North hall at 12:00 p.m. The lunch meal on December 11, 2024, consisted of baked fish, broccoli rice casserole, jello, milk, and coffee. The pureed meal had pureed broccoli noodles instead of the casserole. Trays were passed to the residents in their rooms and the last resident was served and eating at 12:12 p.m. The test tray on December 11, 2024, at 12:12 p.m. revealed that the temperature of the baked fish was 114.2 degrees Fahrenheit (F), the pureed baked fish was 104.2 degrees F, the	F 0804		

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NAME OF PROVIDER OR SUPPLIER: HILLTOP HEIGHTS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WOODMONT ROAD JOHNSTOWN, PA 15905		
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F 0804 SS=E	Continued from page 113 pureed broccoli was 102 degrees F, the pureed noodles was 105.3 degrees F, the broccoli rice casserole was 128.5 degrees F, the jello was 46.4 degrees F, the milk was 43.3 degrees F, and the coffee was 116.6 degrees F. The baked cod, pureed cod, pureed noodles, and pureed broccoli were cool and unappetizing. Interview with the Corporate Dietary Manager on December 11, 2024, at 12:20 p.m. confirmed that foods should be served to residents at proper and palatable temperatures. 28 Pa. Code 211.6(b) Dietary Services.	F 0804		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 114 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. The facility cannot retroactively address the findings. 2. Baseline audit to be completed of kitchen food storage and preparation. 3. Contracted Dietary Manager to educate staff on proper food storage, handling, preparation and distribution to residents. 4. Contracted Dietary Manager/designee to complete weekly sanitation audits to ensure food is received, stored, prepared, served and distributed in accordance with food safety regulations. Audits to be completed weekly for 4 weeks then monthly for 2 months. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0812 SS=E	Continued from page 115 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that food was stored and prepared under sanitary conditions. Findings include: The facility's policies regarding storage of refrigerated foods, as well as sanitization, dated October 24, 2024, indicated that food would be stored in order to maximize food safety and quality, all refrigerated foods prepared and held for more than 24 hours would be marked to indicate the date the food would be consumed or discarded by, and that temperatures for refrigeration were to be between 35 to 39 degrees Fahrenheit with thermometers checked at least twice a day. Observations in the main kitchen on December 9, 2024, at 8:47 a.m. revealed that the walk-in refrigerator had three bags of brussel sprouts with one bag that had a use-by date of November 19, 2024, and the other two had a use-by date of	F 0812		

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F 0812 SS=E	Continued from page 116 November 25, 2024. The brussel sprouts appeared discolored and had increased moisture in the bags. There was an undated silver tray of cooked chicken tenders, and a bag of cilantro that appeared discolored and had increased moisture in the bag that was dated as opened October 23, 2024, and a use by date of November 7, 2024. Interview with Cook/Dietary Aide 6 on December 9, 2024, at 8:58 a.m. confirmed that the chicken tenders should have been dated when prepared and that the expired food should have been discarded. The facility currently did not have a dietary manager and the dietitian and the corporate dietary manager were handling kitchen tasks. Observations in the main kitchen on December 9, 2024, at 9:02 a.m. revealed that there was a large stand mixer with dried, yellow food debris on the bowel and mixing attachment. The meat slicer had dried food debris as well. Interview with Cook/Dietary Aide 6 on December 9, 2024, at 9:04 and 9:20 a.m. confirmed that neither machine	F 0812		

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F 0812 SS=E	<p>Continued from page 117</p> <p>was used that morning, were covered in plastic, and needed cleaned.</p> <p>Observations of the dry storage in the main kitchen on December 9, 2024, at 9:07 a.m. revealed that there was a large container of flour on the shelf. There was no lid and the flour was exposed to air. There were two boxes of food (a box of rolled oats and a box of canned mandarin oranges) sitting directly on the floor. Interview with the dietitian on December 9, 2024, at 9:17 a.m. confirmed that there should be no food on the floor and the flour should be covered.</p> <p>Observations of the dry storage in the main kitchen on December 10, 2024, at 2:01 p.m. revealed that there was no thermometer in the milk cooler. Interview with Corporate Dietary Manager on December 9, 2024, at 2:05 p.m. confirmed there was no thermometer in the milk cooler, and after searching, it was found in another cooler.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>	F 0812		

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F 0812 SS=E	Continued from page 118	F 0812			
F 0867 SS=D		F 0867			

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F 0867 SS=D	Continued from page 119 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	The center recognizes the need for the implementation of and the maintenance of effective Quality Assessment and Assurance/ Quality Assurance and Process Improvement activities to sustain system compliance. 2. Current residents and new admissions have the potential to be affected. The facility Quality Assurance and Process Improvement committee will conduct a root cause analysis to determine steps to implement and sustain systemic correction as it relates to the cited deficiencies. 3. To prevent recurrence, the Nursing Home Administrator and Director of Nursing will be reeducated on the policy for Quality Assessment and Assurance/Quality Assurance and Process Improvement including sustaining systemic correction by the Regional Director of Clinical Services or designee.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

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F 0867 SS=D	Continued from page 120 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	4. To monitor and maintain compliance, the facility Quality Assurance and Process Improvement committee will conduct a weekly review of plan of correction audits and make recommendations as needed.	

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F 0867 SS=D	Continued from page 121 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=D	Continued from page 122 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 0867		

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F 0867 SS=D	Continued from page 123 Based on review of the facility's plans of correction and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) surveys ending January 18, 2024; February 23, 2024; June 19, 2024; September 19, 2024; and October 21, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending December 12, 2024, identified repeated deficiencies related to failure provide notice of bed hold policy, failure to complete comprehensive assessments timely, failure to develop resident care plans, failure	F 0867		

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F 0867 SS=D	Continued from page 124 to provide activities of daily living care to dependent residents, failure to provide quality of care, failure to provide feeding tube management, failure to maintain a complete and accurate account of controlled medications, failure to label and store drugs and biologicals, and failure to provide menus prepared in advance and menus followed to meet residents' needs The facility's plan of correction for a deficiency regarding bed hold notices, cited during the surveys ending January 18, 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 F625, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding notification of a bed hold notices. The facility's plan of correction for a deficiency regarding the timely completion of comprehensive assessment, cited during the survey ending January	F 0867		

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F 0867 SS=D	Continued from page 125 18, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F636, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding timely comprehensive assessments. The facility's plans of correction for deficiencies regarding developing and implementing comprehensive care plans, cited during the surveys ending January 18, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the regulation regarding developing and implementing comprehensive care plans. The facility's plan of correction for a deficiency regarding activities of daily living care to dependent residents, cited during the surveys ending February	F 0867		

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F 0867 SS=D	Continued from page 126 23, 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 F677, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding activities of daily living care to dependent residents. The facility's plan of correction for a deficiency regarding quality of care, cited during the surveys ending January 18, 2024 and September 19, 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 was ineffective in maintaining compliance with the regulation regarding quality of care. The facility's plan of correction for a deficiency regarding feeding tube management, cited during the surveys ending January 18, 2024, revealed that the facility would complete audits and report the results	F 0867		

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F 0867 SS=D	Continued from page 127 of the audits to the QAPI committee for review. The results of the current survey, cited under F693, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding feeding tube management. The facility's plan of correction for a deficiency regarding failure to maintain a complete and accurate accounting of controlled medications, cited during the survey ending January 18, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding maintaining a complete and accurate accounting of controlled medications. The facility's plan of correction for a deficiency regarding menus being prepared in advance and followed to meet residents' needs, cited during the survey ending October 21, 2024, revealed that the	F 0867		

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F 0867 SS=D	Continued from page 128 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 F803, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding menus being prepared in advance and followed to meet residents' needs. Refer to F625, F636, F656, F677, F684, F693, F755, F803. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0867		
F 0908 SS=D		F 0908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395812	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024
NAME OF PROVIDER OR SUPPLIER: HILLTOP HEIGHTS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WOODMONT ROAD JOHNSTOWN, PA 15905		
STATE LICENSE NUMBER: 380502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0908 SS=D	Continued from page 129 483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 0908	1. The facility in the process of obtaining quotes for repair or replacement. Other equipment being used to prepare food. 2. Contracted Dietary Manager/designee to report equipment in need of repair to and in need of maintenance to maintenance director and NHA 3. Dietary educated to report concerns as needed. 4. Contracted Dietary Manager or designee to monitoring operating equipment weekly for 4 weeks then monthly for 2 months. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395812	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024	
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F 0908 SS=D	Continued from page 130 Based on review of manufacturer's direction for use, as well as observations and staff interviews, it was determined that the facility failed to ensure essential equipment was in safe operating condition in the facility's main kitchen. Findings include: Observations in the main kitchen on December 9, 2024, at 8:47 a.m. revealed that the steamer had a note that it was broken and not to use it. Interview with the Corporate Dietary Manager on December 10, at 1:38 p.m. revealed that she has been with the company for about one and a half years and the steamer has not worked since she has been there. The steamer was not repairable and the facility was in the process of reordering a new one. Interview with the Nursing Home Administrator on December 11, 2024, at 3:15 p.m. confirmed that the steamer was not functioning and that the facility was currently receiving price quotes about	F 0908		

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F 0908 SS=D	Continued from page 131 purchasing a new steamer. 28 Pa. Code 207.2 (a) Administrator's Responsibility.	F 0908			

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P 5280	<p>Pharmacy services.</p> <p>(j.1) The facility shall have written policies and procedures for the disposition of medications that address all of the following:</p> <p>(1) Timely and safe identification and removal of medications for disposition.</p> <p>(2) Identification of storage methods for medications awaiting final disposition.</p> <p>(3) Control and accountability of medications awaiting final disposition consistent with standards of practice.</p> <p>(4) Documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition.</p> <p>(5) A method of disposition to prevent diversion or accidental exposure consistent with applicable Federal and State requirements, local ordinances and standards of practice.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5280	<p>1. The facility is unable to retroactively correct the disposition of medications for resident 89.</p> <p>2. Review will be completed of residents discharged 12/15-12/31/24 from the facility or discharged from the hospital to ensure a medication disposition was completed and identified issues will be corrected.</p> <p>3. The facility discharges will be reviewed at morning clinical meeting to ensure the medication dispositions have been completed. Director of Nursing or designee will educate the RN Supervisors including agency on the medication disposition practice and their responsibility to document the disposition when there is a discharge from the facility.</p> <p>4. The Director of Medical Records or designee will audit medication disposition on facility discharge weekly for four weeks then monthly for month. Identified issues will be address when found. Results of this audit will be reviewed by the Quality Assurance and Improvement Committee for additional recommendations if necessary.</p>	<p>Completion Date: 01/14/2025</p> <p>Status: APPROVED</p> <p>Date: 01/03/2025</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395812	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024
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P 5280	Continued from page 1 Based on a review of facility policies and closed records, as well as interviews with staff, it was determined that the facility failed to document the disposition of medications and/or the quantity of drugs disposed for one of three closed clinical records reviewed (Resident 89). Findings include: The facility's policy for discharge medications, dated October 24, 2024, indicated that the nurse was to complete a medication disposition record, which included the amount or quantity of each medication and the nurse releasing the medication. A nursing note for Resident 89, dated October 29, 2024, indicated that the resident ceased to breathe. There was no documented evidence in the clinical record of the disposition of medications and/or the quantity upon death. Interview with the Director of Nursing on December	P 5280		

Pennsylvania Department of Health

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P 5280	Continued from page 2 12, 2024, at 11:30 a.m. confirmed that there was no documented evidence of the disposition of medications for Resident 89, and that there should have been.	P 5280			



Certified End Page

HILLTOP HEIGHTS HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 380502

SURVEY EXIT DATE: 12/12/2024

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, 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