STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 45139 Based on interviews, pertinent document reviews and observations it was determined that the facility failed to respond in a timely manner to a resident request for assistance. This was evident for 2 (Resident #24, #18) observed during a random observation on Nursing unit 1. The findings include: On 11/8/24 during a phone interview the facility ombudsman reported that she had received numerous complaints regarding the time it took for facility staff to respond to the residents calls for assistance. She reported the concerns of alleged call response times as 45-60 minutes. On 11/12/24 the intakes #MD00194596, #MD00208397, and # MD00208682 were reviewed. The review revealed concerns regarding the time it took for the staff to answer the residents' requests for assistance. On 11/14/24 at 1:05 PM the Surveyors were invited to attend a resident council meeting. During the meeting the residents voiced concerns that the call light system had not always functioned properly and sometimes they (the residents) had to wait 30-40 minutes for the call light to be answered. On 11/19/24 at 10:53 AM the Director of Maintenance (Staff #16) was interviewed regarding how the call light system in the facility is designed to work. He reported that every Resident had a call button available at their bedside and bathroom. The call system is activated by pressing that button. When the button was pressed, a light above the resident's room lights up. Additionally, a computer screen at the nurse's station provides a visual and audible alert to indicate to the staff at the nurse's station which resident is requesting assistance. The system also alerts staff to the time that the resident requested assistance. On 11/19/24 at 11:07 AM an observation was made of the call light system at the Unit One nursing station. Observation revealed a visual alert that the call button was activated for Resident #24 at 10:03 AM. On 11/19/24 at 11:10 AM surveyor asked nurse (Staff #11) about Resident #24's call light. Nurse #11 then proceeded to go to Resident #24's room with surveyor and addressed the resident's issue. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 11:11 AM Staff #11 was interviewed regarding the long time between when the residents call button was activated and when a staff member went into the room. Staff #11 confirmed she had been sitting at the nurse's station near the call system but reported that the 400 hall was not her assignment. On 11/19/24 at 11:14 AM during an interview with the Director of Nursing (DON), the concerns that the call light had not been answered for 1 HR and 4 minutes was shared. The DON reported she would look into the matter. On 11/20/24 at 4:08 PM an observation was made of the Unit One nursing station call light system. Observation revealed that Residents #18 had activated her/his call light at 3:58 PM. Further observation revealed a light on over Resident #18's door was on. On 11/20/24 at 4:09 PM the surveyor interviewed Resident #18 who reported that s/he did press the button and was waiting for assistance. Continued observation from 4:08 PM to 4:25 PM revealed that Resident #18's call light remained on and failed to reveal any staff entering the room. Numerous staff were observed in the hall including Nurse # 11 administering medications near Resident #18's room. On 11/20/24 at 4:25 PM Observation was made of staff entering the room and the light being turned off. On 11/20/24 at :26 PM during a brief interview with Resident #18 s/he reported that the staff just came in and addressed her issues. S/he reported that s/he had no further need for assistance. On 11/25/24 at 10:43 AM the Administrator and DON were interviewed regarding their expectations for the staff responding to the Resident call for assistance. The DON reported the staff should make initial contact within the 5 min range. The Director of Nursing reported that she will provide reeducation to the staff regarding call light response.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48259 Based on medical record review and interview it was determined that the facility failed to ensure they informed residents of their right to formulate an advance directive. This was found to be evident for seven (Resident #1, #31, #82, #83, #236, #241, #250) out of nine residents reviewed for advance directives. The findings include: 1) A medical record review on 11/12/24 at 4:25 PM showed that Resident #1 had lived in the facility since August 2022. The further review contained a document completed by the resident's attending provider on 8/12/22 that indicated the resident could make his/her own decisions. An advance directive is a legal statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor because of illness or incapacity. However, the review failed to show Resident #1 had an advanced directive. It also contained no documentation indicating that Resident #1 or his/her representative had been informed of his/her right to formulate an advanced directive or that the facility periodically reviewed the advance directive with the resident and/or the resident representative. In an interview on 11/15/24 at 8:18 AM, staff #10, the social services director, indicated that she only assessed if newly admitted residents already had advance directives in place and did not discuss with residents living in the facility their right to formulate one. In a subsequent interview with staff #10 on 11/15/24 at 08:32 AM, she said that per the facility's policy on advance directives, she was to address advance directives with residents and that they should be given the chance to formulate one or not. Staff #10 also added that it was not something she did. 16218 2) On 11/12/24 review of Resident #31's medical record revealed a Decision Making Capacity form, signed by the physician on 4/10/24, that indicated the resident was able to make health care decisions. Review of the Social Service 72 Hour Meeting Form, signed by the Social Worker (SW Staff #10), revealed the question: Does the resident have an Advance Directive? was marked as No. Further review of the medical record failed to reveal documentation to indicate there was follow up with the resident about initiating an Advance Directive. On 11/13/24 at 3:42 PM the SW #10 indicated if the answer to the Advance Directive question is No she does not follow up. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 review of the Admission packet used by the facility revealed a blank Advance Directive form. On 11/14/24 the Admission Director (Staff #42) reported she just includes the paperwork and that SW would address the Advance Directives. On 11/19/24 at 3:15 PM surveyor reviewed with Director of Nursing the concern regarding failure to address establishing an Advance Directive for Resident #31. 50458 3) On 11/18/2024 at 9:00 AM thru 11:45 AM, review of Residents #82, #83, #236, #241, #250's medical record revealed that AD were not on file. Documentation of any discussions about AD with the Residents and responsible representatives were not in the medical records. On 11/19/2024 at 9:45am, the DON and Staff #10 were interviewed to confirm that there were no AD on file and no documentation of any discussions about AD. The DON and Staff #10 acknowledged the findings. On 11/26/2024 at 12:10 PM, Staff #3 was interviewed and notified of the above findings. He/she acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 16218 Based on medical record review and interview it was determined that the facility failed to ensure a primary care provider was notified of an abnormal lab result. This was found to be evident for 1 (Resident #53) out of 5 resident reviewed for unnecessary medications. The findings include: On 11/20/24 review of Resident #53's medical record revealed the resident was admitted in 2022 and whose diagnosis includes, but is not limited to, hypothyroidism. The resident receives Synthroid for the treatment of the hypothyroidism. The resident's current order was for Synthroid 125 mcg one time a day since 9/20/24. Review of the Treatment Administration Record (TAR) revealed that an ordered lab for a TSH (thyroid stimulating hormone) was obtained on 11/14/24. Further review of the medical record failed to reveal documentation of the results of this TSH level. On 11/21/24 at 11:26 AM, after surveyor inquired about this lab result, nurse #35 printed off the results and provided copy to the surveyor. Review of the TSH results revealed the level was high at 17.98 (reference range was 0.45 - 4.50). The lab report also revealed the results were originally reported on 11/14/24 at 11:18 AM. Further review of the medical record failed to reveal documentation to indicate a primary care provider was made aware of the high TSH results. Surveyor asked the Assistant Director of Nursing (Staff #4) if the results were reviewed by a provider and she indicated she would follow up. Further review of the medical record revealed the primary care nurse practitioner (Staff #48) saw the resident on 11/19/24. Review of the progress note revealed the Chief Complaint: Follow up after laboratory testing. On 11/21/24 at 11:40 AM the ADON (Staff #4) reported the hard copy of the lab results have not been signed off by the provider and she asked surveyor if they were addressed in the note. Further review of the 11/19/24 NP note failed to reveal documentation to indicate the TSH level from 11/12/24 was reviewed. On 11/21/24 at 12:30 PM surveyor informed nurse (Staff #36) that review of the medical record, specifically the 11/19/24 NP note, failed to reveal documentation that the primary care provider was aware of the high TSH level. Nurse #36 made a copy of the result and indicated would follow up. On 11/21/24 at 1:37 PM surveyor reviewed with the Director of Nursing that no documentation was found to indicate the abnormal TSH had been reported to the primary care provider. On 11/22/24 at 10:08 AM review of the medical record revealed the following progress note written on 11/21/24 at 1650 by Nurse #35 : TSH lab from 11/14/24 called to [name of Staff #49] CRNP. Order received to increase levothyroxine [Synthroid] to 150mcg daily to be given with water 30 minutes prior to other meds and meals. TSH in 6 weeks. Resident and family aware.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 16218 Based on review of pertinent documentation and interviews it was determined that the facility failed to ensure resident's were provided advance notification of the date Medicare would not cover their skilled services. This was found to be evident for 1(Resident #14) out of 3 residents reviewed for beneficiary protection notification review. The findings include: On 11/14/24 at 10:30 AM review of the list, provided by the facility, of residents who were discharged from Medicare covered Part A stay with benefit days remaining in the past 6 months revealed that Resident #14 was discharged from services and remained at the facility. Surveyor provided the Beneficiary Protection Notification Review form to the Social Worker (Staff #10) for Resident #14. Review of the Beneficiary Protection Notification Review form revealed the last covered day of Part A Service was 8/7/24 and that the facility had initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The resident was provided both a Notice of Medicare Provider Non-Coverage (NOMNC) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN). Review of the NOMNC and the SNFABN revealed they were signed by the resident on 8/7/24, which was the date services were ending. Both of these forms include information regarding a resident's right to appeal the decision to end services. On 11/18/24 at 1:39 PM the SW #10 reported that therapy will set the date and usually they will let her know ahead of time. When asked about the timeframe for providing the notification forms, SW indicated 3 days prior to the date of service ending. Surveyor reviewed the concern that Resident #14's end date of service and his notification date were both 8/7/24. The SW reported: That one I did not realize [s/he] was discharging and gave it the day of discharge. Surveyor then reviewed with SW the concern that the resident was not provided time to appeal the decision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

48470

Based on medical record and facility investigation documentation and interviews it was determined that the facility failed to protect the residents from verbal abuse and misappropriation of narcotics. This was found to be evident for two (Resident #57 and # 53) out of 19 residents reviewed for abuse.

The findings include:

1) Resident #57 was admitted to the dementia unit of the facility in 2023. A facility reported incident (FRI) related to MD00191982 that involved the resident, regarding verbal abuse, was submitted to the Office of Healthcare Quality.

The facility's investigation packet for the FRI was reviewed on 11/20/24 at 12:37 PM. The review revealed that the facility substantiated verbal abuse by a Geriatric Nursing Assistant (GNA Staff #37). The verbal abuse was witnessed by other staff members (Certified Occupational therapist Assistant [COTA Staff #38] and GNA Staff #39) including a family member of another resident residing in the dementia unit.

Details from the facility's investigation revealed the following: At approximately 4:15 PM, the perpetrator , Staff #37, and Staff #38 were in Resident #57's room. As Staff #38 was walking towards the hallway, she witnessed Staff #37 say You psychotic bitch! to Resident #57. Staff #39, who was in the shower room located next to the resident's room, documented in her statement that she heard screaming between the resident and Staff #37 then calling the resident a psychotic bitch. A statement was also taken from a family member who was with another resident in the day room, corroborated the use of derogatory language. At approximately 4:30 PM, Staff #37 was interviewed by the former Nursing Home Administrator (NHA), former Director of Nursing (DON), and the director of Human Resource (HR) and she admitted to calling the resident a psychotic bitch. Staff #37 was suspended and escorted out of the facility. Assessments and interviews were conducted on the resident and other residents on the unit. Staff #37 was reported to the Maryland Board of Nursing and was terminated from the facility.

On 11/21/24 at 12:51 PM, the current DON was interviewed, and she confirmed the details in the investigation and that abuse was substantiated.

16218

2) On 11/20/24 review of facility reported incident MD00194309, received by the state survey agency on 7/12/23, revealed the following: Inconsistencies were noted between eMAR [electronic Medication Administration Record] and written sign out sheet for narcotic Oxycodone/APAP [acetaminophen] 5/325mg for resident [Resident #53]. [Resident #53]'s order reads as follows: 1 tablet by mouth every 4hrs as needed for knee pain. Resident [Resident #53] has capacity and has reported not receiving the medication as was documented on the paper sign out sheets. Per written sign out sheet, alleged perpetrator [nurse Staff #50] administered Oxycodone/APAP to resident [Resident #53] more frequently than ordered and did not record this on the eMAR.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 review of Resident #53's medical record revealed the resident was admitted in 2022 and whose diagnosis include, but is not limited to, arthritis. The resident had an order, dated 6/17/23 for Oxycodone-Acetaminnophen 5-325 mg give one tablet by mouth every 4 hours as needed for knee pain rated 7-10 (on a 10 point pain scale). Oxycodone-Acetaminnophen 5-325 is a narcotic pain medication and as such is considered a controlled medication. Review of the facility policy for Controlled Substances (Revision Date: November 2022) revealed a controlled substance record is made for each resident who will be receiving a controlled substance. This record contains the name of the resident, the name and strength of the medication, quantity received, number on hand, name of prescriber, prescription number; name of issuing pharmacy; date and time received; time of administration; method of administration; signature of person receiving medication and signature of nurse administering the medication. Review of the Controlled Medication Utilization Record (controlled substance record) in use at the facility revealed Columns for staff to document date, time, dose given, signature of nurse administering the medication and the amount left in the supply. Review of the Controlled Medication Utilization Record (CMUR) for Resident #53's Oxycodone-Acetaminnophen 5-325 revealed 30 doses were received on 6/19/23. A total of 30 doses were removed from this supply between 6/19/23 and 7/2/23. Review of the corresponding Medication Administration Record (MAR) for these dates revealed documentation of 15 doses having been administered to the resident. Further comparison of the MAR and the CMUR revealed: -On 6/19/23 Nurse #50 documented the removal of 1 doses of Oxycodone-Acetaminnophen 5-325 on the CMUR, review of the MAR failed to reveal documentation to indicate the administration of this dose. -On 6/21/23 Nurse #50 documented on the MAR as having administered the Oxycodone-Acetaminnophen 5-325 at 8:01 AM and again just 3 hours later at 11:10 AM, however there is no documentation found on the CMUR to indicate Nurse #50 removed the medication from the supply on this date. -On 6/24/23 Nurse #50 documented the removal of 4 doses of Oxycodone-Acetaminnophen 5-325 on the CMUR, review of the MAR failed to reveal documentation to indicate the administration of any of these four doses. -On 6/25/23 Nurse #50 documented the removal of 3 doses of Oxycodone-Acetaminnophen 5-325 on the CMUR, review of the MAR failed to reveal documentation to indicate the administration of any of these 3 doses. -On 6/29/23 Nurse #50 documented the removal of 2 doses of Oxycodone-Acetaminnophen 5-325 on the CMUR, review of the MAR failed to reveal documentation to indicate the administration of either of these 2 doses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Controlled Medication Utilization Record (CMUR) for Resident #53's Oxycodone-Acetaminnophen 5-325 revealed 30 doses were received on 7/3/23. Nurse #50 signed for the receipt of this supply, no co-signature of a second nurse was found on this form. A total of 26 doses were removed from this supply between 7/3/23 and 7/11/23. Review of the corresponding Medication Administration Record (MAR) for these dates revealed documentation of 12 doses having been administered to the resident. Six of these twelve doses were documented as administered by Nurse #50. Further comparison of the MAR and the CMUR revealed: On 7/3/23 Nurse #50 documented the removal of 2 doses of Oxycodone-Acetaminnophen 5-325 on the CMUR, review of the MAR failed to reveal documentation to indicate the administration of either of these 2 doses. On 7/6/23 Nurse #50 documented the removal of 5 doses of Oxycodone-Acetaminnophen 5-325 on the CMUR, review of the MAR failed to reveal documentation to indicate the administration of 2 of these 5 doses. On 7/10/23 Nurse #50 documented the removal of 4 doses of Oxycodone-Acetaminnophen 5-325 on the CMUR, review of the MAR failed to reveal documentation to indicate the administration of any of these 4 doses. On 7/11/23 Nurse #50 documented the removal of 5 doses of Oxycodone-Acetaminnophen 5-325 on the CMUR, review of the MAR failed to reveal documentation to indicate the administration of any of these 5 doses. On 11/20/24 review of the facility investigation documentation revealed witness statements were obtained from multiple nursing staff and the resident. Review of the statement by Nurse # 35 revealed she was assigned to Resident #53 on 7/11/23 and had administered a percocet (Oxycodone-Acetaminnophen 5-325) at 8:29 AM and upon evaluation the resident stated [his/her] pain was gone and leg felt better. The resident did not want to take regularly scheduled Tramadol at 11:00 AM because s/he didn't have pain at that time and the nurse had encouraged the resident to take the Tramadol to prevent pain from returning. The statement also revealed that Nurse #50 was scheduled to relieve her at 11:00 AM but did not show up on the unit until 12:45. Further review of Nurse #35's statement revealed that when giving report to Nurse #50 she had passed on that the resident did not want any more Percocet. Review of the CMUR revealed documentation that Nurse #50 had documented that she had signed out a dose of Oxycodone-Acetaminnophen 5-325 on 7/11/23 at 12 noon. Review of a statement by Nurse #36 also revealed a that Nurse #50 had not arrived on the unit until 12:45 PM on 7/11/23. Nurse #36's statement indicates that at 12:30 the resident had stated s/he was not in pain. Review of the statement from Resident #53, documented by the previous Director of Nursing on 7/12/23, revealed: S/he denied asking for any prn [as needed] medication. S/he also denied calling out to notify staff that s/he was having pain. Resident stated: 'I was asleep most of the day, and when I go to sleep, I don't wake up and ask for pain medication.' (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Nurse #35's statement revealed that upon returning to work on 7/12/23 while conducting the narcotic count she noticed that Nurse #50 had signed out 4 doses percocet during her shift but when she checked the MAR no percocet was documented since the one she had administered at 8:29 AM. She went on to identify a second resident [Resident #237], who she had taken care of the day before and had denied pain at that time, who had percocet removed by Nurse #50, but not documented as administered. These issues were immediately brought to the Assistant Director of Nursing (nurse #4) and the Director of Nursings (previous DON) attention. On 11/20/24 at 3:33 PM Nurse #35 confirmed the accuracy of her written statement. She reported that she remembered there was more medication taken out than should of been in that time frame. She confirmed that it was Resident #53 who had more meds taken out then it should of been that caught her attention and she reported it as soon as she noticed something was not right. Further review of the facility documentation revealed this incident was reported to the local police and the Drug Enforcement Agency (DEA) and Nurse #50 was reported to the Board of Nursing. The final report to the survey agency included: The facility has substantiated the diversion of medication. [Nurse #50] was terminated from [his/her] position. On 11/20/24 at 3:51 PM the Assistant Director of Nursing (ADON Staff #4) was interviewed in regard to this facility report. The ADON reported they conducted an audit of the residents the nurse had which revealed nothing had happened to require an increase in the pain medication usage. The ADON confirmed that the facility had determined there was drug diversion. When asked if they had conducted education with staff after this incident the ADON indicated they did. Further review of the investigation documentation failed to reveal documentation to indicate training or education was conducted with staff after this incident was identified. On 11/20/24 at 4:01 PM surveyor informed the ADON that no documentation of education was found. Cross Reference to F 761.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48168

Based on record review and interview it was determined that the facility failed to 1) report allegations of abuse, and 2) timely report allegations of abuse. This was evident for two residents (Resident #1 and #12) identified during a review of an employee file and 4 residents (Residents #55, #72, #245, and #51) reviewed in relationship to 25 facility reported incidents reviewed during the survey.

The findings include:

1.) On 11/14/24 at 5:15 PM a random sample of employee records were requested from the Nursing Home administrator (NHA). On 11/15/24 at 9:15 AM the records were received from the Director of Human Resources (Staff #28).

On 11/15/24 at 11:08 AM a review of the employee file for Geriatric Nursing Assistant (GNA #15) was conducted. The file included a notice of discipline and termination dated 3/14/24 due to an allegation of verbal abuse of Resident #1 and Resident #12.

On 11/15/24 at 1:20 PM in an interview with the Staffing Coordinator (Staff #29) confirmed that GNA #15 was terminated in March 2024 for an allegation of verbal abuse of two residents. When asked if there was a facility reported incident for this allegation, Staff #29 said she did not know. After the interview with Staff #29, the surveyor contacted the Office of Health Care Quality (OHCQ) to determine if any facility reported incident existed for the alleged abuse.

On 11/15/24 at 2:26 PM the surveyor received an email from the OHCQ triage staff who confirmed that OHCQ had not received any facility report for Resident #1 or Resident #12.

On 11/15/24 at 2:40 PM an interview was conducted with Registered Nurse (RN #4) and Corporate Nurse (Staff #3) who confirmed that the facility did not report the allegation of verbal abuse for Resident #1 and Resident #12.

On 11/26/24 at 11:29 AM an interview was conducted with the Director of Nursing (DON), NHA, and Staff #3 to review the lack of report of the alleged verbal abuse, and they all and confirmed the deficiency.

2) On 11/25/24 at 11:38 am a review of the facility reported incident # MD00201779 revealed that on 1/20/24 facility staff observed 2 residents (Resident #55 and #72) engaged in inappropriate sexual behavior.

On 11/25/24 at 11:42 AM a review of the facility's investigation file revealed that the Nursing Home Administrator (NHA) was aware of the incident on 1/20/24 at 8:23 PM. An email in the file indicated that OHCQ received the facility's final 5-day report on 1/26/24 but never received the initial report.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/25/24 at 12:39 PM in an interview with Registered Nurse (RN #4), she said she was aware of the incident when it happened. When asked why the initial report was not submitted, she said she could not explain. She confirmed that she was aware that all allegations of abuse were to be reported within 2 hours. On 11/26/24 at 11:29 AM an interview was conducted with the DON, NHA, and Staff #3. They said they were aware that the facility reported the allegation of abuse after the required time frame, and they confirmed the deficiency. 3) On 11/21/24 at 10:45 AM a review of the facility reported incident # MD00190908 was conducted. The review revealed that on 3/29/23 the facility received a radiology report that Resident #245 had a fractured pelvis. The radiology exam was performed on 3/24/23 and was reported to the facility on [DATE]. The facility reported the resident's injury to OHCQ on 4/04/23. On 11/21/24 at 11:20 AM an interview with the DON was conducted. When asked, she confirmed that the Resident #245's injury was reported later than the required time frame. She said she did not have any additional information or explanation since she was not at the facility during that time. On 11/26/24 at 11:29 AM in an interview with the DON, NHA, and Staff #3 to review the late report and they confirmed the deficiency. 48259 4) A review on 11/21/24 at 8:26 AM of a facility-reported incident related to Resident #51 with MD #00205384 showed that an allegation of abuse was reported to the regional vice president of operations on 5/6/24 at 7:25 AM. A continued review of the facility's investigation into the allegation of abuse showed that the allegation was reported to the Nursing Home Administrator (NHA) on 5/6/24 at 9:00 AM. Further review of an email confirmation of when the facility's initial self-report was sent to the state agency revealed that the incident was reported to the state agency on 5/6/24 at 2:16 PM. The facility failed to forward a first report of an allegation of abuse to the state agency immediately but not later than 2 hours once the facility staff became aware of the abuse allegation. In an interview with the NHA on 11/21/24 at approximately 1:05 PM, he confirmed that the allegation was reported late and said that it should have been reported within 2 hours of knowing about it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 48168 Based on record review and interview it was determined that the facility failed to thoroughly investigate allegations of abuse. This was evident for 2 facility reported incidents (#MD00187641 and #MD00201779) of 25 facility reported incidents investigated during the recertification survey. The findings include: 1) On 11/21/24 at 9:50 AM a review of the facility reported incident #MD00187641 revealed an allegation that Licensed Practical Nurse (LPN #31) physically and verbally abused Resident #247 on 1/09/23. On 11/21/24 at 10:01 AM a review of the facility's investigation file revealed that although there were other staff witness statements, and interview statements with other residents, there was no statement written by or received from the alleged perpetrator, LPN #31. On 11/21/24 at 10:20 AM an interview was conducted with the Director of Nursing (DON) who reviewed the facility investigation file and agreed and confirmed that there was no witness statement from the alleged perpetrator and agreed that this was an incomplete investigation. On 11/26/24 at 11:29 AM an interview was conducted with DON, the Nursing Home Administrator, and Corporate Nurse (Staff #3) to review the findings. They were unable to provide any additional information and confirmed the deficiency. 2) On 11/25/24 at 11:38 AM a review of facility reported incident # MD00201779 revealed an allegation of potential resident to resident abuse on 1/20/24. On 11/25/24 at 11:42 AM a review of the facility's investigation file revealed that on 1/20/24 Geriatric Nursing Assistant (GNA #33) observed Resident #55 and Resident #72 engaged in sexual relations. Further review revealed that although the incident occurred on 1/20/24 staff and resident witness interviews were not obtained until 1/23/24 and 1/24/24 . On 11/25/24 at 12:39 PM an interview with the Assistant Director of Nursing (Staff #4) was conducted. When asked why the resident and staff witness statements were done 3 and 4 days after the incident, she replied that she was not sure. She said that she reported the incident up the chain of command at the time of the incident and was not aware of what decisions were made after she reported it. On 11/26/24 at 11:29 AM an interview with the DON, NHA, and Staff #3 was conducted. They confirmed that an immediate investigation was not done for this incident. No additional information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48470 Based on records review and interviews, it was determined that the facility failed to notify the resident and the resident's representative(s) of the transfer in writing. This was evident in 1 (Resident #29) of 1 resident reviewed or hospitalization . The findings include: Resident #29 had been residing in the facility since late 2022. A review of the resident's medical records on 11/13/24 at 11:50 AM, indicated that s/he was sent to the hospital in July of 2024. Further review of the resident's medical records failed to reveal evidence that a written notification of transfer was provided to the resident and/or resident representative (RP). On 11/15/24 at 9:27 AM, the Social Services Director (Staff #10) was interviewed regarding transfers and hospitalization s. Staff #10 reported that she does not handle notifications with transfers and hospitalization s and indicated that the nursing department is the one who handles these kinds of notifications. On 11/18/24 at 11:05 AM, the Licensed Practical Nurse (LPN Staff #9) was interviewed about her process when a resident needs to be transferred or sent to the hospital. Staff #9 enumerated the documents that she would prepare for the transfer and the individuals that she would notify. Staff #9 was specifically asked how she notifies residents and/or RP's, and she reported that she does them verbally either face to face or over the phone. On 11/18/24 at 12:40 PM, a copy of the facility's policy regarding transfers and/or discharge was received from the Director of Nursing (DON) and reviewed. The policy stated that a written notice of transfer is provided to the resident and representative 30 days in advance for planned discharges, as soon as practicable before transfers for emergent or therapeutic leave, and at a practicable time for the long-term care Ombudsman. The DON was interviewed regarding notifications with transfers on 11/18/24 at 1:42 PM. The DON stated, We don't have a written notification, not to my knowledge. Other than the verbal notification that the nursing department does, there is no other notification that we do or send to the resident or RP. The concern was discussed with the DON and she verbalized understanding and acknowledged the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0637

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Assess the resident when there is a significant change in condition

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48259

Based on record review and staff interviews, it was determined that the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment within 14 days following a significant decline in a resident's condition. This was evident for 1 (Resident #10) of 5 residents reviewed for unnecessary medications review.

The findings include:

The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each resident receives the care they need.

The nursing home should complete a significant change in status MDS assessment within 14 days when there's a significant decline or improvement in a resident's status.

A medical record review on 11/13/24 at approximately 2:07 PM showed that Resident #10 had lived in the facility since December 2022, and his/her diagnoses included Parkinson's disease.

The continued review contained an MDS assessment dated [DATE] for Resident #10. The MDS had recorded that Resident #10 had no functional limitations to his upper and lower extremities.

The review also noted that Resident #10 required the following level of assistance for certain Activities of Daily Living (ADL): set-up/clean-up assistance for eating, independent sitting on the side of the bed to lying flat in the bed, independent moving from lying on the back to sitting on the side of the bed, partial/moderate assistance for walking 10 feet, and independent wheeling a wheelchair for 150 feet once seated.

Further review of another MDS assessment dated [DATE] revealed the following: Substantial/maximal assistance for eating, total dependence on staff for sitting on the side of the bed to lying flat in the bed, total dependence on staff for moving from lying on the back to sitting on the side of the bed, non-ambulatory, and total dependence on staff for wheeling a wheelchair for 150 feet.

The review also showed that Resident #10 had functional limitations in his/her bilateral upper and lower extremities. However, the review failed to show that a Significant Change in Status MDS assessment was completed for the significant decline in his/her status.

In an interview on 11/15/24 at 12:16 PM the therapy manager (Staff #14) indicated that therapy started addressing Resident #10's contractures around March 2023. She also added that Resident #10 had limited ambulation around November 2023.

During an interview on 11/15/24 at 12:46 PM an MDS coordinator (Staff #24), stated that Resident #10's decline was gradual and confirmed that she missed completing a Significant Change in Status MDS assessment for the resident and added that she would schedule one.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on observation, record review, and interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately documented. This was evident for 1 (Resident #16) of 3 residents reviewed for vision/hearing; and 1 (Resident #57) of 4 residents reviewed for dementia care. The findings include: The Minimum Data Set (MDS) is an assessment of the Resident that provides the facility information necessary to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. 1) In an observation on 11/12/24 at 11:53 AM, Resident #16 was noted with difficulty hearing and stated to the surveyor, I have bad hearing. They are supposed to be working on hearing aid for me. A record review on 11/19/24 at 2:45 PM contained a care plan focus initiated on 6/16/22 and revised on 10/19/23. The care plan stated, [Resident #16] is at risk for a communication deficit related to being hard of hearing. A continued record review noted an audiology visit report dated 7/16/24 that said, The patient was referred by the facility for decreased hearing. Further review of an MDS assessment dated [DATE] for Resident #16 showed that it was documented in section B that the Resident's hearing was adequate. In an interview on 11/21/24 at 7:14 AM a geriatric nurse assistant (GNA Staff #12) reported that Resident #16 was very hard of hearing and that staff had to talk louder when speaking to him/her. During an interview on 11/21/24 at 7:46 AM, the Director of Nursing indicated that if Resident #16's care plan addressed his/her hearing difficulty, then she expected that his/her MDS assessment should have reflected that he/she had hearing difficulty. 48470 2) Resident #57 has been residing in the dementia care unit of the facility since 2023. On 11/21/24 at 11:10 AM, Resident #57's medical record was reviewed and revealed the most current MDS assessment had an Assessment Reference Date ARD) of 8/23/24. Section E for behavior was conducted by the MDS coordinator (Staff #24). Staff #24 coded the resident as Behavior not exhibited for subsection E0200 for items A)Physical behavioral symptoms directed towards others, B) Verbal behavioral symptoms directed towards others, and C) Other behavioral symptoms not directed towards others. A review of Resident #57's electronic Treatment Administration Record (eTAR) on 11/21/24 at 11:31 AM was conducted. The review revealed orders to document the number of episodes of behaviors for anxiousness, tearfulness, and physical aggression, every shift. The resident was marked as having 1 episode of physical aggression on 8/21/24 for day shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/24 at 12:37 PM, the Director of Nursing (DON) provided a copy of the August 2024 eTAR to the surveyor. A comparative review of the eTAR and the MDS assessment with an ARD of 8/23/24 was conducted with the DON. The DON indicated that Resident #57 was not coded accurately, referring to the documented episode of physical aggression on 8/21/24. The DON stated, That behavior should have been marked in that section. The DON verbalized understanding and acknowledged the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 50458 Based on medical record review staff interview, it was determined the facility failed to provide a resident and/or a resident's representative with a summary of the baseline care plan. This was evident for 3 Residents (#82, #237, #255) of 50 residents reviewed during the survey. The findings include: A baseline care plan must be completed within 48 hours of a resident's admission to the facility and must include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the baseline care plan as well as a list of the resident's current medications must be given to each resident and/or representative. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 11/19/2024 at 8:45 AM during record review, it was revealed that Baseline Care Plans were not discussed with Residents (#82, #237, #255) or their representatives. On 11/20/2024 at 10:20 AM, during an interview, the Director of Nurses (DON) stated that baseline care plans were developed for a resident upon the resident's admission to the facility, that the resident or resident representative was given a copy of the care plan along with summary of their medications during their care plan meeting and to check the social services notes for documentation. This surveyor stated that there were no documentation if the residents or the representative were given copies of the baseline care plan for Residents (#82, #237, #255). The DON acknowledged the findings. On 11/26/2024 at 12:10 PM, Director of Clinical Operations Staff #3 was interviewed and notified of the above findings. She acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48259 Based on interviews and medical record review, it was determined that the facility failed to invite alert and oriented residents to their care plan meetings. This was evident for 2 (#52, #136) of 2 residents reviewed for care planning. {or include the additional 2 for 4 out of 50} The findings include: Care plans are developed to guide residents' care in the facility. They must be created within 7 days of completion of a resident's admission comprehensive Minimum data set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team, including the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the Resident, and the Resident's representative (as practicable). 1) In an interview on 11/12/24 at 11:17 AM, Resident #52 was asked if he/she participated in his/her care plan meeting and responded, I don't think I've had any meeting yet. A record review on 11/15/24 at 8:18 AM showed that Resident #52 was admitted to the facility in October 2024. Further review found that Resident #52 was alert, oriented, and able to make his/her own decisions per a decision-making capacity form signed by an attending provider on 10/18/24. An interview on 11/15/24 at 9:32 AM with staff #10, a social services director, showed that an interdisciplinary care conference meeting for Resident #52 occurred on 10/29/24. Staff from the MDS department, the social services department, the Rehab department, and Resident #52's representative were in attendance. However, the interview failed to show that Resident #10 was aware or invited to the care conference meeting. 16218 1) Review of Resident #136's medical record revealed the resident was able to make his/her own health care decisions, and was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Score of 14/15 on 10/31/24. The resident was admitted in to the facility in October 2024. During an interview on 11/12/24 at 12:23 PM when asked if s/he attended the care plan meetings the resident indicated s/he was not aware of a care plan meeting. On 11/13/24 03:31 PM medical record review revealed a 72 hour care plan meeting had occurred but there was no documentation found to indicate the resident attended or was invited to this meeting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 3:33 PM interview with the Social Worker (SW Staff #10) revealed she usually notifies residents the day of the care plan meeting and that most choose not to attend. On 11/13/24 at 3:42 PM the SW #10 reported in regard to the 72 hour care plan meeting, she did not know if she invited the resident, but knew that she asked the resident who s/he wanted to have attend. The SW went on to report they just had a care plan meeting for Resident #136 the day before but she had not yet put in a note. When asked if she invited the resident to the meeting, the SW responded: No I did not. The SW went on to report that typically she goes and talks to the resident directly but does not always put in a note directly. On 11/26/24 further review of the medical record revealed a Late Entry note for Care Plan Conference with an effective Date of 11/12/24 at 10:30 AM. The attendants included the Activities Aide (Staff #13), the Social Worker (Staff #10) and a family member of the resident. No other attendees were listed. Review of the sign in sheet revealed a notation next to Resident: permission to call family, but failed to indicate why the resident was not attending. On 11/26/24 at 10:15 AM surveyor reviewed the concern with the Director of Nursing regarding the failure to invite the resident to the care plan meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0676

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.

16218

Based on medical record review, interview and observations it was determined that the facility failed to ensure staff assisted resident with wearing eyeglasses. This was found to be evident for 2 out of 3 residents reviewed for vision and hearing.

The findings include:

On 11/12/24 review of Resident #31's medical record revealed an order, in effect since 10/15/24, for: Nurse to collect glasses at bedtime and place in black cases in med cart every night shift.

On 11/12/24 at 3:03 PM Resident #31 was observed sitting in a wheelchair, dressed for the day. Surveyor noted the resident was not wearing eye glasses at the time of this observation.

On 11/19/24 review of Resident #31's 10/14/24 Minimum Data Set assessment revealed corrective lenses (eye glasses) where used during the assessment that the resident had adequate ability to see fine details such as regular print in newspapers or books. Review of the care plan revealed a plan addressing the resident's impaired visual function related to dry eye syndrome and glaucoma but failed to address the use of eye glasses.

Review of the November Treatment Administration Record (TAR) revealed nursing staff were documenting yes to the order regarding placing the glasses in the med cart, every night shift. No documentation was found to indicate staff were assisting the resident with wearing the glasses during the day.

On 11/19/24 at 2:00 PM surveyor observed resident sitting in wheelchair in hall near nursing station. Surveyor noted the resident did not have eyeglasses on at this time.

On 11/19/24 at 2:11 PM the Geriatric Nursing Assistant (GNA Staff #45) assigned to care for the resident, reported she was not aware that the resident had eyeglasses, and stated she has not seen any.

On 11/19/24 at 2:16 PM nurse (Staff #46) was interviewed in regard to the resident's eyeglasses. The nurse reported she thought they were in the bottom of the medication cart and stated that she knew we take them off of him/her before s/he goes to bed at night.

On 11/19/24 at 2:19 PM surveyor observed that Nurse #45 has now gotten the eyeglasses from the med cart and placed on Resident #31. Resident then stated to nurse: Why thank you.

On 11/19/24 at 3:19 PM surveyor reviewed the concern with the Director of Nursing (DON) that no documentation was found in the care plan to indicate the resident has glasses and that the GNA caring for the resident was not aware the resident had glasses. The DON confirmed that the GNA should be aware of glasses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48168 Based on record review and interview it was determined that the facility failed to provide residents with care for activities of daily living. This was evident for 1 complaint (#MD00205800) of 13 complaints reviewed during the recertification survey. The findings include: On 11/12/24 at 3:01 PM a review of complaint #MD00205800 revealed multiple allegations of neglectful care by the facility which included that Resident #242 had mouth sores and no care for them. On 11/12/24 at 3:16 PM a telephone call interview was conducted with the complainant who alleged that facility staff did not clean Resident #242's dentures. On 11/14/24 at 4:15 PM a review of Resident #242's clinical record related to dental care concerns was conducted. The clinical record contained a personal belonging inventory list which indicated that the resident had dentures. A review of the Geriatric Nursing Assistant care documentation failed to reveal any documentation of care for the resident's dentures. On 11/14/24 at 4:15 PM an interview was conducted with the Director of Nursing (DON). When asked if the resident's dentures were cleaned, the DON reviewed the GNA documentation and then replied that denture care was not listed on Resident #242's GNA documentation and she said that she would look to see if there was any indication that the resident had dentures so the GNA knew to provide that care. On 11/14/24 at 4:55 PM the DON brought a printout titled Kardex Report for Resident #242 which she said should have listed the resident's dentures so the GNA would know to provide that care. The DON confirmed that denture care was not listed on the document and confirmed that she could provide no evidence that denture care was provided to the resident. On 11/19/24 at 10:11 AM in another interview with the DON, she said she had no additional evidence and she confirmed the deficiency of the lack of denture care for Resident #242.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 48259 Based on observations, medical record reviews, and staff interviews, it was determined that the facility failed to provide an activities program to meet the needs and preferences of residents. This was evident for 2 (Resident #10 and #34) of 2 residents reviewed for activities. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure each resident receives the necessary care. A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) Several observations were made of Resident #10 lying in bed on 11/13/24. The room was quiet, with no activities going on, and there was no TV or radio on. Throughout the day on 11/14/24, several observations were made of Resident #10 lying in bed, awake, with no activities, and with no TV or radio on. A record review on 11/14/24 at 2:50 PM contained an MDS assessment for Resident #10 completed on 12/26/23. The following answers from Resident #10 were documented in section F: - How important is it to you to listen to music you like? Very important. -How important is it to you to be around animals such as pets? Very important. - How important is it to you to do your favorite activities? Very important. - How important is it to you to go outside to get fresh air when the weather is good? Very important. A review later that day of Resident #10's activity plan of care revised on 10/15/24 contained a focus that stated, [Resident #10] will be involved in activities of interest. The goal of the care plan said, [Resident #10] will participate in group activities of choice. The intervention recorded on the care plan stated, [Resident #10] will be involved in religious and praise events, provide [Resident #10] with 1:1 visit from staff for socialization. However, the plan of care failed to address the resident's needs for Dementia care and failed to show that Resident #10's Activity care plan was updated with their activity preferences. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continued review of October 1-November 14, 2024 activity logs for Resident #10 showed that the resident was involved in one-on-one friendly visits 3 times and one pet visit in October and no proof of activity for November 1-14,2024. The review also review failed to show that Resident #10 was involved in activities that included listening to music and going outside to get fresh air when the weather was good. In an interview on 11/14/24 at 3:50 PM the activities assistant (Staff #13) said that Resident #10 received activities based on what she thought the resident liked, and not based on his/her preferences documented in the MDS assessment. In an interview on 11/15/24 at 9:51 AM, the Director of Nursing stated that there was no documentation of activity logs for Resident #10 for November 1-14, 2024. 16218 2) Review of Resident #34's medical record revealed the resident has resided at the facility for several years and whose diagnosis includes but is not limited to dementia. On 11/12/24 at 12:55 PM resident was observed in her bed. On 11/13/24 at 9:42 AM resident was observed in bed talking to self. The resident was not observed participating iactivitieses or receiving visits by activity staff on either November 12 or 13, 2024. On 11/13/24 at 4:06 PM review of the resident's current care plan for activities revealed the following interventions: Will be invited to spiritual activities of [his/her] faith; will be offered 1:1 activities of [his/her] liking; will be offered and provided with sensory stimulating/relaxing activities during 1:1 visits such as aromatherapy, music, hand massages, etc.; will be provided with a daily and monthly activity calendar. On 11/14/24 at 3:50 PM the activity aide (Staff #13) reported the resident has been coming to some events. She went on to confirm that they have not been documenting one on one visits since 10/23/24. On 11/14/24 at 4:50 PM surveyor requested documentation of activities for Resident #34 for September, October, and November. Review of the documentation provided revealed a computer print out for September 2024 that failed to reveal documentation to indicate provision of activity involvement from September 12 thru September 20, 2024. No computerized documentation was provided for October or November. Review of the paper documentation of group activities failed to reveal documentation to indicate activity involvement from September 30 thru October 22, or from November 1st thru November 12, 2024. No One to One documentation was provided for October or November. On 11/26/24 at 10:12 AM surveyor reviewed the concern with the Director of Nursing regarding the failure to provide activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on medical record review and interview it was determined that the facility failed to ensure staff reviewed/acknowledged specialists recommendations; failure to ensure assessment were completed accurately and failed to follow physician orders. This was found to be evident for five (Resident #31, #256, #16, #11 and #83) out of 50 residents reviewed during the survey. The findings include: 1) On 11/19/24 review of Resident #31's medical record revealed the resident had a care plans addressing fall risk and actual falls since April 2024. Further review of the medical record revealed the resident sustained a fall on 9/8/24 which resulted in a fracture to the fifth metacarpal (bone that connects pinky finger to wrist). The resident was seen by an orthopedist on multiple occasions for follow up. The resident had a cast until it was removed on 9/26/24 when a hand brace was initiated. Review of the Report of Consultation for an orthopedic visit on 10/31/24 revealed the following recommendation: Patient should be wearing brace on hand while awake for 3 weeks. Will evaluate need to continue after next appt. The note also indicated the next appointment was scheduled for 11/21/24. Review of the resident's care plans revealed a plan was initiated on 9/19/24 addressing the metacarpal fracture. The interventions included, but were not limited to, F/U [follow up] with ortho as ordered, and Maintain cast to left hand/fingers. This intervention regarding the cast had not been modified or removed since the removal of the cast. No documentation was found in the care plan or the physician orders regarding the use of the hand brace after the cast removal. On 11/19/24 at 2:00 PM resident was observed sitting in wheelchair in the hall near the nursing station. The resident was not wearing a brace at this time. On 11/19/24 at 2:11 PM the Geriatric Nursing Assistant (GNA Staff #45) assigned to care for the resident, reported she did not know where the resident's hand brace was located and went on to state that the resident takes it off even if they put it on. On 11/19/24 at 3:11 PM surveyor reviewed the 10/31/24 orthopedic consult report with the Director of Nursing (DON) and asked her how she would expect this to be addressed. The DON reported it would go to the nurse when the resident returns from the appointment, then the nurse would enter the order and review it with the provider and then it would go in the provider book for the provider to sign off on. She confirmed that she would expect to see a nursing note to indicate either the order was put in or that the provider had declined the recommendation. Surveyor reviewed the concern that no note was found to indicate this occurred. On 11/26/24 at 10:15 AM surveyor reviewed with the DON and the Nursing Home Administration the concern regarding the failure to implement or address the orthopedist recommendations. 48168 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 11/12/24 at 10:40 AM a review of the facility reported incident # MD00207590 revealed that Resident #256 eloped from the facility on 7/11/24. On 11/12/24 at 11:30 AM a review of Resident #256's clinical record revealed that resident was admitted on [DATE] after a hospitalization . A review of the resident's hospital discharge summary, present in the facility record, revealed that the resident's primary diagnosis was altered mental status and that the resident had a recent CVA (a stroke) and subdural hematoma. Further review of the discharge summary revealed that the resident had an emergency room visit in May 2024 when he/she was found a mile from his/her home and was confused. Additional records from the hospital indicated that during the hospital stay the resident was very confused and needed frequent redirection. Further review of Resident #256's clinical record revealed a nurse progress notes dated 7/06/24 which stated the Resident was observed walking without assistance by double glass doors by dining room with no clothes on pulling on doors attempting to leave. And further stated Resident then got in wheelchair and was wandering in and out of other people's rooms . Resident #256's clinical record also contained an elopement risk document dated 7/06/24 which stated History of elopement while at home: No. History of attempting to leave the facility without informing staff: No. Verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: No. Wanders: No. Wandering behavior a pattern or goal-directed: No. Wanders aimlessly or non-goal-directed: No. Wandering behavior likely to affect the safety or well-being of self/others: No. Wandering behavior likely to affect the privacy of others: No. Recently admitted or readmitted (within the past 30 days) and has not accepted the situation: No. On 11/19/24 at 10:08 AM an interview with the Director of Nursing (DON) was conducted. The concern that Resident #256's elopement risk assessment did not identify the resident's previous elopement and wandering behavior even though there was documentation present in the resident's record which described the resident's wandering behavior. The DON explained that the resident had been determined to have capacity so was not a risk for elopement. When asked if the elopement risk form was completed accurately, she said no it was not. On 11/26/24 at 11:29 AM an interview with the DON, the Nursing Home Administrator and Corporate Nurse (Staff #3) was conducted to review the failure to accurately assess Resident #256's elopement risk. No further information was provided. 48259 3) The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. In an interview on 11/12/24 at 11:37 AM, Resident #16 stated, My left leg is always swollen; it's been like that for years. A record review for Resident #16 showed that he/she had been residing in the facility since 2011, and diagnoses included left-sided weakness due to stroke. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A continued review found an MDS assessment for Resident #16 dated 10/7/24. The MDS recorded that the Resident required maximal to total dependence assistance from staff for all his/her self-care needs. Further review contained an attending provider order dated 11/10/24 for Resident #16 to wear knee-high compression stockings to bilateral lower extremities daily as tolerated for swelling. The order stated that the compression stockings should be applied during morning care and removed before bed. Compression stockings are specially made socks that fit tighter than usual, gently squeezing your legs. Wearing them helps improve blood flow, reduces pain and swelling in your legs, and lowers the chances of getting blood clots and other circulation problems. A review of Resident #16's November treatment administration record showed documentation by a registered nurse (Staff #19), that the compression stockings were applied to the Resident's legs on 11/19/24 at 08:00 AM. However, later that day, in an observation, Resident #16 was sitting in his wheelchair in the activity area. When questioned about using compression stockings for swelling, the Resident stated he/she had socks on his foot and not compression stockings. Resident #16 added, I don't wear anything for swelling. During an interview on 11/19/24 at 2:10 PM, Staff #19 confirmed that the compression stockings were not on the Resident's legs. She then stated that she documented it incorrectly and did not put it on Resident #16's legs. Staff #19 added that she would find out what size Resident #16 was supposed to wear and would order them. In an interview on 11/20/24 at 9:18 AM, the Director of Nursing stated that nurses were to follow the attending provider's orders. She added that she did not expect her nurses to sign for treatments they did not carry out. 48470 4) Resident #11 had been residing in the facility for several years. A review of the resident's bowel and bladder task documentation on 11/15/24 at 8:53 AM, revealed that s/he had no bowel movement (BM) for 3 consecutive days (11/5/24, 11/6/24, 11/7/24). On 11/15/24 at 9:17 AM, Resident #11's bowel protocol orders were reviewed and revealed the following: 1) Milk of Magnesia suspension as needed for bowel protocol step 1 if no BM after 2 days, give at bedtime. 2) Dulcolax suppository as needed for bowel protocol step 2 if no results within 12 hours of Milk of Magnesia 3) Milk of Magnesia suspension as needed for bowel protocol step 1 if no BM after 3 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Dulcolax suppository as needed for bowel protocol step 2 if no results within 12 hours of Milk of Magnesia 5) Sodium Phosphate Enema as needed for bowel protocol step 3 if no results 8 hours after Dulcolax suppository. Call medical staff. A review of the electronic Medication Administration Record (eMAR) for the month of November was conducted on 11/15/24 at 9:22 AM. The review revealed none of the bowel protocol orders were administered. On 11/18/24 at 11:10 AM, the Licensed Practical Nurse (LPN Staff #9) was interviewed about her process in monitoring residents BM. Staff #9 reported that the Geriatric Nursing Assistants (GNA) would usually notify nurses verbally if a resident had not moved their bowels for a couple of days and indicated that she could also check that information in the computer. Later, at 11:23 AM, Staff #9 was asked to check in her computer, Resident #11's medical records and she confirmed that the resident had 3 consecutive days without moving his/her bowels. Staff #9 indicated that she would have started the resident with the Milk of Magnesia and followed the steps in the bowel protocol orders. While reviewing the resident's medical records, Staff #9 also confirmed that the resident did not receive any of the bowel medication as ordered by the physician. The concern was discussed with the Director of Nursing (DON) on 11/18/24 at 1:45 PM. The DON acknowledged that the resident did not receive his/her bowel medication as it was ordered by the physician. 50458 5) Review of Resident # 83's medical record on 11/19/2024 at 11:15 AM, revealed that the resident was admitted to the facility in September 2024. Continued review showed that Resident #83's wife was appointed as his/her decision maker on 10/10/24. Further review showed that on 10/07/2024, Resident #83 started to decline physically and cognitively, and having complaints of hallucinations, pain, vomiting and agitation. Resident #83's decision maker requested for hospice care on 10/10/2024. Later the same day, the resident was seen by attending provider who ordered for a Hospice Consult for Resident #83. Continued review showed that the resident passed away on 10/12/2024 at 06:30. However, the review failed to show that the facility followed through with the physician's order for hospice consult. In an interview with the Director of Nursing on 11/21/2024 at 1:30 PM, she acknowledged that the hospice consultation was not done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER: Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 16218 Based on medical record review, observation and interview it was determined that the facility failed to provide care to prevent the development of pressure ulcers. This was found to be evident for one(Resident #34) out of four residents reviewed for pressure ulcers during the survey. This deficient practice resulted in actual harm to Resident #34. The findings include 1.) On 11/13/24 review of Resident #34's medical record revealed the resident has resided at the facility for several years and whose diagnosis include but are not limited to, dementia, osteoporosis, high blood pressure, and hypothyroidism. The resident had two pressure ulcers, one on each foot, with orders for daily dressing changes. Further review of the medical record revealed these ulcers were originally identified on 8/12/24. Further review of the medical record revealed an order, in effect from 5/18/24 until it was discontinued 8/12/24, to apply small sized border foam dressings as skin prevention on right inner ankle, left lateral pedal (side of foot) area, and right lateral pedal areas daily and as needed. During an interview on 11/20/24, the wound NP #27 revealed she had seen the resident on 5/17/24 during a wound sweep, had identified blanchable red areas and had recommended preventative dressings. The NP reported she attempts to see all residents during a skin sweep conducted quarterly. On 11/19/24 review of the 6/21/24 Minimum Data Set assessment revealed the resident had functional limitations in range of motion with impairment of both sides of the lower extremities (legs) and the resident was dependent on staff for bed mobility and transfers. This assessment also identified the resident as being at risk for pressure ulcers but currently did not have any pressure ulcers. Review of the resident's care plans revealed a plan, initiated 11/9/22, for potential impairment to skin integrity related to advanced age, incontinence and limited mobility. The interventions included, but were not limited to, Medline mattress with pump to reduce pressure, initiated 6/26/24; and Turn and Position every 2 hours, initiated 10/5/23. Further review of the medical record revealed an order, in effect from 8/31/22 until it was discontinued on 6/26/24 for a pressure reducing mattress. Review of the Treatment Administration Records (TAR) revealed staff were documenting the presence of the pressure reducing mattress every shift. On 11/25/24 at 4:00 PM the corporate nurse confirmed the pressure reducing mattress is the regular standard mattress, with no pump. On 11/26/24 at 8:23 AM the corporate nurse reported previously all the mattresses had the pump and then the facility started switching out to regular mattresses. She went on to report she thought they only have a couple of the Medline mattresses left in the building. Further review of the medical record revealed an order for the Medline mattress with pump was in place from September of 2022 until it was discontinued in August 2024. No orders were found for staff to monitor the functionality of the Medline mattress with pump. No documentation was found on the Treatment Administration Record to indicate what mattress was being used from 6/26/24 until a new mattress order was written on 8/12/24 for Continuous Air Flow Mattress with pump. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0686

Level of Harm - Actual harm

Residents Affected - Few

During the 11/20/24 interview, the wound NP confirmed that the Medline mattress with pump is a low air loss mattress. She went on to report that if the resident was already on this mattress she would not have recommended a low air loss mattress, instead she would have documented to continue on the current mattress.

On 11/25/24 at 12:31 PM the Director of Nursing was unable to validate what mattress the resident had on 8/11/24; and indicated it was probably a regular mattress and that is why they ordered the new mattress.

The resident had a room change on 7/26/24. The resident ' s new room was located on a different nursing unit.

Further review of the medical records, including the Treatment Administration Records (TAR) and the Geriatric Nursing Assistant (GNA) documentation for the 30 days prior to 8/12/24 failed to reveal documentation to indicate the resident was being turned and re-positioned every two hours as indicated in the care plan.

On 8/5/24 the resident was seen by a primary care nurse practitioner. The note from this visit includes: Resident is being evaluated today for a Regulatory 30 day visit. Interval history has been reviewed. There were no interval visits or returns to the acute care setting. Resident's weight is up 2 lbs over the past month, favorable.

Further review of the medical record revealed the nursing staff was completing Weekly Skin Checks. Review of these assessments completed in July and on 8/6/24 revealed the resident's skin was intact with no pre-existing conditions or newly identified conditions.

Review of the 8/11/24 Weekly Skin Check, completed by Nurse (Staff #40), revealed documentation that the resident had a pre-existing and a newly identified area, and the Body Diagram section revealed documentation of a skin tear to the knee from a fall. No documentation was found on the 8/11/24 Weekly Skin Check, or elsewhere in the medical record, of the presence of a pressure ulcer prior to 8/12/24.

Further review of the medical record revealed a wound nurse practitioner note (Staff #27), dated 8/12/24, which documented that this was a new consult to assess skin breakdown to bilateral (both) feet and ankles. The note documented 4 pressure injuries:

-Left lateral malleolus (ankle), unstageable 1 cm x 0.8 cm x 0.2cm 80 % slough

-left lateral (outer side) foot; DTI(deep tissue injury); 0.5 x 0.5 x 0.2 cm; 80 % eschar

-left lateral foot distal (closer to toes); DTI; 0.5 cm x 1 cm x 0.0 90% eschar

-right medial (bottom) foot DTI; 1 cm x 1 cm x 0 cm; 80 eschar

Review of policy documentation provided by facility staff during the survey revealed the following definitions:

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	-Slough: Non-viable yellow, tan, gray, green or brown tissue; usually moist; can be soft, stringy and mucinous in texture. -Eschar: Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color; and may appear scab-like. -Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. -Deep Tissue Pressure Injury: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation reveals a dark wound bed or blood-filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia (connective tissue), muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). On 11/20/24 at 8:53 AM an interview was conducted with the wound NP #27. The NP confirmed the 8/12/24 visit was a new consult but she was unable to say who reported it, other than nursing staff. The NP indicated there was a wound referral book on the unit. Review of the Wound Reporting Log, located on the nursing unit in a binder, revealed a notation on 8/11 for Resident #34 by nurse #40. In the column for Wound Type, staff documented Pressure?. In the column for Site, staff documented: L. malleolus (ankle), L. lateral foot and R. med foot. In the column for Current Treatment, staff documented BF (Border Foam). During the 11/20/24 interview, when asked if she thought the resident's wounds were unavoidable, the wound NP reported: If unavoidable I would put that in the note. When asked if she thought these wounds could have developed in a week, she said yes, when asked if they could have developed in a day, she said no. Further review of the 8/12/24 wound NP note failed to reveal documentation that the newly identified wounds were unavoidable. Further review of the medical record revealed the resident was being followed by the wound NP for assessment of pressure ulcers and recommendations for dressings since 8/12/24. A new order for Continuous Air Flow Mattress with Pump was put in place on 8/12/24 and nursing staff have been documenting on the TAR twice daily that they are checking for proper inflation, monitoring for any air leaks and monitoring the cleanliness of the air mattress. Additionally, nursing staff have been documenting on the TAR twice daily, since 8/26/24 of turning and positioning every 2 hours and as needed. A review of the GNA documentation revealed that a prompt was added, on 8/26/24, to document: turn, ambulate, move resident at least every two hours. During the 11/20/24 interview, the wound NP reported the resident had 4 wounds and is currently down to two areas, one stage 3 and one unstageable. Further review of the medical record and observation on 11/21/24 confirmed that two of the pressure ulcers had healed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/25/24 at 10:55 AM surveyor reviewed with the Director of Nursing the concerns that the there was an order for an air mattress since 2022 but no documentation to support that this mattress was being monitored, or was even on the bed, in the weeks prior to the identification of the pressure ulcers; no documentation found to indicate the resident was being turned and repositioned, as indicated in the care plan, in the weeks prior to the identification of four pressure ulcers; and the nursing staff's failure to identify the pressure ulcers on the weekly skin assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48259 Based on observations, record review, and interviews, it was determined that the facility failed to ensure that a resident with a limited range of motion received treatment and services as ordered by the attending provider to prevent further decline in the range of motion. This was evident for 2 (Resident #16 and #40) of 4 residents reviewed for position and mobility. The findings include: 1) In an observation on 11/12/24 at 11:44 AM, Resident #16 was noted with left foot drop and stated, I have limitation in my left hand and on my left foot, I should wear some device, but I haven't had it on for weeks. In a subsequent observation on 11/19/24 at 9:45 AM, Resident #16 was observed in bed, and had no device in place to his/her left extremity. A record review on 11/19/24 at 9:52 AM contained November 2024 order summary report for Resident #16 which recorded an attending provider's order dated 3/3/2015 and reviewed on 11/12/2024 for a brace to Resident #16's left foot drop every shift. Continued review noted an Minimum Data Set (MDS) assessment for Resident #16 dated 10/7/24. Minimum Data Set/MDS is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. The MDS recorded that Resident #16 required maximal to full assistance from staff for all his/her self-care needs. Further review of the MDS showed that Resident #16 had functional limitations of his/her left upper and lower extremities. In an interview on 11/19/24 at 10:02 AM, Resident #16 denied the use of a brace to the left foot drop. In an interview on 11/19/24 at 2:10 PM a registered nurse (Staff #19) reported that Resident #16 use to wear a brace to the left foot drop but could not tell what happened to it. During an interview on 11/19/24 at 3:07 PM the therapy manager (Staff #14), reported that therapy established the use of a left AFO, knee brace for Resident #16 and expected staff to ensure that the resident wore it. An AFO is an ankle foot orthosis which is used to provide support for and improve the function of the foot and ankle. In an interview on 11/20/24 at 9:18 AM, the Director of Nursing (DON) reported that there was a breakdown when the attending provider's order was entered into the facility's electronic health record, so the nurses were not able to see the order in the treatment administration record to apply the brace to the resident's left foot drop. The DON added that the error would be fixed after the surveyor's intervention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51489 2) A contracture is an abnormal shortening of muscle tissue resulting in the muscle becoming resistant to stretching. Failure to prevent a contracture can result in injury caused by the pressure of fingers/fingernails pressing into the palm of the hand. On 11/12/24 at 9:00 AM long-time Resident #40 was observed sleeping in a recliner with the right arm propped across the abdomen with closed fingers, without a splint or palm protector. On 11/12/24 at 2:14 PM a record review of Resident #40 showed the admitting diagnosis was right-sided paralysis secondary to stroke. On 11/14/24 at 9:41 AM Resident #40 was observed sleeping in a recliner with the right hand atop the abdomen with closed fingers and without a splint or palm protection. On 11/15/24 at 12:55 PM a review of the Occupational Therapy Treatment Encounter dated and signed on 10/18/24 at 1:33 PM by a Certified Occupational Therapy Assistant (COTA) (Staff #18) documented that the COTA, resident and Director of Rehabilitation(DOR) (Staff #14) collaborated on various splint options for resident's right hand to promote optimal position and decrease worsening contractures and it indicated that an order was placed for a specialized hand splint on 10/18/24. On 11/15/24 at 11:54 AM the Director of Rehabilitation(DOR) (Staff #14) was interviewed. When asked about the status of Resident #40's splint, s/he responded, I haven't ordered it. It's on a sticky note on my desk. On 11/15/24 at 1:31 PM a review of Resident #40's Treatment Administration Record(TAR) and care plan did not show any documentation for use of a splint or other interventions to prevent contractures. On 11/25/24 at 10:42 AM the Director of Nursing (DON) acknowledged that the facility failed to provide Resident #40 with an appropriate splint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 16218 Based on review of facility reported incident investigation documents and medical records, interviews and observations it was determined that the facility failed to provide adequate supervision to prevent a vulnerable resident from exiting the facility unattended by staff. This was found to be evident for 1 (Resident #234) out of 3 residents reviewed in relation to facility self reports of elopement during the survey. The findings include: Review of Resident #234's medical record revealed the resident was admitted to the facility in December 2021 with multiple psychiatric diagnosis which included paranoid schizophrenia. In November 2022 the resident was receiving multiple psychoactive medications including an antipsychotic, an antidepressant and antianxiety medications. The resident had a court ordered guardian of person since 2016. On 10/8/22 the resident was deemed by two facility providers unable to make health care decisions. Review of a nursing progress note dated 8/27/22 revealed: No behaviors noted other than resident has all of [his/her] stuff packed to go home. Review of the 9/30/22 Minimum Data Set assessment revealed the resident required supervision or touching assistance for walking and did not use a wheelchair. The resident had wandering behavior on 1-3 days during the assessment period. Review of a 11/2/22 nursing progress note, written by Nurse #4, revealed: Resident able to walk around in [his/her] room and out in the hallway with steady gait. Review of the medical record revealed a progress note written by the then Activity Director (Staff #30) on 11/7/2022 at 4:45 PM that revealed: [Resident] sitting in lobby beside Dining Room with [his/her] belongings packed in plastic bags. Observation of the lobby area near the dining room, on 11/15/24 at 9:45 AM, revealed it is next to glass exit doors leading to a road. These doors were noted to be locked at the time of the observation. This lobby is on the second floor of the facility, where all of the resident rooms are located. Interview with the Director of Nursing on 11/15/24 at approximately 9:00 AM revealed these doors were utilized for transporting residents in stretchers in and out of the building up until July 2024. The main facility lobby is located on the first floor. During an interview on 11/15/24 at 10:18 AM surveyor and nurse #4 reviewed the 11/7/22 activity note. After review of the note surveyor asked : If this had been reported to you would you have completed an elopement assessment? The nurse responded yes, and went on to report that she would try to get to the bottom of the situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER: Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of progress note written by the then social worker (Staff #32) on 11/8/22 at 4:04 PM revealed: Resident stated that [he/she] felt that [s/he] should be admitted to an in-patient psych facility. Resident began to state [his/her] diagnosis. [Resident] also began to make delusional statements, as well. Review of the progress note written by social worker (Staff #32) on 11/10/22 revealed: [Resident] once again stated that [he/she] would like to be placed in an in-patient psych facility. [Resident] stated that s/he felt like she was having a breakdown. Review of the nursing progress note, dated 11/30/22 at 8:00 PM revealed: [Resident] attempted elopement and was on the first floor of the parking garage; returned without incident accompanied by [Nurse #4] and [Nurse #7] back to room. Review of the initial self report (MD00186275) submitted by facility staff revealed that on 11/30/22 at approximately 8:00 PM the resident went to the first floor of the building in an attempt at elopement stating I just want to go home. Staff returned the resident to the second floor and placed the resident on 15 minute checks. Resident was placed on 15 minute checks, and was moved to the locked unit to ensure safety. The resident's guardian, attending physician, social worker , and psychiatry were notified for follow up. Further review of the medical record failed to reveal documentation of an elopement assessment prior to 11/30/22. Review of the care plans revealed a plan addressing behavioral issues was initiated in July 2022 for behaviors that included, but was not limited to: frequently packs up belongings. Further review of the care plans failed to reveal interventions to address a potential for elopement prior to 12/1/22. During an interview on 11/15/24 at 10:18 AM nurse (Staff #4) confirmed that sometimes the resident would pack up his/her bags. Nurse #4 reported the resident had significant psychiatric history with delusions but was not considered an elopement risk and indicated it was a surprise when the resident eloped. Observations made throughout the survey revealed a main entrance at the front of the building that leads into the main lobby on the first floor. From this lobby there is a door that leads to the parking garage and an elevator to the resident care area on the second floor. Observations on the second floor revealed codes were required to gain access to the elevators or the stairs that led to the first floor. On 11/14/24 at 2:21 PM observation of the door from the main lobby to the parking garage revealed it is unlocked; and was able to be opened without any impediment. The garage is a small parking lot which leads to an access drive to the front entrance of the facility. It is a short walk to the road that the facility is located on. There is a steep hill down to the main road just outside the garage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/15/24 review of the witness statements revealed the resident was found in the parking garage by two GNAs (Staff 5 and 6) who were on their break. The Resident was attempting to gain access to a truck at the time s/he was found. One GNA remained with the resident while the other went to get assistance. On 11/15/24 at 10:18 AM Nurse #4 reviewed her written statement and confirmed the contents. Review of the statement revealed Nurse #4 was alerted to the situation by one of the GNAs and assisted the resident back inside the facility. When found in the garage the resident was noted to be dressed in a hospital gown, pants, shoes and a jacket and was holding a bag with a few pieces of clothing in it. Nurse #4 confirmed that the resident was found in the parking garage attempting to gain access to a vehicle. On 11/15/24 at 9:52 AM the facility presented to the survey team a plan of correction that was implemented on 11/30/22 with a final date of compliance of 12/6/22. This plan was verified on site on 11/18/24. The plan included : -Initial Performance Improvement Project on Elopements through QAPI [Quality Assurance Performance Improvement]. -Provided education to visitors to seek assistance if any resident attempts to accompany them into the elevator or out the door, posted signs as a reminder to visitors and staff. -Systemic Change to elevator code. -Reviewed and revised elopement risk policy. -Educated staff on policy as well as tips to prevent elopement. -Completed updated elopement risk assessments on all current residents. -Scheduled monthly Elopement Drills for three months. On 11/19/24 at 10:40 AM surveyor informed the DON and Nursing Home Administrator that, after consultation with the office, a determination of IJ Past Non-Compliance was made.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe, appropriate pain management for a resident who requires such services.

48259

Based on medical record review and interviews, it was determined that the facility failed to consistently document the reasons for administering an as-needed (PRN) pain medication and failed to document pain assessment to include the location of the pain and type of pain for a Resident reporting pain. This was evident for 1 (Resident #10) of 5 Residents reviewed for unnecessary medications review.

The findings include:

A medical record review on 11/13/24 at 2:07 PM showed that Resident #10 had been residing in the facility since December 2022 with diagnoses including chronic back pain.

The continued review contained a care plan for pain for Resident #10 that was initiated on 12/20/2022 with revision on 11/11/2024. The interventions on the care plan included but were not limited to Assess and Document non-pharmacological interventions before administering PRN pain medication such as, but not limited to, food, social interactions, positioning, movement, heat/cold, massage, music, administer [pain medicine] as per orders; evaluate effectiveness and consult with [attending provider] accordingly for needed adjustments.

Non-pharmacological Interventions (NPI)- are interventions without the use of medications.

Further review of Resident #10's medication administration records (MAR) for September and October 2024 found an attending provider order dated 9/16/24 for Hydrocodone-Acetaminophen Tablet 5-325 MG to be given to Resident #10 every 4 hours as needed for pain level of 4-10 (A pain scale/level ranges from 0 to 10; 0 means no pain, and 10 means the worst pain. It is used to assess a patient's level of pain so that better treatment can be provided).

Resident #10's MAR had recorded that the nurses administered the medicine to Resident #10 on 9/3/24 for a pain level of 9, 9/4/24 for a pain level of 8, 9/7/24 for a pain level of 7, 9/12/24 for a pain level of 4, 9/17/24 for a pain level of 9, 9/21/24 for a pain level of 3, 9/26/24 for a pain level of 8, 10/1/24 for a pain level of 7, 10/9/24 for a pain level of 7, 10/14/24 for a pain level of 5, 10/20/24 for a pain level of 6, and 10/20/24 for a pain level of 9.

However, the review failed to show a record of Resident #10's pain assessment before and after administering the medicine, including the location, type of pain, non-pharmacological interventions implemented before administering pain medicine, and the specific indications for administering the drug.

The review also noted that after administering the pain medicine, the pain level was 5 on 9/4/24, 5 on 9/7/24, 2 on 9/17/24, 5 on 9/21/24, 8 on 9/26/24, and 3 on 10/9/24. The review failed to show that the staff continued to manage Resident #10's pain at those levels after administering pain medicine.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/15/24 at 7:33 AM, the Director of Nursing (DON) confirmed concerns and stated that the nurses were expected to attempt NPI before administering PRN pain medications. The DON also added that the nurses should have recorded the reasons for administering the PRN pain medicine and the pre and post-pain assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48259 Based on medical record review and interviews, it was determined that the facility staff failed to obtain pre-dialysis treatment records for a resident. This was evident for 1 (Resident #37) of 1 resident reviewed for dialysis. The findings include: A record review for Resident #37 on 11/21/24 at 11:43 AM contained a hospital discharge summary dated 11/02/23 that recorded that the resident had a diagnosis of end-stage renal disease and required hemodialysis. Hemodialysis, also known as dialysis, is a treatment that filters and purifies the blood using a machine in people whose kidneys can no longer perform these functions naturally. A continued review found an attending provider's order dated 11/2/23 for Resident #37 to receive dialysis three times a week on Mondays, Wednesdays, and Fridays at 0640. Further review showed dialysis communication forms for October 1- November 20, 2024, and instructions for filling the forms. The forms included areas for the facility to document the resident's name, the date, vital signs, and general condition of the resident before being transported to dialysis. The instructions stated, Dialysis form to be completed in its entirety (no blank spaces, place N/A if not applicable to that resident) and sent with resident in the binder provided. Be sure to include any change in condition on the form so dialysis is aware. However, the review failed to show pre-dialysis vitals for 10/2/24, 10/4/24, 11/1/24, 11/11/24, and 11/13/24. Pre-dialysis vitals were not recorded on the form for 10/21/24, which also contained a statement by the dialysis center that they were Not filled out by nursing home. Another communication form dated 11/18/24, which was returned to the facility after dialysis, contained a statement by the dialysis nurse that stated, Please complete before dialysis to have a baseline. In an interview on 11/21/24 at 12:01 PM a registered nurse (Staff #11), stated the nurses typically obtained the resident's temperature, pulse, respiration, and blood pressure before dialysis and completed the dialysis communication form with that information to inform the dialysis center of how the resident was doing pre-treatment. In an interview on 11/21/24 at 12:37 PM, the Director of Nursing confirmed concerns and stated she expected the nurses to assess the vitals, fill out the form, and send that record to the dialysis center each time the resident went for dialysis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48168 Based on record review and interview it was determined that the facility failed to employ competent nursing staff. This was evident during the Staffing task investigation, and for 1 complaint (#MD00205800) of 13 complaints reviewed during the recertification survey. The findings include: On 11/12/24 at 3:01 PM a review of complaint #MD00205800 revealed an allegation that facility staff were not competent when they gave Resident #242 care. On 11/15/24 at 9:15 AM employee records were requested from the Director of Human Resources (Staff #28). On 11/15/24 at 11:08 AM the requested employee files were received and reviewed. The review of the records for Registered Nurse (RN #25) failed to reveal any evidence of a competency or skills evaluation. On 11/19/24 at 10:17 AM an interview was conducted with the Director of Nursing (DON), and she was asked for evidence of any skills competency evaluation for RN #25. The DON said she would look and let me know. On 11/19/24 at 11:46 AM in another interview with the DON she explained that the facility did not do competency/skills evaluation when RN #25 was hired but would look for further evidence that a competency evaluation had been done. On 11/19/24 at 4:00 PM in an interview with Staff #28, she confirmed that no competencies existed for RN #25. On 11/26/24 at 11:29 AM an interview was conducted with the DON, Nursing Home Administrator, and the Corporate Clinical [NAME] President (Staff #3) to review the lack of any competency evaluation for RN #25 and they confirmed the deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0740

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident must receive and the facility must provide necessary behavioral health care and services.

16218

Based on medical record review and interview it was determined that the facility failed to ensure ordered 15 minute checks for suicidal ideation; and failed to report increase in agitation that resulted in the administration of Ativan without an order. This was found to be evident for 2 (Resident #234 and #66) out of 50 residents reviewed during the survey.

The findings include:

1) Review of Resident #234's medical record revealed the resident was admitted to the facility in December 2021 with multiple psychiatric diagnosis which included paranoid schizophrenia. In November 2022 the resident was receiving multiple psychoactive medications including an antipsychotic, an antidepressant and antianxiety medications. The resident had a court ordered guardian of person since 2016. On 10/8/22 the resident was deemed by two facility providers, unable to make health care decisions.

Review of the progress notes revealed on 11/10/22 nurse #53, documented: This writer was informed by social services that resident made suicidal ideations toward staff. Resident was placed on 15 min checks for resident safety. Message left for psychologist.

The resident was seen by the primary care Nurse Practitioner (NP) on 11/10/22. The NP note also revealed a plan for 15 minute checks.

Review of the paper chart revealed a corresponding order, dated 11/10/22, for 15 minute checks for suicidal statement to staff. And an order to Notify Geri-Psych Provider of increased depression and suicidal statement to staff.

On 11/18/24 at 3:35 PM the Director of Nursing (DON) confirmed that orders for every 15 minute checks should be in the electronic health record and that it would show up on the Treatment Administration Record (TAR).

Further review of the electronic health record failed to reveal documentation to indicate the order for 15 minute checks was entered into the electronic health record (computer system). No documentation was found on the TAR to indicate these checks were occurring.

Review of the progress notes revealed documentation on 11/13/22 at 1:36 AM, 11/14/22 at 2:02 AM and 11/18/22 at 3:27 PM that indicated the every 15 minute checks were occurring. Further review of the medical record failed to reveal documentation on November 11, 12, 15, 16 or 17, 2022 regarding the every 15 minute checks. No documentation was found to indicate the every 15 minute checks continued in November after the 11/18/22 progress note. No documentation was found to indicate the physician discontinued the order for the every 15 minute checks.

No documentation was found to indicate the resident was seen by psych services in November 2022.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/1/24 a new order for every 15 minute checks was placed in the electronic health record for increased risk of elopement. This order was documented by nursing staff until the resident was discharged . On 11/18/24 at 3:43 PM surveyor reviewed with the DON the concern that the resident had suicidal ideation reported on 11/10/22; was seen by nurse practitioner with an order for every 15 minute checks but review of the electronic health record failed to reveal documentation to indicate this order was put into the electronic health record, and failed to reveal documentation to indicate these checks were occurring, other than a few nursing progress notes that mention it. 2) Resident #66 diagnosis includes, but is not limited to, Alzheimer's disease and depression. Review of the 10/17/24 nurse practitioner (Staff #49) note revealed: .has a history of falls thought related to lorazepam given for severe episodes of agitation . Further review of the medical record revealed that on 11/15/24 Nurse #52 documented: Nursing care continues. Patient alert and confused, easily agitated and difficult to redirect. 1:1 private sitter at bedside to interact and help safely occupy time during waking hours. Patient required multiple attempts and much encouragement to administer HS medications. Approx 2145 patient began yelling loudly and throwing objects around in room. Staff and sitter unsuccessfully attempted to de-escalate patient. PRN Ativan given at 2200 with minimal effect noted at this time. Patient awake in room pacing, confused, talking to himself, but no longer presenting with any physical threat of harm to self or others. Will continue to monitor for safety. Further review of the medical record revealed the resident did not have a current as needed order for Ativan when it was administered by the nurse on 11/15/24. There had been an order on 10/16/24 but it was discontinued on 10/18/24. Further review of the nursing progress notes revealed that on 11/16/24 at approximately 2:30 AM the resident fell in the bathroom. The nurse assessed the resident and no injury was identified. The physician and responsible party were notified of the fall. No documentation was found to indicate the physician was made aware of the behaviors the resident was exhibiting earlier in the evening and the administration of the Ativan. Further review of the medical record revealed nursing staff administered the discontinued Ativan on the evenings of 11/16 and 11/17. On 11/25/24 surveyor reviewed the concern with the corporate nurse (Staff #3) that the Ativan order was discontinued on 10/18/24, but was administered on 11/15/24 due to behaviors. The resident fell a few hours later and the physician was notified of the fall but not of the behaviors that had precipitated the administration of the Ativan. Also that the same nurse continued to administer the Ativan without an order on 11/16 and 11/17. (Cross reference to F 760)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 48470 Based on records review, observations and interviews, it was determined that the facility failed to ensure services provided to a resident with dementia are based on their choices and preferences. This was evident in 1 (Resident #57) of 4 residents reviewed for dementia care. The findings include: Resident #57 was admitted to the facility in early 2023. The resident was observed in the dementia unit on multiple occasions throughout the survey process. In these observations, the resident was watching TV with no other meaningful activity being provided. The observation dates include: 11/13/24 at 12:16 PM, 11/15/24 at 12:55 PM, and 11/19/24 at 2:48 PM. A review of Resident #57's preference evaluations was conducted on 11/21/24 at 10:25 AM. The review revealed that the most recent evaluation was done by an Activities Assistant (Staff #13) dated 11/6/24. The questions in the evaluation were all marked as No response or non-responsive. Further review of the resident's medical record revealed the next date that the preference evaluation was conducted was on 8/6/24 and was done by the same staff member. This evaluation revealed the same answers (No response or non-responsive) to the questions regarding the resident's choices and preferences. Staff #13 was interviewed on 11/21/24 at 10:28 AM and reported her process when conducting the preference interview. Staff #13 also reported that the interviews are done on admission and every quarter thereafter. Staff #13 was questioned on her process when a resident is cognitively impaired and are not able to answer her questions. Staff #13 stated, We are supposed to call the family or a family member to do the interview with. I am already aware that I didn't do them correctly. I was not told how to do them from the get-go, I was just trying to help. On 11/26/24 at 10:28 AM, the concern was discussed with the Director of Nursing, Nursing home Administrator, and the VP of Clinical Services that a resident with dementia was not provided with meaningful activities, because his/her choices and preferences were not established to attain or maintain the highest practicable well-being. All staff acknowledged the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 48259 Based on medical record review, observations and staff interviews, it was determined that the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to ensure that an attending provider's orders for a resident's topical anesthetic medication included a time to remove it; and failed to provide adequate monitoring and indications for use of biological creams. This was evident for 1 (Resident #10) of 5 residents reviewed for unnecessary medications; and 1 (Resident #30) of 3 reviewed for pressure ulcers during this survey The findings include: 1) A record review completed for Resident #10 on 11/13/24 at 2:07 PM, contained an attending provider's order dated 11/8/24 for Aspercreme Lidocaine External Patch 4% (Lidocaine) Apply to back topically two times a day for pain Apply in AM and remove every PM. Lidocaine Patch is used to manage pain. Depending on the product, the patch may be left on the skin for up to 8 or 12 hours. Applying too many patches or topical systems or leaving them on too long may cause serious side effects. Further review of Resident #10's medication administration record (MAR) for November 2024 showed that the patch was placed on Resident #10's back twice daily from November 9 to November 14, 2024; however, the review failed to show that the patch was removed daily. In an interview on 11/15/24 at 6:58 AM, staff #34, a registered nurse, reported that her concern with the attending provider's order for Resident #10's lidocaine patch was that staff could document the time the patch was placed on the resident. However, it did not specify a time for its removal, so staff could not report when it was removed. In an interview with the director of nursing on 11/15/24 at 7:33 AM, she said that Resident #10's attending provider's order for the lidocaine patch was entered into the facility's electronic record without time to remove the patch. 51489 2) On 11/12/24 at 2:14 PM a record review revealed Resident #30 as a long-time resident admitted with unspecified dementia with other behavioral disturbances. On 11/12/24 at 2:31 PM further review of the care plan showed care concerns related to: Activities of Daily Living (ADL) self-care deficit, bowel and bladder incontinence, and skin breakdown. On 11/12/24 at 3:00 PM a review of the Minimum Data Set 3.0 (MDS) section H revealed that resident is incontinent of bowel and bladder. On 11/19/24 at 3:15 PM an interview with Geriatric Nurse Assistant (GNA) (Staff #20) revealed that the resident is a heavy wetter [frequently incontinent], and that she puts fungal cream on often. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 3:20 PM an interview with a Registered Nurse (RN) (Staff #11) reported that GNA's do incontinent care, including apply cream and report to the nurse once it's applied. On 11/19/24 at 3:40 PM GNA (Staff #20) was observed retrieving two tubes of cream from Resident #30's unlocked drawer. Further observation revealed that the tubes were antifungal cream. GNA (Staff #20) identified these tubes as the barrier cream that she applies to Resident #30. On 11/20/24 at 8:21 AM an interview with Nurse Practitioner (NP) (Staff #27) revealed that Resident #30 needed treatment for MASD (Moisture Associated Skin Damage). I recommended a barrier cream. When asked, do you consider antifungal cream a barrier cream? NP (Staff #27) replied, no. On 11/20/24 at 9:41 AM an interview with the Assistant Director of Nursing (ADON) (Staff #4) revealed that GNA's are not supposed to apply medicated creams like Zinc or antifungal creams. On 11/20/24 at 11:12 AM during an interview with a Certified Nurse Assistant (CNA) (Staff #21) s/he denied training on which cream to apply. On 11/21/24 at 8:05 AM a record review of the Medication Administration Record (MAR) showed an order for Zinc Oxide and it failed to reveal an order for antifungal cream. On 11/25/24 at 10:46 AM the Director of Nursing (DON) was made aware that GNA and CNAs were applying antifungal cream as barrier cream. DON replied, they should not be doing that, we will look into it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48259 Based on medical record review and interviews, it was determined that the facility failed to document the specific reasons for administering a psychotropic medication and failed to implement non-pharmacological interventions (NPI) before administering the medicine as needed (PRN). This was evident for 1 (#10) of 5 Residents reviewed for unnecessary medications review. The findings include: A record review for Resident #10 showed attending provider's orders dated 9/17/24 to 10/1/24 and 10/1/24 to 10/10/24, for antianxiety medication to be administered to Resident #10 every 8 hours PRN for anxiety, then 10/10/24 to 11/20/24 two times daily for anxiety/agitation. A review of Resident #10's medication administration record (MAR)for September 1, 2024, to November 15, 2024, was completed. The MAR had recorded that the nurses administered the PRN antianxiety medication to Resident #10 on 9/26/24 and 10/5/24, and the post-medication assessment for both days stated: ineffective. The resident had also received the drug every day from October 10, 2024, to November 15, 2024. However, the review failed to show the specific behaviors for which the antianxiety medication was administered, NPI (Non-pharmacological interventions are interventions without medications) attempted before administering the medicine as needed, what interventions were implemented when the post-medication assessments stated ineffective, ongoing monitoring of changes in behaviors that necessitated the use of the antianxiety medication and ongoing monitoring of side effects related to the use of the medication. In an interview with the director of nursing on 11/15/24 at 7:33 AM, she confirmed concerns and stated that her expectation of the nurses was to attempt NPI before administering the medication as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

48470

Based on observations and records review, it was determined that the facility failed to ensure that medication error rates were below 5% during the completion of the medication administration facility task. This was evident for 2 of the 36 opportunities observed for the medication administration.

The findings include:

On 11/14/24 at 7:13 AM, the Registered Nurse (RN Staff #8) was about to begin her morning medication (med) pass. The surveyor requested to observe Staff #8 in her med pass, and she agreed.

Staff #8 was observed from 7:13 AM until 7:42 AM and had a total of 36 opportunities for medications administered with different routes, for 5 residents.

Later, at 8:14 AM, the medical records of the 5 residents were reviewed to verify the accuracy of the medications that Staff #8 had administered. The review revealed the following concerns:

1) On 11/14/24 at 7:32 AM, Staff #8 administered 1 tablet of Calcium 600 mg. with 10 mcg. of Vitamin D to Resident #33. The review of the medical record revealed the order was for 1 tablet of Calcium 600 mg. with 200 mg of Vitamin D.

2) On 11/14/24 at 7:42 AM, Staff #8 administered 2 tablets of Acetaminophen 500 mg. to Resident #73. The review of the medical record revealed the order was for 1 tablet of Acetaminophen 500 mg.

On 11/14/24 at 10:26 AM, Staff #8 was interviewed about the discrepancies with the medications that she had administered, versus what was ordered for the residents. Staff #8 proceeded to review Resident #33's medication orders and confirmed that what she administered was a different dose. Staff #33 indicated that she would talk to the physician to ask if the order can be changed since the Calcium 600 mg with 10 mcg. of Vitamin D was what the facility had in stock.

Staff #8 then reviewed the medication orders of Resident #73. While Staff #8 was looking into the resident's medical records, she indicated that the resident is supposed to get 2 tablets of the Acetaminophen because s/he had severe back pain. Upon completion of the review of orders, Staff #8 confirmed that Resident #73's order for Acetaminophen was for 1 Tablet of 500 mg 3 times daily and she administered 2 tablets with 500 mg each. Staff #8 indicated that to her knowledge, the resident was to receive and had been receiving 2 tablets each time like how she had administered it.

On 11/14/24 at 11:20 AM, the identified concern with medication errors was discussed with the Director of Nursing (DON) and she indicated that she was already aware and that they had notified the physician to see if the orders can be changed. The medication error rate of 5.56% was discussed with the DON and she verbalized understanding and acknowledged the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 16218 Based on medical record review and interview it was determined that the facility failed to ensure a resident was free from a significant medication error. This was found to be evident for one (Resident #66) out of three resident with orders for as needed controlled medications reviewed during the investigation of drug diversion. The findings include: Resident #66 diagnosis includes, but is not limited to, Alzheimer's disease and depression. Review of the 10/17/24 nurse practitioner (Staff #49) note revealed: .has a history of falls thought related to lorazepam given for severe episodes of agitation . On 11/21/24 at approximately 12:15 PM during the investigation of drug diversion surveyor randomly picked three residents with as needed narcotics from the drug control book. Resident #66's as needed lorazepam Controlled Drug Administration Record was one of the three selected for review. Review of Resident #66's Controlled Drug Administration Record revealed a prescription, dated 10/17/24, for Lorazepam 1 mg every 12 hours as needed; and a supply of 30 tablets was received. The supply currently consisted of 24 tablets. Doses were documented as removed during the evening shifts on November 15, 16 and 17. An additional 3 doses were removed, with half tabs being destroyed, on 11/20 and 11/21. Review of the Medication Administration Record (MAR) failed to reveal an area for staff to have documented the administration of the doses removed on November 15, 16 and 17. On 11/21/24 at 12:23 PM surveyor obtained a copy of the Controlled Drug Administration Record from nurse #36 and asked the nurse if there was an as needed Ativan order. The nurse reports there was an order for 1 mg that was discontinued. On 11/21/24 at 12:44 PM further review of the medical record revealed a physician order, written on 10/16/24 for lorazepam (Ativan) 1 mg give every 12 hours as needed for anxiety/agitation that was discontinued on 10/18/24. There was also a new order on 11/19/24 for a standing dose of Ativan 0.5 mg one table three times a day that would account for the the three half tabs removed on 11/20 an 11/21. Review of the facility policy for Controlled Substances (Revision date of November 2022) revealed the following: Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed. Accountability records for discontinued controlled substances are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation. The consultant pharmacist or designee routinely monitors controlled substance storage records. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed that on 11/15/24 Nurse #52 documented: Nursing care continues. Patient alert and confused, easily agitated and difficult to redirect. 1:1 private sitter at bedside to interact and help safely occupy time during waking hours. Patient required multiple attempts and much encouragement to administer HS medications. Approx 2145 patient began yelling loudly and throwing objects around in room. Staff and sitter unsuccessfully attempted to de-escalate patient. PRN Ativan given at 2200 with minimal effect noted at this time. Patient awake in room pacing, confused, talking to himself, but no longer presenting with any physical threat of harm to self or others. Will continue to monitor for safety. Further review of the nursing progress notes revealed that on 11/16/24 at approximately 2:30 AM the resident fell in the bathroom. The nurse assessed the resident and no injury was identified. The physician and responsible party were notified of the fall. No documentation was found to indicate the physician was made aware of the behaviors the resident was exhibiting earlier in the evening and the administration of the Ativan. There were no nursing progress notes found to indicate why the resident would have required the Ativan when it was removed from the supply on 11/16/24 at 9:00 PM. On 11/18/24 at 7:12 AM Nurse #52 documented: .Upon initial approach for 7p-7a shift patient noted to be agitated, difficult to redirect and experiencing severe auditory/visual hallucinations. Patient did accept due meds @ 2000 (8:00 PM) but with little no to effect on behaviors of yelling, wandering, and being physically aggressive to staff . This note failed to document about the dose of Ativan that was removed from the supply on 11/17/24 at 9:00 PM. On 11/21/24 at 12:56 PM surveyor reviewed with the Director of Nursing (DON) regarding the removal of 3 doses of Ativan without an active order, and that review of progress notes did reveal documentation regarding one of these doses but not the other two. Further review of the medical record on 11/22/24 revealed a note written by Assistant Director of Nursing (ADON Staff #23) with an effective date of 11/21/24 at 8:10 PM: Noted that during evening med pass on 11/15-11/16 -11/17 that resident was given PO [by mouth] Ativan 1 mg each night. Medication was old order that had been discontinued. Nurse on duty, pulled medication and gave it prior to noticing that it had been a d/c'd order. Provider and [family member] aware. Resident did not show any adverse effects from medication error. On 11/26/24 at 10:15 AM surveyor reviewed with the DON the concern regarding failure to prevent a significant medication error.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

48470

Based on observations and interviews, it was determined that the facility failed to store medications in accordance with professional standards by failing to discard expired medications; failing to ensure medicated creams were kept in the locked medication carts or storage rooms; and failure to ensure discontinued controlled medications were removed and discarded. This was evident in 1 of 3 medication carts observed during medication storage and labeling inspection; and 3 (Resident #30, #44 and #66) of 50 residents reviewed during the survey.

The findings include:

1) On 11/15/24 at 1:47 PM, the medication cart for the Haven unit was inspected. An opened Fluticasone Propionate and Salmetrol inhalation powder 100-50 mcg. was labeled with Resident #7's name and had an opened date of 10/1/24. According to the manufacturer's instructions, the medication should be discarded 1 month after opening the foil pack.

The Registered Nurse (RN Staff #8) was present during the inspection of the medication cart. Staff #8 confirmed that the medication should have been discarded on 11/1/24.

On 11/18/24 at 9:25 AM, the finding was discussed with the Director of Nursing (DON). The DON verbalized understanding that the medication should have been discarded already at that time and acknowledged the concern.

51489

2) On 11/19/24 at 3:40 PM a Geriatric Nurse Assistant (GNA) (Staff #20) was observed entering Resident #30's room where s/he pulled two tubes of antifungal cream from the resident's unlocked dresser drawer.

On 11/20/24 at 9:41 AM Assistant Director of Nursing (ADON) (Staff #4) stated, only approved barrier cream is kept in residents' rooms and Zinc is kept on the treatment cart.

On 11/20/24 at 10:21 AM an observation was made in the stock storage closet in hall 200 with ADON (Staff #4). It revealed an empty bin labeled for barrier cream next to a full bin labeled for antifungal cream. ADON (Staff #4) acknowledged that it could be confusing to store antifungal and barrier cream next to each other. When asked what is the policy for storing antifungal cream, ADON (Staff #4) indicated that it should be stored in the nurse's locked medication room.

On 11/20/24 at 10:56 AM the surveyor and Staff #4 entered Resident #30's room. Staff #4 opened the resident's drawer and produced an expired tube of Zinc and two tubes of antifungal cream.

3) On 11/20/24 at 11:12 AM an interview with Certified Nurse Assistant (CNA) (Staff #21) revealed that Resident #44 has a tub of Zinc in the room.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 11:36 AM Staff #4 entered Resident #44's room and located Zinc Oxide, antifungal cream and barrier cream in a wash basin at the resident's bedside. On 11/21/24 at 08:06 AM a review of the facility's Medication Labeling and Storage policy stated: compartments containing medications and biologics are locked when not in use, and trays and carts used to transport such items are not left unattended if open or otherwise potentially available to others. On 11/25/24 at 10:47 AM the Director of Nursing verbally recognized that medications need to be locked and accessed by nurses only. We will ensure that the CNA's don't have access to medications. 16218 3) On 11/21/24 at approximately 12:15 PM during the investigation of drug diversion surveyor randomly picked three residents with as needed narcotics from the drug control book. Resident #66's as needed lorazepam (Ativan) Controlled Drug Administration Record was one of the three selected for review. Review of Resident #66's Controlled Drug Administration Record revealed a prescription, dated 10/17/24, for Lorazepam 1 mg every 12 hours as needed; and a supply of 30 tablets was received. The supply currently consisted of 24 tablets. Doses were documented as removed during the evening shifts on November 15, 16 and 17. An additional 3 doses were removed, with half tabs being destroyed, on 11/20 and 11/21. On 11/21/24 at 12:23 PM surveyor obtained a copy of the Controlled Drug Administration Record from nurse #36 and asked the nurse if there was an as needed Ativan order. The nurse reported there was an order for 1 mg that was discontinued. On 11/21/24 at 12:44 PM further review of the medical record revealed a physician order, written on 10/16/24 for lorazepam (Ativan) 1 mg give every 12 hours as needed for anxiety/agitation that was discontinued on 10/18/24. On 11/21/24 at 12:56 PM surveyor reviewed with the Director of Nursing (DON) the concern regarding the removal of 3 doses of Ativan without an active order. Further review of the medical record on 11/22/24 revealed a note written by Assistant Director of Nursing (ADON Staff #23) with an effective date of 11/21/24 at 8:10 PM: Noted that during evening med pass on 11/15-11/16 -11/17 that resident was given PO [by mouth] Ativan 1 mg each night. Medication was old order that had been discontinued. Nurse on duty, pulled medication and gave it prior to noticing that it had been a d/c'd order. Provider and [family member] aware. Resident did not show any adverse effects from medication error. Review of the facility policy for Controlled Substances (Revision date of November 2022) revealed the following: Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed. Accountability records for discontinued controlled substances are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation. The consultant pharmacist or designee routinely monitors controlled substance storage records. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference to F 760 4) On 11/12/24 at 1:08 PM review of Shift Change - Controlled Substance Inventory Tracker for the Unit 1 Med Cart 400 revealed the day nurse had already signed in the area of the form as the off going nurse on 11/12 at 7:00 PM. Review of the facility policy for Controlled Substances (Revision date of November 2022) revealed the following: Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. On 11/12/24 at 1:29 PM surveyor reviewed the Shift Change - Controlled Substance Inventory Tracker for the Unit 1 Med Cart 400 with the corporate nurse (Staff #3). When asked if she saw anything of concern the corporate nurse identified where the nurse had already signed in the area dated 11/12 at 7:00 PM as the Off going nurse. On 11/20/24 at 4:01 PM surveyor reviewed the earlier observation of staff pre-signing the narcotic count sheet with Assistant Director of Nursing (Staff #4), who responded: they should not of done that.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0776

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48168

Based on record review and interview it was determined that the facility failed to provide timely radiological services to its residents. This was evident for 1 facility reported incident (#MD00190908) of 25 facility reported incidents investigated during the recertification survey.

The findings include:

On 11/21/24 at 10:45 AM a review of the facility reported incident MD00190908 revealed that Resident #245 was found to have a fractured pelvis when a CT scan (computed tomography scan) was performed on 3/24/23. The fracture was reported to the facility on [DATE].

On 11/21/24 at 11:01 AM Resident #245's clinical record was reviewed. The record contained a scanned document of an oncologist consult visit on 2/14/24. The oncologist recommended an MRI (Magnetic Resonance Imaging) due to the resident's complaint of left hip pain. This portion of the scanned consult note was circled in a pink color. Further review of the resident's clinical record failed to reveal any order for an MRI.

On 11/21/24 at 11:10 AM review of the facility investigation file revealed the explanation that the resident was unable to have an MRI for medical reasons, however no reason was given for the delay in ordering an alternative diagnostic test.

On 11/21/24 at 11:20 AM an interview with the Director of Nursing (DON) was conducted. When asked about the delay in Resident #245's CT scan, the DON said that she would look for any information to explain the delay. She noted that the oncologist consult note was sent to a different facility and not received at the resident's facility until 4/04/23. When asked what the expectation was when residents visited outside providers, the DON said the expectation was that if a resident saw an outside provider and no report was received from the visit, that the provider would be contacted within a week to obtain the information.

On 11/26/24 at 11:29 AM an interview with the DON, Nursing Home Administrator, and Corporate Nurse (Staff #3) was conducted to review the concern. No further information was provided. The DON confirmed that the facility staff should have looked for the oncologist consult within a week of the oncologist's appointment and that there was a delay in providing Resident #245 with radiology services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 48168 Based on review of facility staffing data and staff interviews, it was determined that the facility failed to ensure compliance with The Code of Maryland Regulations for Nursing Services - Staffing, 10.07.02.19 which states that A nursing home shall employ supervisory personnel and a sufficient number of support personnel to provide a minimum of 3 hours of bedside care per occupied bed per day, 7 days per week. by failing to ensure staffing at or above 3 hours of bedside care per patient per day (PPD). This was found to be evident for 63 out of 167 days reviewed. The findings include: 1.) On 11/12/24 at 11:15 AM a review of complaint #MD00192372 submitted on 5/16/23 revealed the allegation that the facility was short staffed. On 11/13/24 the Staffing Coordinator (Staff #29) was asked to provide the survey team with the facility's staffing data and actual nursing assignment sheets for April and May 2023. On 11/19/24 at approximately 1:10 PM the facility's staffing data for April and May 2023 was received and reviewed. A review of the PPD data for April and May 2023 revealed that there were 16 of 61 days with a PPD of less than 3.0. On 11/19/24 at 2:45 PM an interview was conducted with Staff #29, and she confirmed the days that were deficient for PPD for April and May 2023. On 11/19/24 at 3:27 PM in an interview with the Director of Nursing (DON), the PPD data deficiency was reviewed, and no further evidence was provided. 2.) On 11/13/24 a review was conducted of complaint #MD00200181 which was submitted on 12/04/23. The review revealed that the complainant alleged that the facility's staff to patient ratio was 1 Geriatric Nursing Assistant (GNA) to every 28 patients, which the complainant alleged was impossible to provide appropriate care. On 11/19/2024 at 3:02 PM Staff #29 was asked to provide PPD data for October 2023. On 11/19/2024 at 3:21 PM Staff #29 provided the October 2023 PPD data. A review of the report revealed that the facility's PPD was less than 3.0 for 9 of the 31 days in October 2023. On 11/19/24 at 3:27 PM in an interview with the DON, the surveyor reviewed the deficient staffing days in October 2023, and she confirmed that the staffing did not meet the state regulations. 3.) On 11/15/24 at 9:08 AM the facility's actual PPD data for 9/01/24 through 11/14/24 was requested. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/24 at 1:20 PM in an interview with the facility's Staff #29, the PPD staffing data was requested again. On 11/15/24 at 2:20 PM the requested PPD report was provided by the Human Resource Director (Staff #28). A review of the PPD report revealed that only three days from 9/01/24 through 11/14/24 had a PPD of 3.0 or above. On 11/15/24 at 2:41 PM an interview was conducted with the Assistant Director of Nursing (Staff #4) and the Corporate Nurse (Staff #3) to review the PPD data. They confirmed that the data showed a deficiency with the state regulation, and they were asked to provide any additional information. On 11/19/24 at 8:11 AM Staff #29 provided a revised PPD data report for 9/01/24-11/14/24 and explained that the previous report contained only projected hours, but the revised report contained actual hours worked. A review of the revised PPD list revealed that the facility's PPD was less than 3.0 on thirty-eight of the seventy-five days reviewed. Staff #29 acknowledged that fact and confirmed that she knew that the facility was non-compliant with the state regulation. She further explained that the facility was taking steps to hire more staff. On 11/19/24 at 10:06 AM an interview with the Director of Nursing was conducted to review the facility's PPD data which showed deficient staffing. The DON said she said she was aware of the deficiency and further explained that the did their best and that the facility had implemented strategies to improve staffing. On 11/26/24 at 11:29 AM an interview with the DON, Nursing Home Administrator and Staff #3 was conducted and they confirmed that they were aware of the facility's deficient staffing. No additional information regarding PPD staffing compliance was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 48470 Based on records review and interviews, it was determined that the facility failed to have a facility assessment that was accurate and complete. This practice has the ability to affect all residents of the facility. The findings include: On 11/20/24 at 2:29 PM a review of the facility assessment was conducted by the surveyor. The review indicated that the facility put not applicable (N/A) in the section where they were asked about the number of beds in the specialty unit. However, in the section where they were asked about the average daily census in the specialty unit, the facility answered 30 beds. On 11/21/24 at 12:37 PM during an interview with the Director of Nursing (DON), she confirmed that the facility was licensed as having a specialty unit and referred to their Dementia unit. After confirming the floorplan with the DON, she confirmed that the Dementia unit only had 22 beds. The concern about the discrepancies were brought to the DON's attention and she indicated that she would look into it. On 11/26/24 at the time of survey exit at approximately 2 PM, no further information was provided by the DON.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48470 Based on record review and interview it was determined that the facility failed to accurately document resident records. This was evident for 2 (Resident #57, and #252) out of the 50 residents reviewed during the survey. The findings include: 1) Resident #57 resided in the dementia unit of the facility and was observed on multiple occasions throughout the survey process. A quick review of the resident's orders on 11/13/24 at 11:11 AM indicated for the nurse to put glasses on the resident when s/he wakes for the day, and a separate order to take the glasses before bedtime to be kept in the treatment room for the night. On the same day, the resident was observed at different times, awake and out of bed, but not wearing eyeglasses for vision. The documented observation times of Resident #57 awake and not wearing his/her eyeglasses for vision include: 11/13/24 at 11:04 AM, 12:16 PM; 11/15/24 at 12:55 PM; and 11/19/24 at 2:48 PM. A review of the facility's visitor sign-in sheet located at the front desk on 11/20/24 at 9:23 AM indicated that the resident's spouse last visited on 11/18/24 in the afternoon. On 11/20/24 at 9:43 AM, the Registered Nurse (RN Staff #8) was interviewed about Resident #57's use of eyeglasses. Staff #8 indicated that the orders for it needs to be deleted or changed since the spouse takes the eyeglasses and keeps it at home. Staff #8 further reported that the resident's spouse comes in to visit almost daily and mostly in the afternoon and brings the eyeglasses for the resident to use. Staff #8 was asked if Resident #57's spouse came in to visit yesterday (11/19/24), and she reported that she cannot confirm if s/he came in or not. A review of the electronic Treatment Administration Record (eTAR) was conducted with Staff #8. The review revealed that on 11/19/24 day shift, Staff #8 signed the order off, indicating that she put the eyeglasses on the resident upon waking, and on the same day the night shift nurse, (Staff #41) signed the order off as taking the glasses from the resident and keeping it in the treatment room. Staff #8 was asked if the resident's eyeglasses were in the treatment room or with the resident at that time, and she reported and confirmed that it was not in the facility. The concern was discussed with Staff #8 about the inaccuracy of the documentation in the resident's medical records and she reported that she used to mark the order as not done and add a note to indicate that the spouse kept them. Staff #8 did not offer an explanation as to why she does not document like she used to but verbalized understanding and acknowledge the concern (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 10:58 AM, the Director of Nursing (DON) was interviewed, and she reported that Resident #57 wears his/her eyeglasses when the spouse brings them in. The concern was again discussed with the DON that nurses are documenting that they are putting the eyeglasses on the resident when s/he wakes during the day and removing and keeping them in the treatment room at night even when there was no credible evidence that the eyeglasses were in the facility. The DON acknowledged the concern and indicated that the orders will be reviewed and updated. 48168 2) On 11/13/24 at 3:42 PM a review of complaint #MD00208397 revealed that the complainant alleged that Resident #252 was neglected by the facility staff from 7/15/24 through 7/22/24. On 11/20/24 1:30 PM a review of Resident #252's Medication Administration Record (MAR) for July 2024 revealed an order for the anti-anxiety medication alprazolam to be given routinely 2 x day. The resident also had an order for and received an antidepressant, bupropion. A review of the Treatment Administration Record (TAR) for July 2024 revealed an area to document any observed side effects of these medications. There was documentation present for each day from 7/16/24- 7/22/24, but only check marks were documented. The instruction stated Indicate letter if observed: 0=None observed; A=Sedation/Drowsiness; B=dry mouth, blurred vision; C=Ataxia (Drunk Walk); D=Morning Hangover; E=constipation, urinary retention; F=Orthostatic Hypotension; G=Increase in behaviors; H=Increased Falls/Dizziness; I=Other. The legend did not contain an option for a check mark. On 11/20/24 at approximately 2:00 PM in an interview with the Director of Nursing (DON) regarding Resident #252's documentation of medication side effect monitoring, she confirmed that the documentation was incorrect. She further explained that when the order was created it was created without the option to allow the nurse to document the values from the legend. She again confirmed that this documentation was deficient.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48168 Based on record review and interview it was determined that the facility failed to submit their Payroll Based Journal (PBJ) information to Medicare. This was evident in the off-site preparation portion and during the on-site recertification survey. The findings include: During the off-site preparation for the recertification survey, the survey team was provided a copy of the facility's Payroll Based Journal Report which indicated that no data was submitted. On 11/12/24 at 9:31 AM during the entrance conference with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) the surveyor provided the [NAME] report and PBJ staffing Data Report which indicated that no data was submitted for the 3rd quarter which ended June 30, 2024. The NHA indicated he would investigate. On 11/19/24 at 10:07 AM in an interview with the DON, she confirmed the facility deficiency that the PBJ was not reported. She further explained that the previous owner submitted the report one day late. She said the NHA was also aware of the deficiency. On 11/26/24 at 11:29 AM in an interview with the Director of Nursing (DON), Nursing Home Administrator (NHA), and the Corporate Clinical Services [NAME] President (Staff #3), the PBJ staffing report deficiency was discussed and they all confirmed the deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 16218 Based on medical record review, observation and interview it was determined that the facility failed to ensure staff completed hand sanitation between dressing changes; and failed to have a physical barrier between the clean and soiled areas of the laundry room to prevent cross-contamination. This was found to be evident for one (Resident #34) out of three residents reviewed for pressure ulcers; and one out of one laundry room observed. The findings include: 1) On 11/13/24 review of Resident #34's medical record revealed the resident has resided at the facility for several years and whose diagnosis includes but is not limited to dementia. The resident had two unhealed pressure ulcers, one on the left foot and one on the right foot, with orders for daily dressing changes. On 11/21/24 at 8:55 AM surveyor observed the nurse (Staff #35) prepare to complete the resident's dressing changes, this included hand sanitation and donning a pair of gloves. The nurse completed the dressing change to the wound on the right foot and then proceeded to complete the dressing change to the wound on the left foot. The nurse failed to change gloves or perform hand sanitation until after the second dressing change was completed. On 11/21/24 at 9:18 AM Nurse #35 confirmed that s/he had not changed gloves between dressing changes and indicated s/he should have done so. On 11/21/24 at 9:56 AM surveyor informed the Infection Preventionist (IP) nurse (Staff #4) of the observation of the nurse's failure to change gloves or perform hand sanitation between dressing changes. The IP nurse acknowledged the concern. 48259 2) During a tour of the facility's laundry rooms on 11/21/24 at approximately noon, an observation was made of an opening between the clean and soiled areas of the laundry room with no door or physical barrier. In an interview with staff #43, the director of environmental services, she reported that the facility was already aware of the concern and was in the process of fixing it. During an interview on 11/25/24 at 11:30 AM, staff #4, the assistant director of nursing and infection prevention nurse, indicated that the newer ownership of the facility was aware of the concern and was in the process of getting a physical barrier between the soiled and clean areas of the laundry room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Tarn Terrace Frostburg, MD 21532	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45139 Based on observation, interview and pertinent document review the facility failed to have a process in place to ensure an automated external defibrillator (AED), was maintained in a working order. This was evident for one automated external defibrillator out of 2 AEDs available in the facility. The findings include: An automated external defibrillator (AED) is a lightweight-portable device. It delivers an electric shock through the chest to the heart when it detects an abnormal rhythm and changes the rhythm back to normal. On [DATE] a review of intake MD#00194596 revealed a concern that the AEDs were not checked regularly and restocked after use. On [DATE] at 1:12 PM an observation was made of Nurse (Staff # 22) demonstrating how to use the AED hanging in the wall cabinet in the 200 hallway. During the demonstration of the AED an audible warming of low battery could be heard. On [DATE] at 1:13 PM during an interview with Nurse (Staff #22), she reported that she had not been told what to do if the battery was low. She reported that her response to the low battery warning would have been to tell the assistant director of nursing (ADON) about the warning. On [DATE] at 1:15 PM Nurse (Staff # 22) returned the AED to the wall cabinet. Further observation revealed a red light in the upper right corner of the AED. Continued observation revealed only one AED pad set was stored with the AED. On [DATE] at 1:30 PM the ADON (Staff 23) and ADON (Staff #4) turned on the AED and confirmed the above observations, and stated they would call the AED company to provide service to the AED. In addition, she reported that the red light should be green (meaning the AED was ready for use). The presence of the red light indicated the AED required attention. She reported that there should be 2 AEDS pads available with the AED. On [DATE] at 1:31 PM the ADON (Staff #4) was interviewed. She reported that she checked the emergency carts (CPR cart) every day and the AEDs every Wednesday. She reported that documentation regarding the AED maintenance checks were with emergency carts. On [DATE] at 1:39 PM the ADON (Staff #4) provided documents titled Daily CPR Cart Checklist for the time frame of [DATE]st through [DATE]th. Review of the above check lists revealed spaces to mark the presence of emergency equipment. The review failed to reveal that there was a space included for the AED. In addition, the ADON failed to provide any documentation that the AED had been routinely checked. (continued on next page)

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] the ADON (Staff #4) provided a document titled AED (Automated External Defibrillator) Maintenance Checklist. The ADON (Staff #4) reported that the facility will now use this new check list to record that the AED is checked. No additional documentation regarding that the AED was routinely checked [DATE]st through [DATE]th was provided prior to the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45139 Based on observations, interviews and pertinent document review it was determined the facility failed to ensure that the resident's call system was functioning properly. This was found to be evident during random observations and had the potential to affect all resident rooms. The findings include: On 11/8/24 during a phone interview the facility ombudsman reported that she had received numerous complaints regarding the time it took for facility staff to respond to the residents calls for assistance. She reported the concerns of alleged call response times as 45-60 minutes. On 11/12/24 the intakes #MD00194596, #MD00208397 and # MD00208682 were reviewed. The review revealed concerns regarding the time it took for the staff to answer the residents' call bells. On 11/14/24 at 1:05 PM the Surveyors were invited to attend a resident council meeting. During the meeting the residents voiced concerns that the call light system had not always functioned properly and sometimes they (the residents) had to wait 30-40 minutes for the call light to be answered. On 11/19/24 at 10:53 AM the Director of Maintenance (Staff #16) was interviewed regarding how the call light system in the facility is designed to work. He reported that every Resident had a call button available at their bedside and bathroom. The call system is activated by pressing that button. When the button was pressed, a light above the resident's room lights up. Additionally, a computer screen at the nurse's station provides a visual and audible alert to indicate to the staff at the nurse's station which resident is requesting assistance. The system also alerts staff to the time that the resident requested assistance. He also reported that the system is currently being worked on. He reported that the system had not been fully functioning prior to his arrival in July 2024. On 11/19/24 at 10:57 AM the DON was interviewed. She confirmed that the call light system had not been fully functioning since May 2024. On 11/19/24 at 11:07 AM an observation was made of the call light system screen located at the Unit One nurse's station. Observation revealed a visual alert that the call button was activated for Resident #24 at 10:03 AM, however the area of the screen that identified the location of the room was not visible at this time. On 11/19/24 at 11:14 AM during and interview with the DON the concerns that the call light had not been answered for 1 hr. and 4 minutes was shared. She replied she would look into the matter. On 11/21/24 12:37 PM the Maintenance Director provided documentation of the work being done by the company that supplies the call light system. He confirmed that the service started on 10/17/24, however, the system had not been fully functioning since May of 2024. On 11/19/24 at 5:17 PM observation was made at the Unit One nurse's station. Observation revealed an audible alert from the call light station. Observation of the screen failed to reveal the room that the alert was calling from. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 5:19 Nurse (Staff #22) was interviewed. During the interview she reported that the audible signal had been going off all day and that it has been reported to maintenance. She reported that they have not been able to use the call light system at the nurse's station. She reported she would look for the lights above the room to determine if a resident is calling for assistance. In addition, she reported that call lights from rooms [ROOM NUMBERS] cannot be seen from the nurse's station because the door frame blocks the lights from being seen when staff are sitting at the nurse's station. On 11/20/24 at 11:42 AM an observation was made of the call light visibility of rooms [ROOM NUMBERS], while sitting at the Haven Unit nurses station. The observation revealed that when the call button in rooms [ROOM NUMBERS] were pressed the light over the door turned on but the call lights could not be seen while sitting at the nurse's station. Continued observation failed to reveal a computer call light system at the Haven nurse's station. The facility's dementia unit is covered by the Haven nurse's station. On 11/20/24 at 11:45 AM nurse (Staff #47) was interviewed. During the interview she confirmed that the nurses cannot see the call lights over rooms [ROOM NUMBERS] from where the nurses sit at the Haven unit nurses station, however, the GNAs can see the light from where they sit at the nurses' station. Staff #47 confirmed there was no computer screen at the Haven unit nurses station that alerts the staff at the station of a resident requesting assistance. On 11/20/24 at 4:37 PM the concerns that the facility's call light system had not been functioning since May were discusses with the Administrator and Director of Nursing (DON). The DON reported that she had been aware of the improper functioning of the call light system and that they were working to fix the system. The DON reported that she had been unaware that there were rooms in the facility where the call light above the residents rooms were not visible to the staff sitting at the nurse's station.