

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Mountain View, A Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 Trevorton Road Coal Township, PA 17866	
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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44738 Based on clinical record review, review of facility documentation, and resident and staff interview, it was determined that the facility failed to ensure that the resident environment remains free of accident hazards for two of two residents reviewed (Residents 1 and 2). Findings include: Clinical record review for Resident 1 revealed a diagnosis list that indicated the resident is dependent on renal dialysis. Current physician orders for Resident 1 indicated the resident had a chair time for dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) at a dialysis center three days a week. The resident utilizes a wheelchair and is transported to and from these appointments by the facility. A quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) for Resident 1 dated June 11, 2024, indicated that staff had assessed the resident as having a BIMS (Brief Interview for Mental Status) of 15, which indicated the resident was not cognitively impaired. An interview with Resident 1 on July 11, 2024, at 2:19 PM revealed the resident was being transported in the transport van and stated, I fell out of the wheelchair. When asked if he had a seatbelt on the resident stated, Nope. Review of the job position summary for the Transport Driver position revealed a position responsibility that included, Assist with resident transport within and outside the facility. Operates the lift, helps secures the residents in the van, and assists the Transportation Aide getting the residents into office buildings or hospitals. Facility documentation revealed an interview between Resident 1 and the Nursing Home Administrator (NHA) dated July 3, 2024, with no time stamp noted, that indicated the resident, .noted he fell out of his chair during transport and slid a few feet and top of head hit the chair in front of him. He stated he did not have his seatbelt on. The resident reported some pain in his lower back and some pain in his neck when he turned his head. The interview further asked if the resident thought to ask someone about his seatbelt and he said he knew something was different but did not think to ask. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A witness statement with the date of event noted as July 3, 2024, from Employee 1, transport driver, reported the employee was transporting the resident back from dialysis at 11:36 AM, when the aide said he fell out of his chair. Employee 1 pulled over right away and called the supervisor before they picked the resident up. Facility documentation noted a follow-up interview with Employee 1 dated July 10, 2024, at 11:03 AM that revealed the employee did not know if Resident 1 was seat belted into the van. An employee telephone statement dated July 10, 2024, at 10:52 AM between Employee 2, Transport Aide, and facility administration regarding if Resident 1 was in his seat belt, and Employee 2 noted, I thought he was, but I don't know, I don't remember if he got buckled in. Facility documentation titled, Transport Investigation Questionnaire, with no date, revealed a question to Resident 1 that noted, During transport to your recent appointments were you secured in the vehicle with a seat belt? The resident reply was documented as, No, I noticed something was different, but it didn't register until she hit the brakes. Wheelchair was locked / strapped in, it's just I wasn't. A PB-22 form (report form for investigation of alleged abuse, neglect, and misappropriation of property) submitted on July 12, 2024, by the facility for Resident 1 revealed in Section V - Findings of Facility Investigation, that the seat belt was not attached to the resident. The facility staff failed to ensure Resident 1 was properly secured in his wheelchair with a seatbelt during transport from dialysis. Clinical record review for Resident 2 revealed a diagnosis list that included a Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer) to the sacrum (a bone in the lower back). Current physician orders dated June 28, 2024, indicated Resident 2 was ordered Dakin's half strength 0.25 % external solution (an antiseptic solution used to clean wounds) apply to sacral wound topically every shift for a Stage 4 pressure sacral ulcer. The order further noted to pack loosely with Dakin's moist rolled gauze. Review of Dakin's solution on webmd.com indicated under precautions that the solution is for external use only and do not swallow. An MDS for Resident 2 dated May 23, 2024, indicated that staff had assessed the resident as having a BIMS of 11, which indicated some cognitive impairment. An electronic Event Submission Report (ERS) submitted on July 10, 2024, noted that Resident 2 drank one sip of Dakin's solution, which was left on her bedside table by staff who completed her wound care. The date of the event was noted as July 9, 2024. The resident was transported to the emergency room (ER) for further evaluation. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident 2 on July 11, 2024, at 2:25 PM indicated the resident remembered the event and had taken a sip of what looked like water that was in a white Styrofoam cup located on her bedside table. Resident 2 further reported she may have swallowed some of the solution and my mouth started to burn. The resident then realized it was not water in the cup. Nursing documentation for Resident 2 dated July 9, 2024, at 11:47 PM revealed that staff had reported the resident ingested Dakin's solution that was left at the bedside in a cup within resident reach. The resident was alert and noted to have mouth burning. It was unclear how much of the solution the resident ingested. The documentation noted the resident took a sip and noticed it tasted funny. Nursing documentation for Resident 2 dated July 10, 2024, at 12:00 AM revealed the resident left the facility and was going to the ER for evaluation. Nursing documentation dated July 10, 2024, at 10:42 AM revealed that upon review of the ER paperwork for Resident 2, no new orders were noted. Clinical documentation for Resident 2 from the ER dated July 10, 2024, revealed the resident presented from the facility after an accidental ingestion of Dakin's solution. The documentation noted the EMS report indicated that the resident was in bed and a Styrofoam cup of Dakin's solution was left at the bedside, which she mistook for a cup of water. The resident reported she took a small sip but did manage to swallow some of it. The clinical impression noted ingestion of corrosive chemical, accident or unintentional, initial encounter. The resident was discharged in stable condition. A witness statement dated July 9, 2024, at 11:26 PM from Employee 3, licensed practical nurse, noted that a nurse aide approached the staff member with a Styrofoam cup and stated that Resident 2 stated she took a sip of the liquid from the cup, and it tasted bad. Employee 3 noted it smelled like Dakin's solution. A witness statement dated July 9, 2024, no time stamp, from Employee 4, registered nurse (RN), noted that the RN was called to assess Resident 2. The RN noticed a bottle of Dakin's solution on the windowsill in the room. A witness statement dated June 9, 2024 (assumed to be a documentation error), no time stamp, from Employee 5, nurse aide, revealed that the resident had her call light on, and Employee 5 checked on the resident and Resident 2 stated, I drank the wrong thing, smell this. Employee 5 took the cup off the resident's tray and smelled it and noticed it was a chemical she drank. Employee 5 took the cup to the nurse and went back to the resident and gave her milk. The resident complained of her mouth burning. The facility staff failed to ensure that the residents environment remained free of accident hazards. The above information from Resident 1 and Resident 2 were reviewed during an interview with the Nursing Home Administrator and Employee 6, Assistant Director of Nursing, on July 11, 2024, at 2:45 PM. 28 Pa. Code 201.18 (e)(1) Management (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(d) Resident care policies		