

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

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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 07/24/2024
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 20725 Based on a review of select facility policies and procedures, facility grievance log documentation, and resident and staff interview, it was determined that the facility failed to make a prompt effort to resolve resident grievances for two of nine residents reviewed (Residents 8 and 9, Unit B). Findings include: The facility policy entitled, Grievance/Complaints - Residents, Resident Representatives, Family Members, or Resident Advocates, last reviewed August 21, 2023, revealed that as necessary, immediate action to prevent further potential violations of any resident rights will be taken by the facility while the alleged violation is being investigated. A grievance official will be appointed by the facility who will be responsible for overseeing the grievance process, receiving, and tracking grievances through to their conclusion, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, and issuing written grievance decisions to the resident or person filing the grievance. The resident or concerned person filing the concern must sign the written concerns. The investigating department will submit a written report of findings and resolutions to social services and administration within not more than five working days of receiving the concern. The resident or person filing the concern on behalf of the resident will be informed of the findings of the investigation and the actions taken to resolve the issue or problem. Review of the facility Grievance Log dated June and July 2024x, revealed that Residents 8 and 9 reported a nurse aide for, .disappearing and not answering call bells, on July 18, 2024. The log indicated that the grievance was resolved on July 18, 2024. Interview with Resident 8 on July 24, 2024, at 1:06 PM revealed that he identified Employee 7 (nurse aide) for concerns related to not answering call bells. Resident 8 stated that Employee 7 wears an earpiece and talks to someone on the phone while she is with him while he takes his shower and while she is on the nursing unit. He stated that Employee 7, disappears, and has had to be paged over the intercom system to return to the unit. Resident 8 stated that he reported these concerns to social services; however, no facility staff have apprised him of any interventions to resolve his concerns with Employee 7. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 9 on July 24, 2024, at 12:53 PM Resident 9 pointed at Employee 7 and stated that she ignores her call bell. Resident 9 stated that when she activates her call bell, Employee 7 will enter the room across from hers (who does not have an activated call bell) and not respond to her call for help. Resident 9 stated that Employee 7 will, just disappear into an empty room or somewhere, and that she empties garbage cans with little to no trash in them to avoid answering call bells. Resident 9 indicated that these issues were discussed during a resident council meeting and that she reported Employee 7 by name to another staff member; although, Resident 9 could not name the specific staff member who received the report. Resident 9 indicated that no facility staff have apprised her of any interventions to resolve her concerns with Employee 7. In response to the surveyor's questioning, the facility provided a Resident Concern/Compliment Form that indicated an employee filed the concern for an event that occurred on July 18, 2024, involving Residents 8 and 9. The nature of the issue included the report that Employee 7 disappears while the other nurse aide needs help, and that Employee 7 empties trash unnecessarily; but the information did not include Employee 7's personal cell phone use while on duty or her ignoring Resident 9's call bell. The investigation provided did not include evidence that facility staff obtained a statement from either Resident 8 or 9 regarding their specific concerns regarding the care and treatment, which had not been furnished, or the potentially inappropriate behavior of staff. Neither Resident 8 nor 9 signed the grievance investigation. The facility only obtained statements from five staff (that included Employee 7). There was no evidence that the facility obtained statements from any resident who resided on the Unit B nursing unit. Interview with the Nursing Home Administrator and Employee 3 (human resources) on July 24, 2024, at 4:34 PM confirmed that although the grievances were reported by two, cognitively intact, residents, staff did not obtain a witness statement from those residents who reported the concerns. Interview with the Nursing Home Administrator, Director of Nursing, and Employee 4 (assistant director of nursing) on July 24, 2024, at 5:30 PM confirmed that neither Residents 8 or 9 have cognitive deficits, and both would be capable of providing a signed statement regarding the nature of their concerns. The facility was unable to provide evidence that the concerns reported by Residents 8 and 9 were thoroughly investigated or reported to the appropriate agencies given the allegation included an issue that an identified staff member neglected to answer call bells. There was also no evidence that the facility kept Residents 8 and 9 appropriately apprised of the progress towards resolution of their concerns. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(3)(5) Nursing services		

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F 0600 Level of Harm - 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. 20725 Based on a review of select facility policies and procedures, clinical record review, personnel record review, and staff interview, it was determined that the facility failed to protect a resident's right to be free from physical abuse by staff that resulted in actual harm with a serious injury of a facial fracture for one of nine residents reviewed (Resident 1, Unit A). Findings include: The facility policy entitled, Resident Abuse and Neglect Prevention Program, last reviewed August 21, 2023, revealed that each resident has the right to be free from verbal, sexual, physical, and mental abuse. Management and staff are jointly and individually responsible to ensure each resident will be free from abuse, neglect, and misappropriation of property. The facility has a plan in place to assure appropriate steps are taken to protect each resident from mistreatment, neglect, abuse, and misappropriation of property. The facility has set forth the following policies and procedures, included in this Resident Abuse and Neglect Prevention Program are the components of: Screening, Training, Prevention, Identification, Investigation, Protection, Reporting, and Conclusion of the Investigation. The definitions of abuse include the willful infliction of injury with resulting physical harm, pain, or mental anguish. Physical abuse includes the use of physical force that may result in bodily injury, physical pain, or impairment. Employees are expected to provide appropriate and quality care to the residents according to training and facility policies/procedures. The component Screening of New/Potential Employees included that it is the policy of the facility to screen potential employees for a history of abuse, neglect, mistreatment, or misappropriation of property. A criminal background investigation will be conducted on all prospective employees utilizing the State Police, and FBI if required. The check will be initiated prior to the employee's date of hire. The component Employee Abuse Prevention and Training included that the facility has implemented a program of education designed to train employees in the prevention and recognition of resident abuse, neglect, and misappropriation. Orientation and annual training will include abuse prohibition practices such as appropriate interventions to deal with aggressive and/or catastrophic reactions of residents, how to recognize signs of burnout/frustration/stress, which may lead to abuse and violations of resident rights. All new employees are required to attend an orientation program, which includes a minimum of two hours of training related to Abuse and Neglect Prevention, Identification/Reporting of Abuse, and Techniques for Caring for the Cognitively Impaired Resident. Agency and/or contract staff will read and acknowledge receipt of the facility Abuse Prevention Program General Policy Statement and Allegation, Suspicion or Witnessed Abuse, Neglect or Misappropriation Intervention, and Reporting policies prior to the initiation of services. The employee signs a statement of receipt of education once completed, which is then maintained in the employee file. Clinical record review for Resident 1 revealed nursing documentation dated July 20, 2024, at 5:34 AM that staff observed fresh bruising, edema (swelling), and blood from an unknown origin. Resident 1's right eye was bruised and edematous, the left eye was bruised and edematous, she had nasal edema, and a very scant amount of blood noted from the nares (nasal passageway). (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Nursing documentation by Employee 5 (licensed practical nurse, LPN) dated July 20, 2024, at 5:49 AM revealed that the writer and another nurse heard this resident yelling while at the nurses' station. One nurse aide that was assigned to the room was seen entering the room at the time. Resident 1 was seen in the hallway by this writer with blood noted from the tip of her nose. Resident 1's bilateral eyes were swollen with fresh bruising noted. Nursing documentation dated July 20, 2024, at 8:00 AM revealed that the Director of Nursing, Area Agency on Aging, and the police were notified by the supervisor of Resident 1's injuries. Nursing documentation dated July 20, 2024, at 8:45 AM revealed that Resident 1 left via ambulance for evaluation. An Investigation of Incident Other Than Fall document dated July 20, 2024, at 6:53 AM for Resident 1, revealed that Resident 1 had swelling and bruising around her eyes and nose reported by Employee 5, that Employee 2 (nurse aide) was a witness, that potential abuse was a possible cause, and that a suspected staff member was asked to leave the facility. An unsigned incident/accident witness statement dated July 20, 2024, noted that the writer and another nurse on the Unit A nursing unit heard Resident 1 yelling and the writer saw Employee 1 (nurse aide) leave the resident's room around 4:40 AM. Within a few minutes, the writer was walking down the hall and observed Resident 1 walking with her head down with blood on the tip of her nose, blood coming out of her nose, and that her bilateral eyes were swollen with deep purple bruising to the right eye. The writer called the supervisor to the unit. The supervisor and the writer entered Resident 1's room and noted fresh blood on the bed linen next to the head of her bed. The writer was approached by Employee 2 (nurse aide) who asked to speak to the supervisor. Employee 2 was reportedly upset and almost in tears. Employee 2 stated that she witnessed Employee 1 forcefully grab Resident 1 by the arm, drag her into the room, shut the door, and throw (Resident 1) forcefully onto the bed face down and held her knees down on her. Interview with the Director of Nursing on July 24, 2024, at 4:27 PM indicated that the unsigned witness statement referenced above was written by Employee 5. A review of Employee 2's witness statement dated July 20, 2024, revealed that Employee 2 witnessed the aide that was assigned rooms one through eight (Employee 1) grab Resident 1 on her arm, drag her to her room, and put her face forward on the bed. An incident/accident witness statement dated July 20, 2024, by Employee 6 (LPN) revealed that during the medication pass at 4:30 AM, Resident 1 was walking in the hall. Employee 1 said, This is my fifth time getting her, something needs to be done. Employee 6 was at the cart at the nurses' station when Employee 6 reportedly heard yelling from Resident 1's room. Physician progress notes from the emergency department (ED) dated July 20, 2024, at 9:59 AM revealed that Resident 1 presented to the ED for evaluation of assault. EMS (Emergency Medical Services) stated that the patient was seen potentially being abused by a member of staff that morning. Imaging was positive for an acute, displaced, nasal bone fracture. Patient is suspected victim of an assault or aggressive behavior at her SNF (skilled nursing facility). Police are involved as is SNF administration. A nasal bone fracture was noted on CT imaging (CT, computed tomography, an imaging scan that uses a series of X-rays and a computer to create detailed images of bones and soft tissues). (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A CT imaging report dated July 20, 2024, for Resident 1, revealed an acute, displaced, nasal bone fracture. Review of Employee 1's personnel record revealed that she began employment at the facility on July 14, 2024. Employee 1's accounting of hours worked revealed that she worked on July 14, 15, 16, 17, 18, 19, and 20, 2024. Employee 1's personnel record provided by the facility revealed no evidence that the employee received training on the facility's abuse prevention program before providing care to Resident 1; or that the facility initiated a State criminal background check prior to Employee 1's date of hire. Interview with the Nursing Home Administrator and Employee 3 (human resources) on July 24, 2024, at 4:34 PM confirmed the above findings related to Employee 1's personnel record. The interview indicated that Employee 1 was a contracted agency employee. The contracted agency provides staffing who are often from other states in the country. Interview with the Nursing Home Administrator, the Director of Nursing, and Employee 4 (assistant director of nursing), on July 24, 2024, at 5:30 PM confirmed that the facility continues to utilize the contracted staffing company who provides employees who are often from other states in the country. The facility could not provide evidence that the facility implemented any measures before or after Resident 1's incident that occurred on July 20, 2024, to ensure that contracted staff receive training on the facility's abuse prevention program before providing care to its residents. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1)(2)(e)(1) Management 28 Pa. Code 201.19(6)(7)(8) Personnel policies and procedures 28 Pa. Code 201.20(b)(d) Staff development 28 Pa. Code 201.29 (a)(c) Resident rights 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services		