

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  07/14/2025
NAME OF PROVIDER OR SUPPLIER  Mountain View Rehabilitation and Senior Living Ctr		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 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding elopements for one of one resident reviewed (Resident 1). Findings include: The current facility policy entitled Elopement/Missing Resident, revealed it is the policy of the facility to provide a safe environment for all residents regardless of orientation status and to supervise those residents at risk for elopement based upon the comprehensive assessment and specific care plan of each resident. Clinical record review revealed the facility admitted Resident 1 on December 16, 2024, with diagnosis including dementia, with behavior disturbance. Resident 1 resided on the locked memory care unit from December 16, 2024, to May 12, 2025, when Resident 1 was moved to the F nursing unit. Review of Resident 1's most recent quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated June 20, 2025, revealed nursing staff assessed Resident 1 as having a BIMS (Brief Interview for Mental Status) score of 4 (severe impaired cognition). Nursing documentation dated May 26, 2025, at 12:13 PM noted Resident 1 was at the front entrance wanting to leave. Documentation revealed staff made attempts to bring Resident 1 back to the nursing unit, but Resident 1 refused stating there is a bomb back there and my wife is here to get me. Nursing documentation dated June 24, 2025, at 10:56 PM revealed Resident 1 wanders frequently to other units. Nursing documentation dated July 7, 2025, at 6:46 PM noted Resident 1 had exit seeking behaviors. Documentation revealed Resident 1 was wearing his jacket at this time asking where the exit is, stating he is going home, and if they do not let him leave, he is calling the police. Resident 1 was retrieved from the main entrance twice this shift. Resident 1 was noted becoming angry when staff attempted to redirect him. Nursing documentation dated July 8, 2025, at 5:57 AM noted no exit seeking behaviors for this shift. Resident 1 remained in bed, and documentation indicated wander guard was replaced to Resident 1's right ankle. Nursing documentation dated July 9, 2025, at 8:50 PM revealed Resident 1 was outside with a staff member. Resident 1 is an elopement risk and was escorted back into the facility by staff. Documentation revealed Resident 1 was moved back to the locked memory care unit. Review of Resident 1's physician orders revealed an order dated December 16, 2024, for staff to check Resident 1's wander guard placement every shift. Review of Resident 1's Treatment Administration Record dated July 2025, confirmed staff were to be checking Resident 1's wander guard placement every shift. Review of Resident 1's plan of care initiated on December 17, 2024, and currently in place noted Resident 1 is an elopement risk/wanderer as evidenced by his disorientation to place, and impaired safety awareness. Interventions included staff identify wandering pattern, provide structured activities, and a wander alert. Interview with Employee 1 (dietary aide) on July 14, 2025, at 1:07 PM revealed that she was a new employee with her first day of work on July 9, 2025. She stated that her shift was over, and she was leaving the facility on July 9, 2025, at approximately 8:15 PM. Employee 1 stated she exited the building from the main entrance and a man followed her out, stating he was going to the police station to file a report. When she entered the parking lot a visitor asked her if the man was supposed to be outside. Employee 1 told the visitor she doesn't know as it is her first day of work. Employee 1 stated she asked the visitor to keep an eye on Resident 1 while she went back into the facility to get staff to help her. Employee 1 revealed when she returned outside the visitor remained in the parking lot and Resident 1 was walking down the road in front of the facility. Interview with Employee 2 (nurse aide) on July 14, 2025, at 11:41 AM revealed that she was working when Resident 1 eloped out of the facility. She stated that when Employee 1 came onto the unit she stated, I think I left a resident outside. Employee 2 stated that when she arrived outside Resident 1 was not with the visitor, but was down the hill, walking along the road. She stated it took herself and three other staff to get Resident 1 back into the facility. Employee 2 stated that Resident 1 did not have a wander guard on when he was brought back into the facility. The facility failed to provide the highest practical care related to Resident 1.28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		