STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395045	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Senior Living Ctr	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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Actual harm Residents Affected - Few	Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to implement interventions related to fall injury prevention and failed to provide adequate supervision resulting in a fall with injury for one of three residents reviewed (Resident CR1).This deficiency is cited as past noncomplianceFindings include: Closed clinical record review for Resident CR1 revealed a diagnosis list that included Alzheimer's Disease with Late Onset (a progressive brain disorder that affects memory, thinking, and language), the need for assistance with personal care, and lack of coordination. Review of facility documentation titled, Fall Risk, dated July 18, 2025, at 4:57 PM revealed that facility staff assessed the resident as a score of 10, which indicated a category of High Risk. Facility staff documented the resident's fall risk predictive factors that included the LOC (level of consciousness) as Poor recall, judgement, safety awareness. Review of Resident CR1's care plan revealed the resident had care plans that addressed the following: impaired cognitive function related to the medical history that was initiated on March 12, 2021; an activities of daily living (ADL) self-care deficit related to the medical history that was initiated on March 3, 2021; and resistive to care at times, will refuse medications, and hearing aids and will attempt to get out of bed and transfer independently if environment around her is not calm or quiet to remove herself from environment that was initiated November 23, 2021. Further review of Resident CR1's care plan revealed that the resident was at risk for falls related to the medical history dated as initiated on March 3, 2021. An intervention included having the bed in the lowest position at all times while in bed initiated on May 16, 2025 A review of the task list (located in the electronic health record where staff document specific care related events for a resident) for Resident CR1 revealed there was a Fall Prevention task. It included having the bed in the lowest position at all times while in bed and also included to reinforce the resident's toileting program. A K noted next to the task indicated that the task shows on the Kardex (documentation by nursing to note important information and care planning and facilitate resident care). Nurse aide staff were also noted as documenting under this specific task. Closed clinical record review for Resident CR1 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated May 19, 2025, that noted facility staff assessed the resident as rarely/never understood. Further review of the MDS noted that facility staff assessed the resident as needing substantial/maximal assistance to roll left and right (The ability to roll from lying on back to left and right side and return to lying on back on the bed); however, was not marked as dependent on staff to roll. Review of facility documentation revealed a form titled Incident/Accident and noted Employee Statement with a date of event noted as August 2, 2025, at 0650 [6:50 AM]. The resident name was noted as Resident CR1. The written and signed employee statement from Employee 1, nurse aide, noted the staff member was giving morning care to the resident who was a Hoyer lift (a mechanical lift used to transfer residents). After washing and dressing the resident, the staff member noted, .I went to get a Hoyer from the shower room. Upon return, Employee 1 found the resident on the floor, face down. Clinical nursing documentation for Resident CR1 dated August 2, 2025, at 10:20 AM from Employee 2, registered nurse, revealed Employee 2 was alerted to the resident's room by the nurse aide who entered the room to discover the resident lying face down on the floor. A three centimeter (cm) by two cm laceration was noted above the resident's right eye and a 1 cm laceration to the bridge of the resident's nose. The resident was unable to give a description of the event due to advanced dementia, per the documentation. The documentation further noted that the nurse aide who reported the fall, . stated he was providing care to the resident and left her room to get the Hoyer to transfer her out of bed after care was finished. Upon arrival to the room, it was noted by nursing staff that the bed was still in a high position, and it had been left in a high position when the aid left to obtain the Hoyer. The resident has a history of attempting to transfer herself from her bed and chair though she is not able to do so safely. The documentation noted, .it would appear likely she attempted to stand up from her bed and fell forward. The documentation noted the resident was sent to the hospital for evaluation and treatment. An interview with Employee 2 on August 26, 2025, at 1:28 PM revealed that Employee 2 was the nursing supervisor at the time. Employee 2 stated the licensed practical nurse (LPN) reported that the bed was in the high position. Employee 2 further reported that Resident CR1 was able to scoot around in bed. Review of the facility Incident/Accident form noted Employee Statement with a date of event as August 2, 2025, at 0650. The resident name was noted as Resident CR1. The written and signed employee statement from Employee 3, licensed practical nurse, indicated in part that, Hoyer lift was at the foot of the bed and bed was raised in high