

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  09/17/2025
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 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  (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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations and staff interview, it was determined that the facility failed to provide a clean, comfortable, homelike environment on two of four nursing units (A and B Nursing Units), the facility chapel area, a common dining area, and the main kitchen. Findings include: Observation of the facility chapel area on September 17, 2025, at 10:29 AM revealed the following: A blue colored carpeted area was heavily stained, especially where it abutted the tiled flooring. The black transition strip between the two floors was broken and also loose in areas. The personal laundry area had a build-up of lint on the floor, in a small sized plastic trash can, and on the walls surrounding the dryer. There were two large water stains on the ceiling tiles. There was a lidded trash can near the entrance to the chapel that had paper products sticking out from underneath the lid. A used linen cart next to it had a used maroon colored food bowl on top of it. A follow-up observation on September 17, 2025, at 1:57 PM revealed these items were still present. Observation of a common dining area off the main hallway leading to the chapel had a refrigerator that had three used and balled up gloves on top of it. A follow-up observation on September 17, 2025, at 1:57 PM revealed these items were still present. There were two garbage receptacles observed in this dining area. One garbage receptacle was almost full, and the garbage bag was not secured and falling into the receptacle. The second garbage bag had fallen down into the receptacle and there was trash piled on top of it. A follow-up observation on September 17, 2025, at 1:57 PM revealed these items were still present. Observation of the A Nursing Unit on September 17, 2025, at 10:59 AM revealed the following: A common area had an electrical receptacle that was starting to come out of the wall. A black colored plastic shelf was located inside of a pantry area that contained a microwave and storage cupboards. An interview with Employee 6, nurse aide, revealed that the shelf is where resident snacks are stored when brought in by visitors. The bottom shelf contained manufactured holes that covered the span of the shelf. The holes contained an extensive amount of dirt and debris. The surrounding floor in this pantry had an extensive build-up of dirt and debris. A storage unit off the main dining area of the A Nursing Unit had a refrigerator that Employee 6 indicated was sometimes used by activities staff to store resident related items. The refrigerator contained three aluminum foil items that were not labeled or dated, a large unlabeled and undated pitcher with an unidentified liquid, two uncovered food bowls open to the ambient environment that were unlabeled and undated that Employee 6 identified as puree peanut butter and jelly. There was an extensive amount of dirt and debris on the floor behind an ice machine in the corner. There was a large bag of pears in a tote that were open to the ambient air with no dates or labels and a tote of cookies that contained a package that was open to the ambient air. A cabinet under the sink in the main dining area had a damaged section on the exterior of the cabinet where a piece of the cabinet was missing near the floor. Observation of the B Nursing Unit on September 17, 2025, at 11:26 AM revealed a large, clear plastic tote on top of the refrigerator in front of the nurse's station. The tote contained various resident snacks. The bottom of the tote had a significant build-up of debris and food crumbs. The refrigerator top was dust covered, and snacks were observed discarded behind a potted plant on top of the refrigerator. Observation of the main kitchen on September 17, 2025, at 2:10 PM revealed a lidded receptacle near the locker area that contained various used linens from the kitchen. There was no bag, and the linens were placed directly into the bin. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 17, 2025, at 3:40 PM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited deficiency 5/2/2025 28 Pa. Code 201.18(b)(3)(e)(2.1) Management</p>		

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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.  (continued on next page)

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to protect residents from staff neglect resulting in a fall from a wheelchair with serious injury for one of seven residents reviewed (Resident CR1). This deficiency is cited as past noncompliance Findings include: Closed clinical record review for Resident CR1 revealed a diagnosis list that included vascular dementia (a type of dementia caused by reduced blood flow to the brain and leading to cognitive impairments such as memory loss, loss of judgment, and loss of complex motor skills). Review of facility documentation titled, Fall Risk, dated July 18, 2025, at 1:09 PM revealed that the facility assessed Resident CR1 as a score of 11, 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, and safety awareness. Review of Resident CR1s care plan revealed the resident had care plans that addressed the following: impaired cognitive function related to the medical history; a communication problem related to dementia; an activity of daily living (ADL) self-care deficit related to activity intolerance, impaired balance, and limited mobility; and a potential for falls related to deconditioning and gait/balance problems. Further 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 July 22, 2025, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 0, which indicated cognitive impairment. Further review of the MDS revealed that facility staff assessed the resident's functional status as follows: 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) as dependent on staff; sit to lying (the ability to move from sitting on side of bed to lying flat on the bed) as dependent; lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support) as dependent; sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) as dependent on staff; chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair as dependent; and walking was marked as not applicable. Physical therapy documentation for Resident CR1 noted a PT (physical therapy) Evaluation and Plan of Treatment dated July 8, 2025. In the section titled, Initial Assessment/Current Level of Functioning and Underlying Impairments, therapy staff documented precautions as assist with two with arm-in-arm technique for transfers; out of bed to wheelchair with leg rests and foot buddy. Wheelchair mobility documented the resident as dependent on staff to wheel 50 feet with two turns. The bilateral lower extremity strength was documented as impaired. Further review of physical therapy documentation for Resident CR1 revealed a PT Discharge summary dated [DATE], that noted a functional reach assessment documented as two inches that therapy staff noted as predictive of falls, an elderly mobility scale documented as 0 out of 20 (an assessment that indicated the resident needs assistance from staff for mobility), standing balance with upper extremity support as poor to poor. The documentation further noted the resident was dependent on staff for bed mobility, transfers, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and wheel 50 feet with two turns. The therapy tab in Resident CR1's electronic health record (EHR) noted precautions that included (PT) assist x2 with arm in arm technique for transfers, OOB (out of bed) to wheelchair with leg rests and foot buddy. An interview with the Director of Nursing on September 17, 2025, at 3:30 PM revealed that Resident CR1 did not self-propel in the wheelchair. Nursing documentation for Resident CR1 dated September 6, 2025, at 5:05 PM revealed that staff had notified the registered nurse that a resident had fallen out of her wheelchair. The resident was observed laying on her left side in the hallway. Bleeding was observed from a laceration on the left side of the resident's head above the eye. Emergency medical services (EMS) were called and the resident was transported to the hospital for evaluation. Review of the facility Incident/Accident form noted an Employee Statement with a date of event as September 6, 2025. The resident's name was noted as Resident CR1. The written and signed employee statement from Employee 2 (the staff members signature was identified by the Nursing Home Administrator), licensed practical nurse, noted in summary that Employee 1, nurse aide, came around the corner going very fast and flying the resident to the side and thrust out of the wheelchair and onto the floor headfirst. The resident's head immediately started bleeding. Employee 2 noted the nurse aide was advised that she was going way too fast. Review of the facility documentation revealed a form titled, Employee Statement Regarding Knowledge of Resident Incident that was dated September 6, 2025. The resident involved was noted as</p>		