

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 05/01/2026
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.			
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview it was determined that the facility failed to ensure that active physician orders incorporated resident or appropriate resident representative's wishes related to end-of-life care for seven of 14 residents reviewed for advance directives concerns (Residents 2, 3, 6, 13, 14, 22, and 71). Findings include: Clinical record review for Resident 3 revealed that the facility admitted her on February 23, 2026. Resident 3's profile information indicated that her niece was her responsible party, health care representative, and power of attorney for her care and finances. A Brief Interview for Mental Status (BIMS, an assessment tool with a numerical scoring system to determine cognitive deficits) admission assessment dated [DATE], at 10:35 AM assessed Resident 3's score as a four, severely impaired. An admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated March 2, 2026, indicated that Resident 3 only sometimes understood others and only sometimes was understood by others. The BIMS score was four, which indicated severe cognitive impairment. A POLST (Physician Orders for Life Sustaining Treatment, portable medical order form that records treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency) signed by the medical practitioner on February 26, 2026, included only Resident 3's signature, not her responsible party's signature. The POLST implemented DNR (Do Not Resuscitate, do not provide chest compressions or assist with breathing), limited additional interventions (do not intubate or provide mechanical breathing assistance), care for Resident 3. Active physician orders for Resident 3 dated February 23, 2026, implemented DNR instructions in the event of a medical emergency. Interview with Employee 1 (registered nurse regional consultant) on April 30, 2026, at 12:48 PM confirmed that the facility did not have evidence that Resident 3's responsible party participated in advance directives planning on the POLST form for Resident 3. Clinical record review for Resident 14 revealed an active physician order dated November 7, 2019, for Full Code (chest compressions and breathing assistance). Resident 14's clinical record contained no POLST or advance directives documentation. The surveyor requested evidence that Resident 14 or his responsible party participated in the end-of-life care decisions during an interview with the Nursing Home Administrator on April 29, 2026, at 2:00 PM and April 30, 2026, at 2:15 PM. Nursing documentation dated April 30, 2026, at 8:45 AM (following the surveyor's questioning) indicated that a registered nurse spoke with Resident 14's brother to review a POLST with him. Clinical record review for Resident 71 revealed active physician orders for Full Code. Resident 71's clinical record contained no POLST or advance directives documentation. Resident 71's clinical record contained legal documentation that a court adjudicated him incompetent on August 8, 2023, and another party was awarded guardianship for Resident 71. The surveyor requested evidence that Resident 71's legal guardian participated in advance directive planning during interviews with the Nursing Home Administrator on April 29, 2026, at 2:00 PM, April 30, 2026, at 2:15 PM, and May 1, 2026, at 9:20 AM. No further evidence was provided during the onsite survey. Clinical record review revealed the facility admitted Resident 2 on December 3, 2025, with an active physician order for DNR order. Resident 2's (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clinical record contained no POLST, or advance directive documentation. Nursing documentation dated April 30, 2026, at 2:48 PM (following the surveyor's questioning) indicated that a registered nurse spoke with Resident 2's daughter to review a POLST with her. Clinical record review revealed the facility admitted Resident 22 on March 17, 2026, with an active physician order for full code. Resident 22's clinical record contained no POLST, or advance directive documentation. The above findings for Residents 2 and 22 were reviewed with the Nursing Home Administrator and Director of Nursing on May 1, 2026, at 9:31 AM. Clinical record review for Resident 6 revealed they were admitted on [DATE]. The most recent MDS completed on April 7, 2026, indicates that the resident is rarely/never understood, which has been the condition of the resident since their admission. The resident had a physician's order written on September 4, 2024, indicating they were a Full Code. Resident 6's clinical record contained no POLST, or advance directive documentation. Nursing documentation dated May 1, 2026, at 9:34 AM (following the surveyor's questioning) indicated that a staff member spoke with Resident 6's daughter to review a POLST with her, and the resident was to be a DNR. Clinical record review for Resident 13 revealed they were admitted on [DATE]. The most recent MDS completed on March 8, 2026, indicates that the resident is rarely/never understood, which has been the condition of the resident since their admission. The resident had a physician's order written on January 20, 2026, indicating they were a DNR. Resident 13's clinical record contained no POLST, or advance directive documentation. Documentation related to Resident 6's and 13's advanced directives were requested by the surveyor on April 29, 2026, at 2:15 PM, and again on April 30, 2026, at 2:45 PM, and no documentation was provided. The above findings for Residents 6 and 13 were reviewed with the Nursing Home Administrator and Employee 1, on May 1, 2026, at 10:30 AM, and they confirmed that no documentation for Resident 6 or 13 could be located. 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to thoroughly investigate and report to the appropriate agencies an incident of resident abuse for one of one resident reviewed for resident-to-resident abuse concerns (Resident 2); and failed to implement abuse prevention policies related to screening newly hired employees for three of five employees reviewed (Employees 4, 6, and 8). Findings include: The facility policy entitled, Resident Abuse and Neglect Prevention Program, last reviewed January 30, 2026, revealed that it is the policy of the facility to screen potential employees for a history of abuse. All reasonable efforts will be made by the facility to obtain information from previous and/or current employers in an attempt to screen for history of abuse, neglect, or mistreatment of residents. A criminal background investigation will be conducted on all prospective employees utilizing the State police, and Federal Bureau of Investigation (FBI) if required. This includes but is not limited to contacting the State's nurse aide registry and verification of professional licensure status. The check will be initiated prior to the employee's date of hire. An FBI background investigation is required if the potential candidate has not resided in the state of Pennsylvania for the past two years. Results of the criminal background investigation shall be available within 30 days of hire for State police reports, and within 90 days for FBI reports. New employees shall not be permitted to continue working if the report results are not received within the appropriate time frame. Verification of current Pennsylvania professional licensure status or nurse aide registry with a copy of a valid certification, registry number or professional license is required prior to the first day of employment. Potential employees shall be required to provide at least three references on the application for employment. The three references will be a combination of work or personal. 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. The employee signs a statement of receipt of education once completed which is then maintained in the employee file. The Identification and Investigation of Suspected Abuse/Neglect/Misappropriation, section of the policy noted that any individual(s) observing an incident of abuse or suspects abuse has a responsibility to intervene immediately so that the safety of the resident can be ensured. All management and staff are jointly and individually responsible to ensure that any complaint, allegation, or suspicion of abuse, or witnessed resident abuse, is reported immediately to the supervisor of the area. The registered nurse supervisor will notify the appropriate personnel of the incident. An incident report will be completed documenting the alleged abuse and results of the physical examination (any physical injuries noted to the resident(s)). Upon receiving a report of abuse or alleged abuse, the registered nurse supervisor, Director of Nursing/assistant director of nursing, or Nursing Home Administrator will begin the investigation. The Regulatory Reporting, section of the policy noted that the facility will report alleged and substantiated incidents to the Pennsylvania Department of Health, additional state agencies, and/or local authorities per federal and state requirements. Interview with Employee 9 (human resources) and Employee 10 (human resources) on April 30, 2026, at 3:50 PM, revealed that the verbiage in the facility's currently utilized attestation of Pennsylvania residency completed by new hires notes, Have you be (sic) a resident of Pennsylvania for 2 or more years? The document does not have the prospective employee provide the dates of residency or attest that he/she resided in the state of Pennsylvania consecutively for the past two years. Review of personnel records for newly hired employees with Employee 9 and Employee 10 on April 30, 2026, at 3:50 PM revealed the following concerns: Employee 4 (nurse aide) was hired by the facility on January 19, 2026. The available documentation in Employee's personnel records revealed no evidence that the facility obtained Employee 4's nurse aide registry verification or that Employee 4 completed Abuse and Neglect Prevention, Identification/Reporting of Abuse, and Techniques for Caring for the Cognitively Impaired Resident (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	training. Employee 4's personnel record contained an attestation signed December 11, 2025, that she was a resident of Pennsylvania for two or more years. The attestation, or other evidence in Employee 4's available personnel records (e.g., dates of current or previous addresses), did not stipulate that the two years of Pennsylvania residency were the previous two consecutive years. Employee 6 (licensed practical nurse) was hired by the facility on February 9, 2026. Information available in Employee 6's personnel file did not include the dates that she worked at the employment locations listed. Interview with Employees 9 and 10 on the date and at the time of the review confirmed that the facility could not thoroughly verify Employee 6's alleged employment history without knowing the dates she was allegedly employed. Employee 8 (social worker) was hired by the facility on March 16, 2026. Evidence of Employee 8's abuse prevention education indicated that he received the education on March 23, 2026 (one week after his date of hire). Interview with Employee 10 on May 1, 2026, at 12:00 PM indicated that the facility could not provide evidence that Employee 8 did not have resident contact during the week before his documented abuse training. Information available in Employee 8's personnel record revealed that the Pennsylvania criminal background verification was not obtained until April 30, 2026 (following the surveyor's request for Employee 8's personnel record). Interview with Employee 10 on May 1, 2026, at 12:00 PM confirmed that the facility could not provide evidence of an attempt to obtain Employee 8's criminal background verification before, or within 30 days, of his date of hire. The surveyor reviewed the above concerns regarding pre-employment screening for Employees 4, 6, and 8, during an interview with the Nursing Home Administrator and the Director of Nursing on May 1, 2026, at 9:20 AM. The facility policy entitled Abuse Investigation and Reporting, last reviewed without changes January 30, 2026, revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be thoroughly investigated by facility management. Allegations of abuse and neglect will be reported to local, state, and federal agencies (as defined by current regulations. All alleged violations involving abuse or neglect will be reported by the facility Administrator, or his/her designee to the State licensing/certification agency responsible for surveying/licensing the facility, the local/state ombudsman, the resident's representative, law enforcement officials, and the resident's attending physician. An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than two hours if the alleged violation involves abuse or resulted in serious bodily injury, or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. Clinical record review revealed the facility admitted Resident 2 on December 3, 2025. Nursing documentation dated March 17, 2026 (late entry documented on March 20, 2026), at 7:15 PM noted the nurse on A nursing unit heard Resident 117 say something about Resident 2 being on his bed. Documentation revealed on the nurse's way to Resident 117's room a thud was heard. Upon arrival Resident 117 was witnessed standing in the doorway and Resident 2 was lying on his back on the floor. Documentation revealed Resident 117 stated I am not a wussy, he kicked me and swung at me, so I put him down. When the nurse asked Resident 2 what happened he stated, he hit me once and I went down. Documentation revealed a resident witness was interviewed and he stated they were wrestling and the one resident was hunched over and then started to fall. He tried to catch himself but couldn't. Documentation revealed that everything was reported to the Director of Nursing. Interview with Employee 1 (registered nurse regional consultant) on May 1, 2026, at 12:14 PM, confirmed that the facility did not complete an investigation, obtain witness statements, notify law enforcement, or notify the Department of Health related to the resident-to-resident allegation of physical abuse with Resident 2. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(3)(e)(1) Management 28 Pa Code 201.19(1)(3)(8)(10) Personnel policies and procedures 28 Pa. Code 201.20(b)(d) Staff development 28 Pa. Code 201.29(c) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide a dependent resident with activities of daily living assistance for two of five residents reviewed (Residents 84 and 64). Findings include: Observation of Resident 84 on May 26, 2026, at 11:58 AM revealed that her hair appeared unkempt. Clinical record review revealed the facility admitted Resident 84 on October 3, 2025. Review of Resident 84's most recent quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident care needs) dated March 30, 2026, noted staff assessed Resident 84 as dependent on staff for bathing. Review of Resident 84's Kardex (documentation system used by staff to organize and reference key resident information essential for resident care) revealed she is to receive a bath every Wednesday and Saturday. Review of a Documentation Survey Report (electronic documentation completed by nurse aide staff for the completion of ADL care) from January 1 to May 1, 2026, revealed there was no documentation that staff assisted Resident 84 with a shower after March 19, 2026 (44 days). The findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on April 29, 2026. The Director of Nursing confirmed the above findings for Resident 84 on May 1, 2026, at 9:51 AM. Observation of Resident 64 on April 28, 2026, at 1:23 PM revealed he had a full beard on his face. Resident 64 was asked if this was their preference, and the resident shook their head no. Review of Resident 64's clinical record revealed that they had a care plan (outline of an individual's health needs, specific care requirements, and the actions necessary to achieve desired health outcomes) that includes a focus of ADL (activity of daily living) Self Care Performance Deficit initiated on April 28, 2023, and a corresponding intervention initiated on May 19, 2025, that states the resident prefers to have a mustache. The above information related to Resident 64 was reviewed with the Nursing Home Administrator and Employee 1, RN Regional Consultant on April 30, 2026, at 2:45 PM. 483.24(a)(2) ADL Care Provided for Dependent Residents Previously cited deficiency 5/2/2025 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and resident, family, and staff interview, it was determined that the facility failed to ensure residents received proper treatment and assistive devices to maintain hearing abilities for three of five residents reviewed for vision/hearing concerns (Residents 3, 14, and 68). Findings include: Clinical record review for Resident 68 revealed a diagnoses list that included unspecified bilateral hearing loss since February 27, 2024. Review of a plan of care initiated by the facility on March 5, 2024, to address Resident 68's communication problem related to her hearing deficit revealed that she is to have bilateral hearing aids put in her ears in the morning and taken out at hour of sleep (HS). Interview with Resident 68 on April 28, 2026, at 3:02 PM revealed her claim that she was, deaf; and that she had been waiting for hearing aids. The surveyor had to speak loudly and state questions repeatedly to complete an interview with Resident 68 while she did not have hearing aids in her ears. An active physician's order dated September 1, 2024, instructed staff to apply Resident 68's hearing aids bilaterally in the morning and remove hearing aids and place the hearing aids on a charger in the medication room at bedtime. Review of Resident 68's medication and treatment administration records (MAR and TAR, electronic documentation completed by licensed staff to record care implemented) dated April 2026 noted that staff documented Resident 68's refusals to utilize old hearing aids while she waited for new hearing aids. Interview with Resident 68's daughter on April 29, 2026, at 11:36 AM indicated that Resident 68 was fitted for hearing aids before December 2025. She contacted the hearing aid company who reported to her that the facility did not forward payment for the hearing aids; therefore, they have hearing aids that they will not release until payment is made. Per Resident 68's daughter, the provider indicated that they are waiting for bill payment for two other residents as well. The surveyor requested any evidence of Resident 68's professional audiology services since December 2025 during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 1 (registered nurse corporate consultant), on April 29, 2026, at 2:00 PM. The Nursing Home Administrator provided a copy of a payment check dated April 30, 2026, at 10:00 AM (following the surveyor's questioning) made out to the facility's contracted audiology provider for \$10,800.00 (ten thousand eight hundred dollars). Social services documentation dated April 30, 2026, at 11:12 AM (following the surveyor's questioning) revealed that the staff contacted the facility's contracted audiology services provider who stated that they will be in the facility on Wednesday May 6, 2026, regarding Resident 68's hearing aids. Clinical record review for Resident 3 revealed nursing documentation dated February 23, 2026, at 4:08 PM that Resident 3 arrived at the facility with hearing aids for both ears that staff locked in the medication cart as both, were dead. Nursing documentation dated February 24, 2026, at 3:11 PM indicated that Resident 3's bilateral hearing aids were in the medication cart; the licensed practical nurse charge nurse was instructed to replace the batteries and give them to the resident. Nursing documentation dated February 25, 2026, at 1:34 PM noted that Resident 3's right hearing aid was functioning, but her left hearing aid was not functioning. The writer indicated that social services staff were notified. Review of Resident 3's TAR and MAR dated April 2026 revealed no evidence that staff attested to the use of hearing aids. Observation and attempted interview with Resident 3 on April 28, 2026, at 2:19 PM revealed her to be hard of hearing and without any hearing aids. Interview with Employee 11 (nurse aide), Employee 12 (licensed practical nurse), and Employee 13 (licensed practical nurse) on April 28, 2026, at 2:19 PM confirmed that Resident 3 did not have any hearing aids and none were in the medication cart. Review of an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated March 2, 2026, revealed that staff assessed Resident 3's hearing as adequate with the use of a hearing aid. The Care Assessment Area (CAA, critical component of the Minimum Data Set (MDS) that helps identify resident-specific issues and develop individualized care plans in long-term care settings) for Resident 3's communication (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needs triggered staff to proceed to a care plan as she was only sometimes understood and had impaired ability to understand. Review of plans of care developed by the facility determined no plan of care that included Resident 3's hearing aid use. A quarterly MDS assessment dated [DATE], indicated that staff completed Resident 3's assessment without the use of a hearing aid. Resident Assessment Instrument (RAI/MDS) instructions to complete Section B0200: Hearing of the MDS includes to, Ensure that the resident is using their normal hearing appliance if they have one. Hearing devices may not be as conventional as a hearing aid. Some residents by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure the hearing appliance is operational. Interview with Employee 14 (licensed practical nurse/MDS reimbursement specialist) on April 30, 2026, at 12:00 PM indicated that she was not aware of the RAI instructions regarding ensuring a hearing device is used to complete the hearing assessment portion of the MDS. She confirmed that Resident 3 did not have a hearing aid for the March MDS assessment. The surveyor reviewed the above concerns regarding Resident 3's hearing aid use during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 1, on April 29, 2026, at 2:00 PM. Review of Resident 3's TAR dated April 2026 revealed that the facility initiated an intervention on April 30, 2026, at 6:00 AM (following the surveyor's questioning) that staff insert a hearing aid in Resident 3's right ear every morning and remove every evening. Staff are to document Resident 3's refusal to wear and keep the device in the medication room when not in use. Clinical record review for Resident 14 revealed a diagnoses list that included unspecified hearing loss since January 11, 2016. An active physician's order dated July 28, 2022, instructed staff to please utilize resident's hearing aids; in every morning, out at HS, and as needed per resident's request. Nursing documentation dated November 29, 2025, at 6:47 PM revealed that Resident 14 complained that his hearing aids were not working; and staff replaced the batteries. Review of an annual MDS assessment dated [DATE], indicated that Resident 14 had moderate difficulty hearing with the use of a hearing aid. A quarterly MDS assessment dated [DATE], indicated that staff assessed Resident 14 had moderate difficulty hearing; however, staff documented that a hearing aid was not used for the assessment. Review of Resident 14's TAR and MAR revealed that licensed staff initialed the implementation of Resident 14's hearing aids the morning of April 28, 2026. Interview with Resident 14 on April 28, 2026, at 1:35 PM revealed him to be very hard of hearing. The surveyor needed to speak loudly and repeat simple sentences/questions close to Resident 14's left ear to obtain resident responses. Resident 14 pointed to a charger on his bedside stand to indicate that he had hearing aids, but Resident 14 indicated that they needed battery replacement. Interview with nurse aide staff leaving Resident 14's room at the time stated, might have batteries at nurses' desk. Nursing documentation dated April 28, 2026, at 1:48 PM (after surveyor's above observation and interview) revealed that staff changed the batteries in Resident 14's hearing aids; however, they were not functioning per Resident 14. The nurse made social services aware. Nursing documentation dated April 29, 2026, at 2:11 PM revealed that Resident 14's hearing aids were, out for repair. Nursing documentation dated April 29, 2026, at 10:39 AM revealed that Resident 14's bilateral hearing aids were removed by social services and sent for repair. Social services documentation dated April 29, 2026, at 10:33 AM confirmed that staff contacted the Veteran's Administration (VA) regarding Resident 14's hearing aids that do not function; and that the staff sent the hearing aids to the front office to mail to the VA. Review of Resident 14's MAR and TAR dated April 2026 indicated that staff initialed Resident 14 had his hearing aids in use on April 28 and 30, 2026, although resident interview, observation, and clinical record documentation confirmed that was not accurate. The surveyor reviewed the above concerns regarding Resident 14's hearing aid services during an interview with the Nursing Home Administrator and Employee 1 on April 30, 2026, at 3:06 PM. 483.25 (a) HearingPreviously cited 5/2/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement interventions to prevent resident fall recurrence for one of nine residents reviewed for falls (Resident 3); and failed to ensure an environment free from potential accident hazards on three of four open nursing units (F Unit, Residents 3, 26, 68, 74, and 166; B and E common lounge area, and Cranberry common dining area). Findings include: Clinical record review for Resident 3 revealed nursing documentation dated February 23, 2026, at 4:08 PM that Resident 3 arrived at the facility and that she had scabs (unhealthy, leathery, often black tissue that covers a wound surface) on her left knee and shin from falling. An admission fall risk assessment dated [DATE], indicated that staff assessed Resident 3 at a high risk for falls (score of 19). Nursing documentation dated March 15, 2026, at 5:07 PM revealed that staff found Resident 3 on the floor in her room and that she complained of left leg pain. Nursing documentation dated March 15, 2026, at 4:25 PM revealed that x-ray results determined Resident 3 had a hip fracture. Staff notified the physician who instructed staff to send Resident 3 to the emergency room. Nursing documentation dated March 16, 2026, at 9:17 AM revealed that the interdisciplinary team reviewed Resident 3's fall, determined she lost her balance and fell, and that the facility would, follow up upon return to facility. Nursing documentation dated March 20, 2026, at 2:22 PM revealed that Resident 3 returned to the facility from the hospital. Review of the plan of care initiated by the facility on February 23, 2026, to address Resident 3's risk for falls revealed no new fall prevention interventions dated from March 15, 2026 (date of her fall and fracture) and March 20, 2026 (date of her return from the hospital). Documentation Survey Report data dated after Resident 3's return from the hospital on March 20, 2026, revealed that Resident 3 required the assistance of two staff and a roller walker for ambulation in her room and transfers with weight bearing as tolerated on her left lower extremity. Nursing documentation dated March 29, 2026, at 8:30 AM revealed that staff found Resident 3 on the floor in front of her wheelchair by the nurses' desk. Nursing documentation dated March 30, 2026, at 10:04 AM revealed that the interdisciplinary team reviewed Resident 3's fall in the hallway, determined that she fell from her wheelchair, that she was receiving skilled therapy services, and that they would try a different chair for Resident 3 when she was out of bed. Nursing documentation dated April 1, 2026, at 10:15 AM revealed that the licensed practical nurse called the registered nurse to the unit to report that while Resident 3 was in the bathroom, with 2 (two) staff members present, she stood up to turn and pivot into her wheelchair and through (sic) her body down to the floor, as staff was able to support her and lower her to the floor. Review of the facility's investigation of Resident 3's April 1, 2026, fall revealed that the facility determined that although Resident 3 required the assistance of two staff with transfers, only one staff member was present in the bathroom with her at the time of her fall. The investigation determined that during the transfer, Resident 3, threw self backwards knocking the wheelchair back out of reach and at that time the staff member was unable to reach the wheelchair. The facility suspended the nurse aide pending the investigation; and asserted that the nurse aide would return to work after she received individual (one-to-one) education on resident care plans, following resident plans of care, and the importance of utilizing two-assist techniques when a resident's transfer status dictates such. Interview with the Nursing Home Administrator on April 30, 2026, at 11:50 AM confirmed that the facility had no evidence of care plan revisions implemented after Resident 3's fall on March 15, 2026, until her subsequent fall on March 29, 2026. The interview confirmed that Resident 3 sustained a fall on April 1, 2026, when staff failed to implement Resident 3's plan of care for two staff to assist with transfers. The interview confirmed that the facility did not have evidence that the employee who was suspended following Resident 3's fall on April 1, 2026, completed required education upon her return to work on April 9, 2026. The interview also confirmed that the facility did (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not address the incorrect documentation by the registered nurse on April 1, 2026, that reported two staff were present with Resident 3 on April 1, 2026, when she fell in the bathroom. Interview with Employee 18, maintenance director, on April 30, 2026, at 9:57 AM, confirmed that an outlet located near a water source should be equipped with GFCI (Ground-Fault Circuit Interrupter, can interrupt or cut off electricity in the event of an electrical problem). Observation of the F Unit on April 30, 2026, at 1:12 PM revealed the bathroom shared by Resident 68, Resident 74, and Resident 3 was equipped with an electrical outlet to the left of the sink in the bathroom. The electrical outlet near the sink was not a GFCI outlet. Observation of the F Unit on April 30, 2026, at 1:14 PM revealed that the bathroom in Resident 166's room was equipped with an electrical outlet with a working nightlight to the left of the sink in the bathroom. The electrical outlet near the sink was not a GFCI outlet. Observation of the F Unit on April 30, 2026, at 1:17 PM revealed that the bathroom in Resident 26's room was equipped with an electrical outlet with a working nightlight to the left of the sink. The electrical outlet near the sink was not a GFCI outlet. The surveyor reviewed the above F Unit electrical outlet concerns during an interview with the Nursing Home Administrator on April 30, 2026, at 2:15 PM. Observation of the B and E common lounge area on April 30, 2026, at 1:05 PM revealed an electrical outlet adjacent to a sink and accessible by residents that was not a GFCI outlet. Observation of the Cranberry common dining area on April 30, 2026, at 1:06 PM revealed three electrical outlets adjacent to a sink and accessible by residents that were not a GFCI outlet. Concurrent interview with Employee 18 and Employee 33, maintenance staff, and observation of the B and E common lounge and Cranberry common dining area on April 30, 2026, at 3:18 PM confirmed that the outlets were not GFCI protected and unsure if there was a GFCI breaker. Cross refer F908 483.25(d)(1)(2) Free of Accident Hazards/supervision/devices Previously cited deficiency 5/2/25 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on review of facility documentation, observation, clinical record review, and resident and staff interview, it was determined that the facility failed to implement interventions to promote acceptable parameters of nutrition for three of 13 residents reviewed for nutritional concerns (Residents 12, 18, and 84); and provide nutritional supplements as per the physician order to promote acceptable parameters of nutrition for three of 13 residents reviewed for nutritional concerns (Residents 29, 107, and 170). Findings include: Current physician orders for Resident 29 revealed an order dated March 7, 2025, for Med Pass 2.0 (a type of nutritional supplement) four ounces give four times a day 120 milliliters (ml). Review of the current care plan for Resident 29 revealed the resident has a nutritional problem or potential nutritional problem related to the medical history. An intervention included to provide and serve supplements as prescribed; 2.0 120 ml QID (four times a day). Review of the medication administration record (MAR) for Resident 29 for March 2026 revealed the Med Pass 2.0 was not documented as administered per the physician order on the following dates/times: 9:00 AM dose:March 11; March 21-24; March 27; March 29-31. 1:00 PM dose:March 21-23; March 27; March 29; March 31. 5:00 PM dose:March 21-22; March 29. 9:00 PM dose:March 29 Review of the MAR documentation for March 2026 revealed the following Administration Notes for the Med Pass 2.0 for Resident 29: March 21, 2026, at 8:03 AM: not availableMarch 21, 2026, at 12:21 PM: unavailableMarch 21, 2026, at 5:41 PM: unavailableMarch 22, 2026, at 9:13 AM: unavailableMarch 22, 2026, at 12:20 PM: unavailableMarch 22, 2026, at 4:42 PM: unavailableMarch 23, 2026, at 10:32 AM: UAMarch 23, 2026, at 1:13 PM: UAMarch 24, 2026, at 9:11 AM: unavailableMarch 25, 2026, at 1:14 PM: Med Pass 2.0 unavailable Boost given, MD awareMarch 26, 2026, at 3:01 PM: Med Pass unavailable. Boost given. MD awareMarch 26, 2026, at 3:02 PM: Med Pass unavailable. Boost given. MD awareMarch 27, 2026, at 1:02 PM: not availableMarch 27, 2026, at 9:50 PM: Med Pass 2.0 unavailable or boost/neither is available facility is waiting on a shipment from pharmacy.March 29, 2026, at 10:03 AM: not available in facilityMarch 29, 2026, at 12:19 PM: not available facility awareMarch 29, 2026, at 4:53 PM: not available, MD awareMarch 29, 2026, at 8:57 PM: not available, MD awareMarch 30, 2026, at 9:06 AM: unavailable, Boost given, MD made aware.March 30, 2026, at 12:08 PM: Med pass unavailable. Boost given, MD made awareMarch 31, 2026, at 10:38 AM: unavailable, MD awareMarch 31, 2026, at 1:23 PM: unavailable A nutrition progress note for Resident 29 dated April 2, 2026, at 12:05 PM noted an intervention of 120 m Med Pass 2.0 QID (each provides 255 calories and 10 grams / protein). The documentation did not address the availability of the Med Pass 2.0 or that the dietary staff were aware that the resident had missed multiple doses of the prescribed Med Pass 2.0. Current physician orders for Resident 107 revealed an order dated February 5, 2026, for Med Pass 2.0 four ounces give two times a day 120 milliliters (ml). Review of the current care plan for Resident 107 revealed the resident has a nutritional problem or potential nutritional problem related to the medical history. An intervention included to provide and serve supplements as prescribed; MED pass 2.0 4 oz bid (two times a day). Review of the medication administration record (MAR) for Resident 107 for March 2026 revealed the Med Pass 2.0 was not documented as administered per the physician order on the following dates/times: 9:00 AM dose:March 11; March 21-24; March 26-27; March 29-31 9:00 PM dose:March 21; March 29 Review of the MAR documentation for March 2026 revealed the following Administration Notes for the Med Pass 2.0 for Resident 107: March 21, 2026, at 8:11 AM: unavailableMarch 21, 2026, at 10:49 PM: unavailableMarch 22, 2026, at 8:04 AM: unavailableMarch 23, 2026, at 10:21 AM: UAMarch 24, 2026, at 8:54 AM: unavailableMarch 25, 2026, at 1:07 PM: Med Pass 2.0 unavailable Boost given, MD awareMarch 26, 2026, at 2:43 PM: Med pass unavailable. Boost given. MD aware.March 27, 2026, at 12:41 PM: unavailableMarch 29, 2026, at 9:57 AM: not available in buildingMarch 29, 2026, at 8:49 PM: not available, MD awareMarch 30, 2026, at 8:03 AM: Med Pass unavailable, boost given, MD aware.March 31, 2026, at 10:20 AM: unavailable Review of physician orders for Resident 170 revealed an order dated March 4, 2026, at 9:00 PM and discontinued on March (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	16, 2026, for Juven (a type of nutritional supplement) 0.97 ounce packet give two times a day and mix packet with 240 ml of water or beverage of choice. Review of the medication administration record (MAR) for Resident 170 for March 2026 revealed the Juven was not documented as administered per the physician order on the following dates/times: 9:00 AM dose:March 5 - 16 9:00 PM dose:March 5 - 9; March 11; March 13-15 Review of the MAR documentation for March 2026 revealed the following Administration Notes for Juven for Resident 170: March 5, 2026, at 2:08 PM: awaiting deliveryMarch 5, 2026, at 10:11 PM: awaiting deliveryMarch 6, 2026, at 9:09 AM: not availableMarch 6, 2026, at 8:58 PM: not availableMarch 7, 2026, at 8:06 AM: awaiting deliveryMarch 7, 2026, at 9:51 PM: med not availableMarch 8, 2026, at 9:46 AM: awaiting deliveryMarch 9, 2026, at 9:19 PM: none in houseMarch 10, 2026, at 9:38 AM: awaiting deliveryMarch 10, 2026, at 9:41 PM: supplied chocolate boost as that was the supplement we have on the unitMarch 11, 2026, at 9:43 AM: awaiting deliveryMarch 11, 2026, at 9:09 PM: unavailableMarch 12, 2026, at 9:17 AM: awaiting deliveryMarch 13, 2026, at 9:45 AM: awaiting delivery/response from MD to change orderMarch 13, 2026, at 9:43 PM: supplied a boost as juven is not availableMarch 14, 2026, at 10:20 AM: awaiting response for md to change orderMarch 14, 2026, at 8:22 PM: awaiting response for md to change order, not availableMarch 15, 2026, at 11:48 AM: u/aMarch 15, 2026, at 11:31 PM: Awaiting response for therapeutic exchange for house stock supplement(s).March 16, 2026, at 8:21 AM: awaiting order for substitute Documentation dated March 12, 2026, at 3:12 PM for Resident 170 noted, Resident also ordered Juven, but is unavailable. Requested to change to Prosource. Awaiting response. The above missing doses of physician ordered supplements for Residents 29, 107, and 170 were reviewed in a meeting with the Nursing Home Administrator and Employee 1, registered nurse regional consultant, on April 30, 2026, at 2:30 PM. The facility stated they would have to investigate the matter further. The above information for Residents 29, 107, and 170 were reviewed again in a meeting with the Nursing Home Administrator and Director of Nursing on May 1, 2026, at 9:46 AM and Employee 1 on May 1, 2026, at 9:56 AM. The facility was still looking into the matter. The facility provided documentation on May 1, 2026, at 2:15 PM titled, Item history by facility by weekly, which indicated Nutren 1.5 24/8 oz and listed a quantity of two for the date range of March 1-7, 2026. Med Pass 2.0 vanilla 24/8 oz was documented as four for quantity for the date range of March 1-7, 2026, and a quantity of two for the date range of March 29 - April 4, 2026. There was also a purchase order for Med Pass 2.0 vanilla (quantity two) with an approval date of March 27, 2026; a Med Pass 2.0 vanilla 12/32 oz purchase order approved March 30, 2026, for a quantity of four. There was no documentation provided by the facility for Residents 29, 107, and 170 to indicate why the residents had missed multiple doses of their physician ordered supplementation on the dates above (i.e. a supply issue, problem with order, failure to order, etc.). The facility failed to provide nutritional supplements as per the physician order to promote acceptable parameters of nutrition for Residents 29, 107, and 170. The facility policy entitled Impaired Nutrition/Unplanned Weight Loss- Clinical Protocol, last reviewed without changes January 30, 2026, revealed the nursing staff will monitor and document the weight and dietary intakes of residents in a format which permits comparisons over time. The staff and physician will define the individual's current nutritional status and identify individuals with significant weight loss or gain, or significant risk for impaired nutrition. The physician will consider whether any assessment including additional diagnostic testing is indicated to help clarify the severity or consequences of significant weight loss and/or impaired nutrition. The staff will report to the physician significant weight gains or losses, or any abrupt or persistent change from baseline appetite or food intake. Determination of significant weight loss will be assessed and reported to the physician if greater than five percent body weight loss in the last 30 days, or greater than 10 percent body weight loss in the last 180 days. Clinical record review revealed the facility admitted Resident 18 on May 22, 2025. Further review of Resident 18's clinical record revealed the following weight assessments: January 7, 2026, 199.9 poundsFebruary 18, 2026, 178.8 pounds (a 21.1-pound, 10.55 percent significant weight loss)March 4, 2026, 182.5 pounds There was no evidence that staff obtained a re-weight or notified Resident 18's physician after the February 18, (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2026, significant weight loss. A weight change note dated March 6, 2026, at 10:52 AM confirmed Resident 18 had a significant weight loss over the past 90 and 180 days. She added Med Pass 2.0 to help support nutritional needs and stabilize pattern. Clinical record review revealed the facility admitted Resident 84 on June 30, 2025. Further review of Resident 84's clinical record revealed the following weight assessments: February 4, 2026, 126.4 poundsMarch 9, 2026, 101.6 pounds (a 24.8-pound, 19.62 percent significant weight loss)March 26, 2026, 107.9 pounds There was no evidence that staff obtained a re-weight or notified Resident 84's physician after the March 9, 2026, significant weight loss. A nutrition progress note dated March 27, 2026, at 1:07 PM revealed Employee 34 (certified dietary manager) documented that he notified Resident 84's physician of a 11.2 percent significant weight loss in less than 90 days. He recommended to start 120 ml Med Pass 2.0 twice daily to promote weight stability, and weekly weights. Clinical record review revealed the facility admitted Resident 12 on February 28, 2025. Further review of Resident 12's clinical record revealed the following weight assessments: January 7, 2026, 178.8 poundsFebruary 24, 2026, 126.2 pounds, (a 52.6 pound, 29.41 percent severe weight loss)February 25, 2026, 124.8 poundsMarch 4, 2026, 128.2 pounds Further review of Resident 12's clinical record revealed no assessment of Resident 12's severe weight loss, or any interventions addressing the severe weight loss until March 6, 2026. The registered dietitian documented a weight change note on March 6, 2026, noting the possible cause was unknown at this time. The registered dietitian added health shakes with Resident 12's meals and weekly weights for additional monitoring. There was no documentation that Resident 12's physician was notified timely of the severe weight loss. The surveyor reviewed the above nutritional concerns with Residents 18, 84, and 12, with the Nursing Home Administrator and Employee 1 (registered nurse regional consultant) during a meeting on April 30, 2026, at 2:40 PM. The above findings for Residents 18, 84, and 12 were reviewed with Employee 34 on May 1, 2026, at 11:03 AM, and he was unable to provide any further documentation. 483.25(g)(1) Maintains acceptable parameters of nutritional statusPreviously cited 5/2/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide food in accordance with resident preference and physician ordered diets on one of four open nursing units (F Unit, Residents 4, 26, 71, 127, and 175). Findings include: Interview with Resident 175 on April 28, 2026, at 1:56 PM revealed that he frequently receives meals from the kitchen that are not according to his preferences or his physician ordered diet. Resident 175 provided the tray ticket from his meal tray that indicated that he was to maintain a 2000 milliliter fluid restriction; however, Resident 175 stated that he no longer had that restriction. Resident 175 stated that he often does not receive double portions that is specified on his meal tray ticket. Clinical record review for Resident 175 revealed a discontinued physician's order (in effect as of December 16, 2024) that included a 2000 milliliter fluid restriction. The order was discontinued on October 12, 2025. An active physician order dated October 12, 2025, no longer included a 2000 milliliter fluid restriction. The surveyor reviewed Resident 175's dietary concerns during an interview with Employee 1 (registered nurse regional consultant) and the Nursing Home Administrator on April 30, 2026, at 2:15 PM. Interview with Resident 127 on April 28, 2026, at 1:56 PM revealed that he stopped attending resident council or food committee meetings because the facility did not make any changes or improvements. Resident 127 stated, they do what they want. During an interview with Resident 71 on April 29, 2026, at 9:40 AM he stated, They promise you stuff and don't deliver. Resident 71 continued to provide examples of meal items on the planned menu that do not arrive on his tray such as, Promised oatmeal and get grits (Cream of Wheat), promised cinnamon buns and they don't come. Resident 71 stated that he compares the piece of paper (that) comes with tray (tray ticket), to what is on the meal tray and knows that the meals are not provided as per the planned menu. During an interview with Resident 4 on April 28, 2026, at 12:46 PM she stated that the kitchen staff, switch, menu items. Resident 4 stated that she is not supposed to get any vegetables except cauliflower; that they knew about it ever since been here, years. the only vegetable I like is cauliflower. Observation of Resident 4's lunch tray during the interview revealed a large, uneaten, portion of green beans. Review of Resident 4's meal ticket revealed no indication to omit vegetables except cauliflower. Observation of the lunch meal provided to Resident 4 on April 29, 2026, at 12:30 PM revealed a portion of beef that was covered in gravy. Resident 4 provided her meal ticket delivered with the tray that instructed that she was not to have gravy. The surveyor reviewed Resident 4's concerns that her preferences are not honored by dietary staff during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 1 on April 29, 2026, at 2:00 PM. Interview with Resident 26 on April 30, 2026, at 1:17 PM revealed that she did not receive the lunch meal that she was supposed to receive. Resident 26 stated that she was to receive a turkey entree, but she received a ham entree that she was not going to eat. Resident 26 stated that she was supposed to receive gravy on the side and she did not receive it. Resident 26 stated that staff had to call to get her gravy. Interview with Employee 11 (nurse aide) on April 30, 2026, at 1:25 PM confirmed that Resident 26 did not receive gravy per her meal tray ticket. Employee 11 stated that staff, always have to call for gravy for her because the kitchen does not send it per her tray ticket. Interview with Employee 3 (nurse aide) on April 30, 2026, at 1:35 PM confirmed that Resident 26 is supposed to receive a side of gravy on her meal tray; however, she had to call the kitchen to have a portion sent to her after she received her meal. Employee 3 stated that she called the kitchen to have turkey provided for Resident 26 as per her meal ticket; however, she was told that they did not have any left and she would receive the ham alternative. Employee 3 stated that Resident 26 would not eat the ham entree. Interview with Employee 15 (food service director) on May 1, 2026, at 11:48 AM confirmed that the kitchen ran out of the turkey entree before all residents were served; and Resident 26 received a substitute ham entree. Employee 15 denied knowledge that Resident 26 had repeated concerns that she did not receive a (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	side of gravy as per her preference. Employee 15 stated that nursing unit staff are to call kitchen staff for meal concerns and kitchen staff document these calls on a log. Employee 15 provided a log with only one entry that reported Resident 26's gravy concern (dated April 30, 2026). The log did not reflect numerous calls regarding Resident 26's desired gravy condiment as reported by Resident 26 and the nurse aides that work on her unit. 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) (e)(1)(2)(4) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.6(a) Dietary services		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interview, it was determined that the facility failed to prepare/serve food items in accordance with professional standards of practice in the facility's main kitchen. Findings include: Observation on May 1, 2026, at 11:15 AM of tray line (a structured system in foodservice operations for meal assembly and distribution) revealed improper use of hair nets. Employee 16, dietary cook, was observed walking between the tray line and the food preparation area, wearing a hair net and a beard net with long hair extending out from under the net, and the beard net pulled down under their mouth, exposing long beard hairs and a mustache above the netting. Employee 17, kitchen supervisor, was observed overseeing tray line with a beard net pulled down under their mouth, exposing a mustache above the netting. The above information was reviewed with the Nursing Home Administrator on May 1, 2026, at 12:15 PM. 483.60(i)(1)-(2) Food safety requirements Previously cited deficiency 5/2/25 28 Pa. Code 201.14(a) Responsibility of licensee		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on a review of select facility policies and procedures, clinical record review, observation, and resident, family, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection on one of four open nursing units (F Unit, Residents 3, 4, 68, and 74). Findings include: Observation of a medication administration pass for Resident 4 on April 29, 2026, at 10:31 AM with Employee 21 (licensed practical nurse) revealed Employee 21 donned gloves to administer an eye drop to Resident 4's right eye. Employee 21 removed her gloves after the eye drop administration, placed the eye drop medication back in the medication cart drawer, typed on the computer on the medication cart, before she moved the medication cart to the nurses' station. Employee 21 did not perform hand hygiene after removing her gloves. Interview with Employee 21 on April 29, 2026, at 10:49 AM confirmed that she did not perform hand hygiene after removing her gloves. Employee 21 pointed to the alcohol hand sanitizer on her medication cart; and stated that she had been trained to perform hand hygiene after removing gloves. The facility policy entitled, Categories of Transmission-Based Precautions, last reviewed January 30, 2026, revealed that transmission-based precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. Contact Precautions are for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Examples of infections requiring Contact Precautions include diarrhea associated with Clostridium difficile (C. diff, a species of bacteria that can infect the colon and cause severe diarrhea). If a private room is not available, the Infection Control Coordinator will assess various risks associated with other resident placement options (e.g., cohorting). Wear gloves when providing any care to the resident. Remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or waterless antiseptic agent. Wear a gown for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. Remove the gown and perform hand hygiene before leaving the resident's environment. When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope or bedside commode to a single resident to avoid sharing between residents. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. The above policy did not address appropriate hand hygiene after Contact Precautions implemented for organisms not affected by alcohol-based sanitizers such as C. diff. The facility policy entitled, Enhanced Barrier Precautions (EBP), last reviewed January 30, 2026, revealed that to minimize the transmission of germs transferring from residents to staff hands and clothing, staff will wear gown and gloves when providing care to residents that require significant physical contact and are at high risk of acquiring or spreading multi-drug resistant organisms (MDROs). EBP, refers to an infection control intervention designed to reduce transmission of MDROs that requires staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or spreading an MDRO. High-contact resident care activities include transferring residents from one position to another, providing hygiene, changing bed linens, and assisting with toileting. A physician's order for EBP will be obtained. Residents who are on EBP due to colonization with a target MDRO will only be cohorted with another resident infected or colonized with the same organism. The nursing staff and/or infection preventionist will ensure that staff are aware of a resident requiring EBP. The facility policy entitled, Handwashing/Hand Hygiene, last reviewed January 30, 2026, revealed that the facility considers hand hygiene as the primary means to prevent the spread of infections. Use an alcohol-based hand rub or soap and water after contact with objects in the immediate vicinity of the resident, after removing gloves, and before and after entering isolation precautions settings. Wash hands with soap and water for the following situations: When hands are visibly soiled Before eating After using the bathroom After contact with a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident with infectious diarrhea including, but not limited to infections caused by C. diff Observation of the doorway to Resident 68 and 74's room on April 28, 2026, at 2:32 PM revealed a sign labeled Contact Precautions and a sign labeled Enhanced Barrier Precautions. An organizer on the door contained isolation gowns and gloves. The Contact Precautions sign noted that everyone must clean their hands before entering the room and wash them with soap and water when leaving the room; staff must use dedicated equipment. Clinical record review for Resident 68 revealed an active physician order (dated February 18, 2026) for EBP every shift for history of ESBL (Extended Spectrum Beta Lactamase, enzymes produced by certain bacteria that confer resistance to a wide range of antibiotics, making infections caused by these bacteria difficult to treat) in her urine. Interview with Resident 68 on April 28, 2026, at 2:40 PM revealed that she takes herself to the bathroom in her room. Resident 68 stated that she has had an occasion when the resident in the room next door opens the door while she is in there. Resident 68 stated that her roommate is also independent in the room and uses that bathroom. Clinical record review for Resident 74 revealed the following active physician orders: Enhanced Barrier Precautions (EBP) every shift related to ESBL Resistance, dated April 14, 2026. Contact precautions for C. diff, every shift for diarrhea; discontinue C. diff contact precautions if C. diff negative, dated April 24, 2026. Observation of a medication administration pass for Resident 74 on April 29, 2026, at 11:09 AM revealed Employee 22 (licensed practical nurse) entered Resident 74's room without donning a gown or wearing gloves to administer her medications. Employee 22 sorted through Resident 74's belongings to find respiratory treatment equipment to administer additional medication to Resident 74. Employee 22 used a stethoscope that she kept on her person to listen to Resident 74's lungs. Employee 22 did not wash her hands with soap and water before leaving Resident 74's room. Employee 22 used an alcohol pad to clean the earpieces and bell of her stethoscope before draping the stethoscope around her neck. Alcohol-based sanitizers are ineffective against C. diff because the bacterium forms spores that are resistant to alcohol. Continued observation of Employee 22 on April 29, 2026, from 11:12 AM to 11:19 AM revealed her to leave the medication cart, go to the medical supply storage room behind the nurses' station, obtain new tubing for Resident 74's respiratory treatment equipment, and return to Resident 74's bedside without donning PPE. While in Resident 74's room on April 29, 2026, at 11:21 AM Employee 22 noted that her roommate's (Resident 68) oxygen tubing was not applied correctly in her nose. Employee 22 adjusted Resident 68's nasal oxygen tubing, used alcohol-based hand sanitizer (that is ineffective against C. diff), and left the nursing unit to go to the supervisor's office to obtain medication from the stock supply. Employee 22 returned to Resident 74's room on April 29, 2026, at 11:46 AM, applied a gown and gloves to enter the room, and began the administration of Resident 74's respiratory treatment. During Resident 74's treatment, Resident 68's daughter was sitting on Resident 68's bed, observed Resident 74's respiratory treatment, and asked, does she have something contagious that I should know about? Continued observation of Resident 68 and 74's room on April 29, 2026, at 11:58 AM revealed Resident 68's daughter assisted her mother to ambulate to the bathroom. Resident 68's daughter was not wearing a gown or gloves. Interview with Resident 68's daughter on May 4, 2026, at 12:22 PM revealed that she received no education or instruction from facility staff regarding special precautions or additional care necessary when visiting her mother (e.g., handwashing, avoiding direct contact with environmental surfaces in the room such as her bed, or wearing gloves). Resident 68's daughter indicated that she requested that the facility obtain testing of her mother's urine; and that the doctor ordered an antibiotic for her mother last week for a urinary tract infection. Interview with Resident 74 on April 29, 2026, at 12:00 PM confirmed that she independently utilizes the same bathroom in the room as needed. Interview with Employee 24 (licensed practical nurse) on April 30, 2026, at 1:12 PM confirmed that Residents 3, 68, and 74 use the same bathroom. Clinical record review for Resident 3 revealed no diagnoses of C. diff or history of ESBL infection or colonization. Observation on April 29, 2026, at 11:59 AM revealed Employee 23 (nurse aide) entered Resident 68 and 74's room to provide a new incontinence pad on Resident 68's (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed because it was reportedly wet from urinary incontinence. Employee 23 wore gloves to change the pad but did not don a gown. Interview with Employee 23 on the date and time of the observation indicated that she believed the PPE signage and equipment on the room door was for Resident 74, not Resident 68. Observation of Employee 22 completing Resident 74's respiratory treatment on April 29, 2026, at 11:56 AM revealed that she cleaned the oxygen tubing at the sink in the room, bagged the equipment, used her stethoscope to listen to Resident 74's lungs, removed her gown and gloves, performed hand hygiene at the sink in the room, and exited the room to the medication cart. Employee 22 did not utilize an effective method to clean her stethoscope after use with Resident 74. Nursing documentation dated April 30, 2026, at 3:33 PM noted that the physician reviewed Resident 68's laboratory results from urine testing and provided a new order to start Macrobid (an antibiotic) twice daily for seven days. Interview with Employee 26 (licensed practical nurse/infection control prevention coordinator) on April 30, 2026, at 9:20 AM confirmed that Employee 22 should have used the wipes that contain bleach to clean her stethoscope that was not dedicated equipment for Resident 74. Employee 26 also confirmed that the facility should have implemented a bedside commode for Resident 74 until the suspected C. diff infection was ruled out. Employee 26 stated that the facility did not consider Resident 3's (not diagnosed with a history of ESBL or C. diff) use of the bathroom that was used by Residents 68 and 74 (on EBP for a history of ESBL and contact precautions for C. diff). Observation of Resident 68's room on April 28, 2026, at 2:32 PM revealed that she used supplemental oxygen. A respiratory mask not in use at the time of the observation was stored on top of Resident 68's bedside stand. The mask was not bagged or otherwise protected from potential environmental contaminants. Interview with Resident 68 indicated that she received respiratory medication through the mask three times a day. Clinical record review for Resident 68 revealed medication administration records dated April 2026 that indicated that she received Albuterol Sulfate Inhalation Nebulization Solution (Albuterol Sulfate, medication inhaled to dilate the airways or prevent spasms of the airways in residents who have lung conditions) three times a day at 8:00 AM, 1:00 PM, and 9:00 PM. The surveyor requested the facility's policy or procedure regarding the storage of oxygen equipment when not in use during an interview with the Nursing Home Administrator and the Director of Nursing on April 29, 2026, at 2:00 PM. The facility policy provided, entitled, Oxygen Storage, reviewed January 30, 2026, did not address measures the facility staff would take to protect oxygen equipment such as face masks when not in use to prevent potential environmental contamination. Interview with Employee 22 on April 29, 2026, at 11:19 AM confirmed Resident 68's respiratory equipment was not bagged in an antimicrobial bag as per the facility's practice. The surveyor reviewed the above infection control concerns during an interview with the Nursing Home Administrator and Employee 1 (registered nurse regional consultant) on April 30, 2026, at 2:15 PM. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 5/2/25 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on review of facility documentation and staff interview it was determined that the facility failed to maintain documentation of staff COVID-19 vaccination status, for two of two staff reviewed (Employees 27 and 28). Findings include: Interview with Employee 27 (nurse aide) on April 29, 2026, at 9:29 AM revealed that she declined the COVID vaccination that the facility offered last year. Interview with Employee 28 (nurse aide) on April 29, 2026, at 9:31 AM revealed that she received COVID vaccinations in the past but declined the COVID vaccination the facility offered last year. Interview with Employee 26, (infection preventionist) on May 1, 2026, at 11:23 AM revealed that she was unable to provide evidence that she maintained staff documentation of their current COVID-19 vaccination status. Review of Employees 27 and 28's employee health files also revealed no evidence of their vaccination status. The surveyor reviewed the above noted findings with the Nursing Home Administrator on May 1, 2026, at 11:51 AM. 483.80 Infection control Previously cited 5/2/2025 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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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. Based on observation and resident and staff interview, it was determined that the facility failed to ensure a clean, comfortable, and homelike environment on two of four open nursing units (G unit emergency exit doorway, and F unit, Residents 4, 95, and 127). Findings include: Interview with Resident 4 on the F unit hallway on April 28, 2026, at 12:50 PM revealed that she requested the surveyor observe her room. Observation of Resident 4's room on April 28, 2026, at 12:52 PM revealed personal possessions that blocked the door to the bathroom, blocked access to the handwashing sink, blocked access to her and her roommate's closet, covered the majority of dresser and furniture surfaces, and covered a large portion of the floor space. Resident 4 stated on the date and time of the observation that she required staff assistance to organize her room and remove two of the storage totes that were present in the room. Resident 4's manual wheelchair (not in use while she sat in a motorized wheelchair) was stored on her roommate's side of the room (in front of the closets). Resident 4's storage totes also were stored on her roommate's side of the room. Items on Resident 4's floor included personal cleaning wipes and a roll of toilet paper. The bifold door for the closet was broken from the mounting track and hung open into the room. Interview with Employee 2 (housekeeping/laundry director) on April 29, 2026, at 10:03 AM indicated that she made a list twice over two months for activities staff to go through Resident 4's possessions with her. Employee 2 stated that she was on the unit at this time to take storage totes from Resident 4's room. Employee 2 confirmed that the number of possessions that covered surfaces in Resident 4's room prevented housekeeping staff from effectively cleaning the room. The surveyor reviewed the above findings regarding Resident 4's room with the Nursing Home Administrator and the Director of Nursing on April 29, 2026, at 2:00 PM. Interview with Resident 127 on April 29, 2026, at 12:00 PM revealed that he believed Resident 95 stored food in his bedside stand that was unsafe for him to eat. Observation of Resident 95's bedside stand with Employee 3 (nurse aide) on April 29, 2026, at 12:39 PM revealed a sandwich bun with ketchup wrapped loosely in a napkin stored directly in his bedside stand drawer. Employee 3 removed several packets of undated packets of mayonnaise, and an empty (and uncleaned) bowl that looked to have contained fruit. Employee 3 removed two bowls of what appeared to be prepared hot cereal (Cream of Wheat) that had no date of preparation or expiration. Employee 3 also removed two containers of apple juice that had no expiration date indicated, and a container of lemonade that had no expiration date on the container. Employee 3 also removed a lidded cup that contained liquid that Employee 3 believed was cold coffee. The surveyor reviewed the findings related to Resident 95's room during an interview with Employee 1 (registered nurse corporate consultant) and the Director of Nursing on April 30, 2026, at 9:35 AM. Observation on April 29, 2026, at 10:05 AM of the G unit revealed an emergency exit door in the hallway was rusted at the base of the door on both sides. A 0.5-inch gap was noted where the outdoor sidewalk was clearly visible. The 0.5-inch gap extended from the threshold of the door, two feet up towards the door handle. At the base of the wall to the left of the door the baseboard was peeled away, revealing painted drywall that was peeling and bubbling. Around the threshold of the door was noted dust, debris including food crumbs, a piece of chocolate candy, and three needle cap seals (round, 0.5-inch coverings that are removed from needle packaging prior to use). The above information regarding the G unit emergency exit doorway was reviewed with the Nursing Home Administrator and the Director of Nursing on April 29, 2026, at 2:15 PM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited 5/2/25 and 9/17/25 28 Pa. Code 201.18(b)(3)(e)(2.1) Management		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review and staff interview, it was determined that the facility failed to monitor the use of psychotropic medications for one of five residents reviewed for potentially unnecessary medications (Resident 2). Findings include: Clinical record review for Resident 2 revealed active physician orders for staff to administer the following psychotropic medications: Lexapro (an antidepressant medication) 10 milligrams (mg), two tablets in the morning for depression. Trazadone (an antidepressant medication) 50 mg, half a tablet in the morning and one tablet at bedtime for depression. Seroquel (an antipsychotic medication) 25 mg, one tablet two times a day for psychosis. A physician order dated January 9, 2026, instructed staff to monitor Resident 2's behavior related to agitation and anxiety. There was no documentation in Resident 2's clinical record that staff monitored Resident 2's behaviors related to his psychosis and depression. Resident 2's clinical record failed to provide evidence that the facility was monitoring for potential side effects from Resident 2's use of the above-mentioned psychotropic medications. Interview with Employee 1 (registered nurse regional consultant) on May 1, 2026, at 1:06 PM confirmed the above findings for Resident 2. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, clinical record review, review of select facility documents, and staff and resident interview, it was determined that the facility failed to provide resident assistance to attend activities of interest for one of two residents reviewed for activities (Resident 140). Findings include: Interview with Resident 140 on April 28, 2026, at 12:55 PM, revealed that they enjoyed some of the activities, especially bingo which was scheduled for that day at 2:00 PM. Resident 140 stated that they are dependent on staff to take them to the activities, and often they do not come to get them. Observation on April 28, 2026, at 3:15 PM, revealed that bingo was ongoing, but Resident 140 was not present. Concurrent interview with Resident 140 revealed that they did not change their mind and they still wanted to attend Bingo today, but staff did not come to take them. Review of Resident 140's clinical record reveals they have a care plan (outline of an individual's health needs, specific care requirements, and the actions necessary to achieve desired health outcomes) Focus that was initiated on August 18, 2020, that states the resident is dependent on staff for activities. Interview with Employee 25, activities director, on April 30, 2026, at 9:30 AM, revealed that Resident 140 was supposed to be brought to the bingo activity on April 28, 2026, by an aide, however the aide did not bring them. The above information was reviewed with the Nursing Home Administrator and Employee 1, RN Regional Consultant on April 30, 2026, at 2:45 PM. 28 Pa. Code 201.29 (a) Resident rights		

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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. Based on clinical record review, review of facility documentation, and staff and resident interview, it was determined that the facility failed to provide the highest practical care regarding physician ordered medications, allergies, and devices for three of 35 residents reviewed (Residents 53, 116, and 140). Findings include: During an interview with Resident 140 on April 28, 2026, at 12:55 PM, they stated that they had increased pain in their right shoulder because the nurse had not applied their pain patch. The resident allowed the surveyor to assess the resident's shoulders, and no patch could be located on either shoulder. Clinical record review for Resident 140 revealed that the resident had an active physician order for a topical pain patch written April 10, 2026, that stated, Aspercreme Lidocaine External Patch 4 % (Lidocaine) apply to right shoulder topically one time a day for right shoulder pain and remove per schedule. Further review revealed that the patch was signed in the MAR (Medication Administration Record) as completed for April 28, 2026, indicating that the patch was applied during the 9:00 AM medication administration. Clinical record review revealed that the patch was documented as removed on the resident's MAR on April 28, 2026, during the 9:00 PM medication administration, but no documentation was found indicating that the patch was not present or that it had been located and applied/reapplied throughout the day. On April 28, 2026, at 4:16 PM, it is documented that Resident 140 reported pain of an eight out of ten (severe pain) and was administered an as needed pain medication Oxycodone (an opioid medication used to manage severe pain) 5mg (milligram) tablet. The above information related to Resident 140 was reviewed with the Nursing Home Administrator and the Director of Nursing on April 29, 2026, at 2:15 PM. Review of Resident 53's clinical record revealed that they had an allergy to adhesive active since January 28, 2026. Further review of the resident's clinical record revealed a progress note written on April 14, 2026, by a licensed practical nurse, that stated, Ileostomy continues to leak. stoma powder and adhesive attempted. The above information regarding resident 53 was reviewed with the Nursing Home administrator and Employee 1, RN Corporate Consultant, on May 1, 2026, at 10:30 AM. Clinical record review for Resident 116 revealed a diagnoses list that included the presence of a neurostimulator. Hospital documentation for Resident 116 revealed an implant list that included an implantable pulse generator implanted on May 24, 2019, and a kit pulse generator implanted on September 25, 2020. Further review of the clinical record for Resident 116 revealed no evidence that the facility addressed the neurostimulator or implemented a person-centered care plan related to the device (addressing the type of neurostimulator, assessments, complications, etc.). The above information for Resident 116 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 29, 2026, at 2:40 PM. 483.25 Quality of Care Previously cites 5/2/25, 7/14/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on a review of select facility policy and procedure, clinical record review, and staff interview, it was determined that the facility failed to provide care consistent with professional standards of practice, for a resident who required dialysis services for one of two residents reviewed for dialysis concerns (Resident 7). Findings include: Review of the facility policy titled, Dialysis - Renal Dialysis Policy, last reviewed on January 30, 2026, noted (in part) a section titled, Post-Dialysis Care. This section of the policy noted that staff are to evaluate the dialysis access site for bleeding, signs/symptoms of infection, intact placement, etc. Document the observation of the access site. The policy also noted that if a shunt is present, assess the presence or absence of a bruit (a sound produced by blood flow) and thrill (a palpable vibration). Clinical record review for Resident 7 revealed a diagnoses list that included chronic kidney disease stage four (an advanced stage of kidney disease indicating severe damage to the kidneys which filter waste and excess fluid from the blood) and dependence on renal dialysis (a machine that performs a basic function of the kidney by cleansing the blood of impurities). A current care plan for Resident 7 revealed the resident needs dialysis related to renal (kidney) failure and has an arteriovenous (AV) fistula (surgically created connection between an artery and a vein to provide access for hemodialysis) in the left arm. The care plan indicated Resident 7 received hemodialysis three times a week at a dialysis center. Review of nursing documentation for Resident 7 dated April 21, 2026, at 10:08 AM revealed a nursing progress note that noted left arm fistula pulsatile with a positive bruit and thrill. Further clinical record review for Resident 7 revealed no documentation that staff had assessed the AV fistula site for a bruit and thrill routinely or upon post-dialysis care as indicated in the facility policy. The facility failed to provide appropriate assessment for the dialysis fistula for Resident 7. The findings regarding Resident 7's dialysis fistula were confirmed during a meeting with the Nursing Home Administrator and Director of Nursing on May 1, 2026, at 9:46 AM. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on clinical record review and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for one of one resident reviewed for mood and behaviors (Resident 9). Findings include: Clinical record review revealed the facility admitted Resident 9 on October 14, 2024, with diagnoses including, Alzheimer's Dementia (disease that affects memory, thinking and behavior) and Post Traumatic Stress Disorder (PTSD, a mental and behavioral disorder that develops related to a terrifying event). Review of Resident 9's care plan-initiated April 30, 2025, revealed a mood problem related to chronic PTSD, noting Resident 9 has a history of unspecified childhood trauma, exposed to multiple childhood events that she does not like to discuss, or provide details, including her triggers noting she also has Alzheimer's and vascular dementia. A MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident care needs) dated January 16, 2026, revealed staff assessed Resident 9 as having severe cognitive impairment. Review of Resident 9's clinical record revealed there were four family members listed as her emergency contacts. There was no evidence the facility attempted to determine Resident 9's triggers by interviewing Resident 9's family, reviewing previous history and physical reports, or physician assessments, to help identify Resident 9's triggers to prevent re-traumatization. Reviewed the above findings for Resident 9 with the Nursing Home Administrator and Director of Nursing during a meeting on April 30, 2026, at 2:21 PM. Interview with Employee 1 (registered nurse regional consultant) on May 1, 2026, at 9:27 AM confirmed the above findings for Resident 9 and was unable to provide any further documentation. 483.25(m) Trauma-informed care Previously cited 5/2/2025 28 Pa Code 211.12 (d)(3)(5) Nursing services		

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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	
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility documentation, and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents with indwelling catheters and assessments for two of four employees reviewed (Employees 31 and 32). Findings include: A review of the facility Resident Matrix (CMS-802, form used to identify pertinent care categories for residents who reside in the facility) revealed that the facility had a total of 15 residents with indwelling urinary catheters and six residents with tube feedings. Facility documentation titled, Competency Check Off, revealed a list of competencies for licensed practical nurses that included (in part) foley catheter care and PEG (percutaneous endoscopic gastrostomy tube; a feeding tube placed through the abdomen and into the stomach) / G-tube (gastrostomy tube; a feeding tube placed through the abdominal wall and into the stomach) care. Facility documentation titled, Competency Check Off, revealed a list of competencies for registered nurses that included (in part) PEG / G-tube Care and Resident Assessment. A request by the surveyor for staff competencies that included tube feeding and resident assessment (change in condition) was made for Employee 31 (registered nurse). A request for staff competencies that included tube feeding and foley/indwelling catheter care was made for Employee 32 (licensed practical nurse). The above competencies were requested in a meeting with the Nursing Home Administrator and Director of Nursing on May 1, 2026, at 9:46 AM and with Employee 1, registered nurse regional consultant, on May 1, 2026, at 9:59 AM. The facility failed to provide any documentation that the above employees had completed competency evaluations in the areas requested. The facility failed to ensure staff exhibited the appropriate competencies and skill sets to provide nursing and related services necessary for each resident. 483.35(a)(3)(4) Nursing Services Previously cited deficiency 5/2/25 28 Pa Code 201.20(a)(6)(d) Staff development		

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

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on employee personnel review and staff interview, it was determined that the facility failed to complete a performance evaluation of each nurse aide at least once every 12 months for two of three nurse aides reviewed (Employees 29 and 30). Findings Include: The facility noted the following hire dates for two current employees reviewed for performance evaluations: Employee 29's (nurse aide) hire date of May 20, 2018; and Employee 30's (nurse aide) hire date of April 28, 2025. A request to review the annual performance evaluations during a meeting with the Nursing Home Administrator and Employee 1 (registered nurse regional consultant), on April 30, 2026, at 2:30 PM and during a meeting on May 1, 2026 at 9:46 AM during a meeting with the Nursing Home Administrator and Director of Nursing, revealed no documented evidence that the facility is completing the evaluations at least once every 12 months. Interview with the Employee 1 on May 1, 2026, at 12:52 PM confirmed that the facility could provide no documentation that performance evaluations were completed on the above staff members. It was also unclear when the last performance evaluations were completed. 28 Pa. Code 201.19(2) Personnel policies and procedures		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by one of three residents reviewed (Resident 2). Findings include: Clinical record review for Resident 2 revealed the facility admitted him on December 3, 2025, with diagnoses including dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) added August 5, 2025. A review of Resident 2's admission Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated December 10, 2025, indicated that the facility assessed Resident 2 as having a diagnosis of dementia, or cognitive loss. The facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 2's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. The findings were reviewed with the Nursing Home Administrator and Employee 1 (registered nurse regional consultant) during a meeting on April 30, 2026, at 2:41 AM. They confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Resident 2's dementia prior to surveyor's questioning. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident's attending physician addressed and responded appropriately to pharmacy recommendations for three of five residents reviewed (Resident 18). Findings include: Clinical record review revealed the facility admitted Resident 18 on May 22, 2025. Further review of Resident 18's clinical record revealed a consultant pharmacy review dated June 30, 2025, noting Resident 18 is receiving Risperdal (an antipsychotic medication) but lacks an allowable diagnosis to support its use. A pharmacy recommendation dated December 30, 2025, revealed the consultant pharmacist again noted Resident 18 is receiving Risperdal but lacks an allowable diagnosis to support its use. There was no documentation noting Resident 18's physician addressed and responded appropriately to the June 30, and December 30, 2025, pharmacy recommendations. Interview with Employee 1 (registered nurse regional consultant) on May 1, 2026, at 12:49 PM confirmed the above findings Resident 18. 483.45(c) Drug Regimen Review. Previously cited 5/2/2025 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, and staff interview, it was determined that the facility failed to ensure that all drugs used in the facility are stored and disposed of in accordance with professional standards, on one of four nursing units (G nursing unit). Findings include: Observations on the G nursing unit on April 29, 2026, at 10:05 AM, revealed half of a white oval pill, with a 2 on one side and an F on the other side, on the floor in a corner at the end of the hallway, located next to the emergency exit G door. During a concurrent interview with Employee 19, LPN, they indicated they did not know how the pill would come to be on the floor in that location, and no trash is taken out through this doorway. The above information was reviewed with the Nursing Home Administrator and the Director of Nursing on April 29, 2026, at 2:15 PM. 483.45(h) Storage of Drugs and Biologicals Previously cited 5/2/24 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on a review of Quality Assurance and Performance Improvement (QAPI) meeting attendance and staff interview it was determined that the facility failed to ensure the committee consisted of the minimum members (Medical Director) at least quarterly. Findings include: Review of facility documentation (after a request from the surveyor to review the quality assessment and assurance QAA / QAPI committee meeting attendance) titled QAPI Committee Members, from March 4, 2025, to the current survey ending May 1, 2026, revealed that the facility's most recent QAPI committee meeting occurred in March 2026. Attendance records indicated that the facility medical director or designee did not attend any of the meetings and there was no associated sign-in for the medical director on the meeting sign-in sheets provided by the facility (dated March 4, 2025; April; July 2025; October 2025; November 2025; December 2025; January 2026; and March 2026). The above information was reviewed in a meeting with the Nursing Home Administrator on May 1, 2026, at 9:46 AM and the facility provided no further evidence that the facility's medical director (or designee) participated in at least quarterly QAA / QAPI committee meetings. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3)(e)(3) Management		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and staff interviews it was determined that the facility failed to ensure all electrical equipment was in safe operating condition (facility bathroom - kitchen). Findings include: Observations on April 30, 2026, at 9:50 AM of the staff bathrooms outside the main kitchen revealed an electrical outlet located on the wall behind the sink, a foot away from the faucet. The outlet was noted to have a metal cover that appeared rusted. The hot air hand dryer was plugged in to the outlet and functioning. The outlet was not equipped with a GFCI (Ground Fault Circuit Interrupter, required to protect people from electrical shocks by detecting ground faults and quickly interrupting power). Interview with Employee 18, maintenance director, on April 30, 2026, at 9:57 AM, confirmed that both the men's and the women's bathrooms were not equipped with a GFCI outlet, and that an outlet located near a water source should be equipped with GFCI. A follow up interview with Employee 18 on April 30, 2026, at 12:15 PM, revealed that the outlets were not located on a GFCI circuit at the breaker box. The above information was reviewed with the Nursing Home Administrator and Employee 1, RN Regional Consultant, on April 30, 2026, at 2:45 PM. Cross refer F689 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(3) Management 28 Pa Code 204.19. Plumbing, heating ventilation and air conditioning and electrical		