

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Mountain Laurel Healthcare and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Leonard Street Clearfield, PA 16830	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>38012</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident's responsible party was notified about the need to alter treatment or medications for two of eight residents reviewed (Residents 2, 5).</p> <p>Findings include:</p> <p>The facility's policy regarding a change in condition, dated October 24, 2023, indicated that the facility would promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status. Unless otherwise instructed by the resident, a nurse would notify the resident's representative when the resident was involved in any accident or incident that resulted in an injury, including injuries of unknown origin; a significant change in the resident's physical, mental, or psychosocial status; a need to change the resident's room assignment; a decision has been made to discharge the resident from the facility; or a transfer to the hospital.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated February 8, 2024, revealed that the resident was understood and could understand, had moderately impaired cognition, and had diagnoses that included dementia.</p> <p>A Certified Registered Nurse Practitioner's note for Resident 2, dated October 23, 2023, revealed that the resident had a continued decline in condition and orders were received to obtain a UA (urinalysis) and C&S (culture and sensitivity-used to determine the type of bacteria growing). A nursing note, dated October 28, 2023, at 1:14 a.m. revealed that the final results of the UA C&S were received and reviewed by the provider and new orders were received to start 100 milligrams (mg) of Macrobid (antibiotic) twice a day for seven days for a urinary tract infection. The resident's Medication Administration Record (MAR) for October and November 2023 revealed that the resident received Macrobid from October 28 to November 3, 2023. There was no documented evidence that the resident's responsible party was notified about the physician's orders for Macrobid.</p> <p>A nursing note for Resident 2, dated February 18, 2024, revealed that the resident was exposed to Influenza A (flu) and new orders were received to start 75 mg of Tamiflu (used to treat flu) one time a day for 10 days for exposure to Influenza. The resident's MAR for February 2024 revealed that the resident received Tamiflu from February 18 to 27, 2024. There was no documented evidence that the resident's responsible party was notified about the physician's orders for Tamiflu.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An annual MDS assessment for Resident 5, dated February 6, 2024, revealed that the resident was understood and could understand and had moderately impaired cognition.</p> <p>A nursing note for Resident 5, dated February 19, 2024, at 11:38 p.m. revealed that the resident was positive for flu and physician's orders were received to start 75 mg of Tamiflu twice a day for five days and 15 milliliters (mL) of guaifenesin (used to treat cough) four times a day for three days. The resident's MAR for February 2024 revealed that the resident received Tamiflu from February 20 to 24, 2024, and guaifenesin from February 20 to 22, 2024. There was no documented evidence that the resident's responsible party was notified about the physician's orders for Tamiflu and guaifenesin.</p> <p>Interview with the Director of Nursing on May 2, 2024, at 4:15 p.m. confirmed that there was no documented evidence that Resident 2's and Resident 5's responsible parties were notified when there was a change in medication/treatment and should have been.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38012</p> <p>Based on review of clinical records and facility investigation reports, as well as staff interviews, it was determined that the facility failed to ensure that the resident environment remained free of accident hazards by failing to ensure that a resident's swallowing ability was assessed for potential safety hazards for one of eight residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated February 8, 2024, revealed that the resident was understood and could understand, had moderately impaired cognition, received a mechanically altered diet, and had no signs or symptoms of a possible swallowing disorder. Physician's orders, dated November 15, 2023, included an order for the resident to receive a mechanical soft, ground texture diet.</p> <p>A nursing note, dated April 2, 2024, at 6:53 p.m. revealed that Licensed Practical Nurse 1 was sitting with Resident 2 during dinner and she asked the resident if he was okay. He did not respond and had no airway exchange. She administered two thrusts of the Heimlich maneuver and pizza then became dislodged from the resident's mouth. The resident then stated he was okay.</p> <p>The facility's investigation, dated April 2, 2024, revealed that the root cause of the incident involving Resident 2 was due to the resident not being able to properly chew pizza.</p> <p>A witness statement from Nurse Aide 2, dated April 2, 2024, at 9:41 p.m. revealed that she gave Resident 2 his tray and the pizza was already cut up. She told the kitchen to stop sending pizza up because he choked on it, but they sent it up anyway. The kitchen said that he was allowed to have it because it was soft.</p> <p>Interview with Speech Therapist on May 2, 2024, at 3:34 p.m. revealed that Resident 2 was on their caseload, but she was unaware that Resident 2 had difficulty with eating pizza prior to the incident that occurred on April 2, 2024.</p> <p>Interview with Nurse Aide 2 on May 2, 2024, at 5:19 p.m. revealed that for the past couple months (March and April) Resident 2 has had problems with eating pizza. She had tried to cut his pizza into tiny bites before but that did not work. She indicated that she told the kitchen and a licensed practical nurse about his difficulty with eating pizza.</p> <p>There was no documented evidence that Resident 2's difficulty with eating pizza was assessed in March and April 2024 to determine if he was safe to eat pizza.</p> <p>Interview with the Nursing Home Administrator on May 2, 2024, at 5:40 p.m. revealed that staff should have passed the information of Resident 2 having difficulty with eating pizza up the chain back in March and April and had speech therapy assess him to see if he was safe to eat pizza at that time.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		