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 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Healthcare and Rehabilitation Ctr	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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of facility policies, manufacturer's instructions, and clinical records, as well as resident and staff interviews, it was determined that the facility failed to provide necessary treatment and services for a Stage 3 pressure ulcer for one of nine residents reviewed (Resident 4), resulting in a deterioration of the wound; and failed to follow physician's orders in a timely manner for one of nine residents reviewed (Resident 3), which resulted in a delay of treatment.Findings include: The facility's wound care policy, dated March 19, 2026, indicated that to promote healing of wounds, it was the policy of the facility to have a physician's order for the procedure. The following documentation was to be recorded in the resident's medical record: the type of wound care given, the date and time the wound care was given, the position in which the resident was placed, the name and the title of the individual providing the wound care, any changes in the resident's condition, all assessment data (i.e. wound bed color, size, drainage, etc.) obtained when inspecting the wound, how the resident tolerated the procedure, and if the resident refused the treatment and reason(s) why. The facility's skin assessment policy, dated March 19, 2026, indicated that a full body, or head to toe, skin assessment would be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment could also be performed after a change of condition or after any newly identified pressure injury. The facility's policy for negative pressure wound therapy (NPTW, also known as a wound vac), dated March 19, 2026, indicated that to promote healing of wounds, it was the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Negative pressure wound therapy (an active wound care treatment that uses controlled sub-atmospheric (negative) pressure to assist and accelerate wound healing. The therapy may be gauze based, foam based, or peel and stick, and includes an evacuation tube and a computerized pump that applies the negative pressure) would be provided in accordance with physician orders, including the desired pressure setting, continuous or intermittent therapy, and frequency of dressing changes. Negative pressure wound therapy was to be used only when the goal was wound healing, the wound bed had minimal necrotic tissue, and treatment was underway for any wound infection. The physician was to be notified of any complications associated with the use of NPTW. The manufacturer's instructions for the wound vac, dated April 15, 2024, revealed the machine should be frequently monitored to ensure the pump was on and delivering negative wound pressure, and that the wound dressings should not stay in place longer than 72 hours. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated December 26, 2025, indicated that the resident was cognitively intact, was dependent on staff for his care needs, was frequently incontinent of bowel, had limited range of motion of his lower extremities, had Stage 4 pressure ulcer (full thickness tissue loss with bone, tendon or muscle exposed), and had diagnoses that included paraplegia (paralysis that impairs the lower half of the body). A physician's order, dated December 25, 2025, included orders for the wound on the resident's right buttock / ischium (the lower and back part of the hip bone) to be cleansed with normal saline solution, a 6 x 8 centimeter (cm) piece of white foam put into the tunnel/shelf at the 2 o'clock position, a rope of white foam placed into the tunnel at the 10 o'clock position, for any undermining (occurs when tissue beneath the wound edges separates from the underlying tissue) and black foam (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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NAME OF PROVIDER OR SUPPLIER Mountain Laurel Healthcare and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Leonard Street Clearfield, PA 16830	

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F 0686 Level of Harm - Actual harm Residents Affected - Few	to wound bed, wound vac over all pressure at 125 millimeters of mercury (mmHg), and was to be changed every Tuesday, Thursday, and Saturday, and as needed for slippage/soilage. A wound consultation for Resident 4, dated February 17, 2026, revealed the resident was seen for sacral and gluteal (buttock) wounds, and the sacral wound was definitely showing improvement. The resident had a stage 4 pressure ulcer on his right buttock/ischium that measured 4.0 x 8.7 x 1.2 cm, tunneled 5.3 cm at 3 o'clock, and undermined 0.1 cm at 9 to 10 o'clock. The plan was to cleanse the wounds to the right ischium with soap and water, apply white foam to the two tunnels, black foam to the wound bed, pressure of 125 mmHg, and to be changed on Tuesday, Friday, and Sundays, and as needed. The resident was to return to the clinic in two weeks. Review of Resident 4's Treatment Administration Records (TAR's) for February 2026 revealed that the treatments to the right buttock/ischium were completed at the wound clinic on February 17, 2026. A treatment note dated February 19, 2026, at 6:28 p.m. revealed the resident requested to have the wound vac treatment time changed to be done in the morning due to him not being able to sleep after the treatment was done in the evening. However, there was no documented evidence that the wound vac treatment to the resident's right buttocks/ischium was completed on the morning of February 20, 2026. A treatment note, dated February 21, 2026, at 10:26 p.m. revealed the resident refused the wound vac treatment and wanted to have it done in the morning. However, there was no documented evidence that the wound vac treatment to the resident's right buttocks/ischium was completed on the morning of February 22, 2026. A treatment note, dated February 24, 2026, at 2:08 p.m. revealed that the wound vac was not charging and a new one would be sent over night. There was no documented evidence that the wound vac had been changed from February 18 through February 23, 2026 (6 days) and no documented evidence that a registered nurse had assessed the wound condition at that time. The rounding physician was notified the wound vac wasn't charging, ordered wet to dry dressings every shift, and the wound clinic was to be called in the morning. A review of the TAR for February 2026 revealed there was no documented evidence that the wound vac was frequently checked to ensure that the power was on and delivering negative pressure per the manufacturer's instructions. There was no documented evidence that the wound clinic physician was notified that the wound vac was not being used, the condition of the wound at that time, or that wet to dry dressings were being applied to the right buttock/ischium, every shift. A wound consultation for Resident 4, dated March 3, 2026, revealed that the wounds were significantly worse and the wound vac needed to be kept on the wounds. The wound on the right buttock/ischium measured 15.5 x 10 x 5.2 cm, tunneled 7.5 cm at 3 o'clock, undermined 5.2 cm at 9 to 10 o'clock. Debridement of the right buttock/ischium wound was completed with removal of non-viable skin, abnormal edge, slough (dead tissue within a wound, often appearing as a yellow, tan, or white fibrous material), exudate (wound fluid or drainage), and necrotic (dead, non-viable tissue that impedes healing and increases the risk of infection, requiring prompt identification and removal) subcutaneous tissue. Interview with the Certified Wound Care Associate (Licensed Practical Nurse at Wound Clinic) on March 13, 2026, at 10:35 a.m. revealed Resident 4 did not arrive with a wound vac during his visit on March 3, 2026. She called the facility's supervisor, and the supervisor never called back and the wound clinic or the wound clinic physician was never informed that the resident was not using the wound vac. Interview with Licensed Practical Nurse 1 on March 13, 2026, at 2:59 p.m. revealed the wound vac was off at that time and the resident had some necrotic areas and slough on the outside of the wound. She reported that the wound smelled bad, and she thought something wasn't right with it. Interview with Licensed Practical Nurse 2 on March 17, 2026, at 8:52 a.m. revealed Resident 4's wound had been the worst it's ever been, and he was in more pain at night and had a hard time sleeping. Interview with Licensed Practical Nurse 3 on March 13, 2026, at 3:08 p.m. revealed that she was told there was necrotic tissue under the wound vac and the wound vac was discontinued. She reported that the wound vac wasn't charging, the wound vac went completely dead, and they had to prop up the wound vac so the cord would stay in. Interview with Registered Nurse 4 on March 16, 2026, at 10:38 a.m. confirmed that the resident's wound was getting (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	worse, there was no wound assessment completed during that time and when wound clinic instructed her to call the wound clinic physician regarding the change in the wound condition. She stated that she left a message for the wound clinic physician but never spoke with him. Interview with Licensed Practical Nurse 5 on March 16, 2026, at 4:56 p.m. revealed Resident 4 did not like getting his wound vac changed during the evening due to pain with turning. She put a note in the computer to have the time of his wound vac treatment changed to morning, but didn't think it was changed. Interview with the Director of Nursing on March 17, 2026, at 6:40 p.m. and March 18, 2026, at 4:07 p.m. respectively, confirmed that there was no documented evidence that the wound vac was changed on the evening of February 19 or the mornings of February 20, 22, or 23, 2026, that there were not any routine checks of the wound vac ordered, was not made aware that the wound vac wasn't functioning until February 24, 2026, and there was no evidence of a wound assessment completed on February 25, 2206. An admission nursing note for Resident 3, dated February 6, 2026, at 10:36 p.m. revealed the resident had an abrasion on her left calf and a friction area to her left buttock. Both heels are reddened and need to be elevated off the bed for pressure relief. Physician's orders for Resident 3, dated February 6, 2026, included an order to cleanse left buttocks wound with soap and water, pat dry. Apply Zinc (a barrier cream) every shift. May discontinue when healed. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 3 dated February 12, 2026, revealed that the resident was cognitively intact, required extensive assistance with care needs, and had diagnoses that included paraplegia (partial or complete inability to move lower legs) and diabetes (body cannot regulate blood sugar). A care plan for Resident 3, dated February 16, 2026, indicated the resident was at risk for skin breakdown due to the diagnoses of paraplegia and diabetes. Physician's orders for Resident 3, dated February 9, 2026, included an order for a wound care consultation. A nursing note dated February 9, 2026, at 7:57 p.m., revealed that the resident was seen by the rounding provider who updated several orders, including a consult for wound care. A physician's note for Resident 3, dated February 10, 2026, at 6:11 p.m., revealed that Resident 3 had an area on her bottom, and the resident's sister requested wound care to follow. A clinical note for Resident 3, dated February 19, 2026, at 8:33 a.m., revealed wounds with the following treatment: wound to right buttocks, preventative skin measures in place. A clinical note for Resident 3, dated February 20, 2026, at 9:53 am. revealed wounds with the following treatment: moisture-associated skin damage to right buttock, preventative skin measures in place. A clinical note for Resident 3, dated February 21, 2026, at 9:56 a.m., revealed wounds with the following treatment: moisture-associated skin damage to left buttock, preventative skin measures in place. A clinical note for Resident 3, dated February 22, 2026, at 11:08 a.m. revealed wounds with the following treatment: moisture-associated skin damage to buttocks, preventative skin measures in place. A wound care consultation for Resident 3, dated March 3, 2026, revealed new treatment orders for the resident's bilateral buttocks. Physician's orders for Resident 3, dated March 3, 2026, included an order for Zinc Oxide External Paste, apply to bilateral buttocks topically every shift for wound healing. Apply medical grade honey after cleansing with soap and water and patting dry. There was no documented evidence in the clinical record that Resident 3 was seen by a wound consultant from February 9, 2026, when ordered until March 3, 2026, and no documented evidence that an appointment had been made for the consult and/or the resident refused to be seen. Interview with the Director of Nursing on March 12, 2026, at 6:01 p.m. confirmed that Resident 3 was not seen by a wound consultant between February 9, 2026 and March 3, 2026 and had no documented evidence that the resident had been scheduled and/or refused to be seen. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.