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 04/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders for medications were followed for two of 20 residents reviewed (Residents 8, 13) and failed to ensure medications were administered to the correct resident for three of 20 residents reviewed (Residents 12, 14, 15), resulting in medication errors. Findings include: The facility's medication administration policy, dated March 19, 2026, revealed that staff were to obtain and record vital signs, when applicable or per physician orders. When applicable, hold medications for those vital signs outside of the physician's prescribed parameters. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated April 2, 2026, revealed that the resident was cognitively intact and required assistance from staff for all daily care needs. Current physician's orders for Resident 8, included an order for the resident to receive 50 milligrams (mg) Metoprolol Tartrate two times a day and to hold if the systolic blood pressure (top number) is less than 100 or heart rate is less than 60. Observations of medication administration on April 28, 2026 at 5:10 p.m. revealed that Licensed Practical Nurse 2 administered Metoprolol Tartrate to Resident 8 without obtaining his heart rate or blood pressure prior to administration. Interview with Licensed Practical Nurse 2 on April 28, 2026 at 5:18 p.m. revealed that she should have obtained Resident 8's blood pressure and heart rate prior to administering the Metoprolol Tartrate and she did not. An admission MDS assessment for Resident 13, dated February 11, 2026, revealed that the resident was cognitively impaired and required assistance from staff for all daily care needs. Physician's orders for Resident 13, dated April 17, 2026, included an order for the resident to receive 25 mg Synthroid (thyroid medication) at 8:00 a.m.; and 10 mg of Oxycodone (pain medication) at 8:00 a.m. and 4:00 p.m. daily by mouth.A nursing note for Resident 13, dated April 18, 2026, at 5:58 a.m. revealed that the resident became upset when his 8:00 a.m. medications were administered at 6:00 a.m. He stated that he requested that medications were to be at 8:00 a.m. and 8:00 p.m. The resident's Medication Administration Record (MAR) was not updated to reflect the order. An annual MDS assessment for Resident 12, dated March 31, 2026, revealed the resident was cognitively impaired and had diagnoses that included dementia, anxiety, and depression.A nursing note for Resident 12, dated April 7, 2026, at 12:26 a.m. revealed that a staff member reported that she gave some vitamin pills in error to the wrong resident. She stated that the resident gave her the name of another resident. She compared the picture in the computer prior to giving the resident the medications and felt that it did not resemble the resident but thought it may have been an old picture. She did not ask any other staff to identify the resident. The nurse was unfamiliar with the resident and did not ask anyone for help.A nursing note for Resident 12, dated April 7, 2026, revealed that the interdisciplinary team reviewed the medication error that occurred on April 6, 2026. Resident 12 was sitting in her wheelchair outside of Resident 16's room. When Licensed Practical Nurse 3 asked the resident her name, she stated she was Resident 16. The photos of Resident 12 did not resemble the current state as the photos were not updated. Resident 12 was mistaken for Resident 16 and calcium + Vitamin D and magnesium were administered to Resident 12 whole in pudding. Resident 12 was observed chewing on medications and when another nurse asked if the resident was given medications, she informed Licensed Practical (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse 3 that the resident was not Resident 16. Licensed Practical Nurse 3 reported that she gave some vitamins in error to the wrong resident and stated that the resident gave her the name of another resident. She compared the picture in the computer prior to giving the resident the medications and felt it did not resemble the resident but thought it may have been an old picture. She did not ask any other staff to identify Resident 12.A quarterly MDS assessment for Resident 14, dated February 24, 2026, revealed that the resident was cognitively impaired and was dependent on staff for daily care needs. A nursing note, dated April 20, 2026 revealed that an interdisciplinary team reviewed an incident from April 17, 2026 regarding a medication error for Resident 14. Upon investigation it was determined that resident was given 0.5 mg Clonazepam instead of 60 mg Morphine during morning medication pass. An admission MDS assessment for Resident 15, dated April 2, 2026, revealed that the resident was cognitively intact and was independent with daily care needs. A nursing note for Resident 15, dated April 16, 2026 revealed that the resident was given 5-325 mg of Hydrocodone/APAP (narcotic pain medication) instead of 5-325 mg of Oxycodone/APAP (narcotic pain medication). Interview with the Nursing Home Administrator on April 28, 2026 at 6:43 p.m. confirmed that the above referenced medication errors should not have happened and that Resident 13's MAR should have been updated to reflect the correct times for administration and were not. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly secured for four of 20 residents reviewed (Residents 1, 4, 10, 17), and failed to ensure that the medication cart was secured when it was out of site.Findings include:The facility's policy regarding medication, dated March 19, 2026, indicated that all drugs and biologicals will be stored in locked compartments, such as medication carts and that during medication pass, medications must be under the direct observation of the person administering the medications or locked in the medication storage area/cart.Physician's orders for Resident 1, dated August 21, 2024 included an order for the resident to receive 1 milligram (mg) clonazepam two times per day; an order dated March 4, 2023 for the resident to receive 1000 mg metformin hydrochlorothiazide two times per day; an order dated January 13, 2026 for the resident to receive 400 mg magnesium oxide two times per day; and an order dated June 16, 2023 for the resident to receive 500 mg Vitamin C two times per day.Physician's orders for Resident 4, dated December 24, 2024 included an order for the resident to receive 20 milliequivalents (MEQ) potassium chloride two times per day and an order dated December 6, 2024 for the resident to receive 30 milliliters (ml) lactulose solution four times per day. Physician's orders for Resident 10, dated May 15, 2025 included an order for the resident to receive 20 mg Atorvastatin at bedtime; an order dated May 28, 2025 for the resident to receive 40 mg Pepcid two times day; and an order for the resident to receive 1000 mg Ranexa every 12 hours. Physician's orders for Resident 17, dated November 5, 2025 included an order for the resident to receive 12.5 mg Metoprolol Tartrate two times per day and an order dated November 5, 2025 for 8.6 mg Senna at bedtime.Observations during medication administration on April 28, 2026 at 5:01 p.m. revealed that there were five pre-poured medication cups with pills and liquids in them. The cups had a first name printed on them and were sitting on top of the medication cart, unsecured. The cups were identified as belonging to Residents 1, 4, 10, and 17. The medication cart was unlocked and there were three drawers that were ajar. Resident 9 was observed sitting near the medication administration cart when Licensed Practical Nurse 1 left the cart unsupervised to enter a resident's room. At 5:01 p.m. Licensed Practical Nurse 1 administered a cup of pre-poured medications to Resident 1. At 5:12 p.m. Licensed Practical Nurse 1 administered a cup of pre-poured medications to Resident 4. At 5:07 p.m. Licensed Practical Nurse left the medication cart and entered a resident's room. The medication cart was out of her site. At 5:15 p.m. Licensed Practical Nurse 1 left the medication cart in the hall with pre-poured medications sitting on top, unsecured, and the drawers to the cart ajar with Resident 9 sitting next to the cart. Licensed Practical Nurse 1 entered another resident's room to administer medications, leaving the cart in the hall, unsecured and with pre-poured medications on top. Interview with Licensed Practical Nurse 1 on April 28, 2026 at 5:21 p.m. revealed that she pre-pours her medications for some of the residents because they like to go to the dining room for supper and it is easier to do that. She stated that she should not have left them unsecured on top of the medication cart when the cart was not in her direct line of site. She further confirmed that she should not have left the medication cart unlocked with doors ajar when the cart was out of her direct line of sight. She stated that R4 does not like to take the Lactulose so she has to have it prepared to sneak it into his milk during the supper meal. She stated that Resident 17 was out at the hospital and that she had her medications prepared prior to realizing that she was not back yet from her procedure.Interview with the Nursing Home Administrator on April 28, 2026 at 6:48 p.m. confirmed that the medications should not have been pre-poured or left on the medication cart unsupervised and that the medication cart should have been locked with all drawers closed when not in direct sight of the nurse.28 Pa. Code 211.9(a)(1) Pharmacy services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of policies, observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices and techniques were followed during the administration of medications for two of 20 residents reviewed (Residents 2, 3).Findings include: The facility's policy regarding medication administration, dated March 19, 2026 revealed that staff should remove medication from source, taking care not to touch the medication with their bare hand. Observations during medication administration on April 28, 2026 at 5:15 p.m. revealed that Licensed Practical Nurse 1 was preparing to administer Resident 2's medications. She popped a pill into her bare hand and then dropped it into the medication cup. She then proceeded to administer the medication to Resident2.Observations on April 28, 2026 at 5:07 p.m. revealed that while popping the medications into Resident 3's medication cup a pill fell out of the cup and into the medication cart. Licensed Practical Nurse 1 picked up the pill with her bared hand and placed it in the cup. She then proceeded to administer the medication to Resident 3.Interview with Licensed Practical Nurse 1 on April 28, 2026 at 5:28 p.m. revealed that she should not have touched the pills with her bare hands and then administer them to the residents.Interview with the Nursing Home Administrator on April 28, 2026 at 6:44 p.m. confirmed that Licensed Practical Nurse 1 should not have touched pills with her bare hands and then administer them to the residents.28 Pa. Code 211.12(d)(1) Nursing services.