

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: 395331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
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)		
F 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a resident does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless unavoidable. Based on clinical record reviews and staff interviews, it was determined that the facility failed to monitor, assess and analyze, and attempt new interventions for a resident's increased verbal, physically-aggressive behaviors, and sexual behaviors for one of seven residents reviewed (Resident 1). Findings include: A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated May 11, 2026, indicated that the resident was moderately cognitively impaired and had diagnoses that included dementia. The resident's care plan, dated May 27, 2026, revealed that staff were to keep the resident away from other residents when she was restless or agitated. Nursing note for Resident 1, dated May 14, 2026, revealed that the resident was admitted to the facility for long term care because she had become increasingly aggressive at home. Nursing note for Resident 1, dated May 15, 2026, revealed that the resident had an altercation with another resident and that they had to be separated. Nursing note for Resident 1, dated May 17, 2026, revealed that she hit and pushed another resident down and was screaming at her. Nursing note for Resident 1, dated May 20, 2026, revealed that she was displaying confrontational behaviors towards other residents who were ambulating by her in the hallway. Nursing note for Resident 1, dated May 23, 2026, revealed that the resident has been verbally abusive towards her roommate and other residents. She would not allow her roommate into their room and was slamming her door. She continued to display increased behaviors, made rude comments and negative remarks to others. Nursing note for Resident 1, dated May 24, 2026, revealed that she continues to walk around the unit arguing with the other residents, swearing and calling them names. Refused all care and would not bathe or change her clothes. Nursing note for Resident 1, dated May 28, 2026, revealed that she had been in a physical altercation with the same resident she had an altercation with on May 15, 2026. Nursing note for Resident 1, dated May 30, 2026, revealed that the resident continued to engage in aggressive behavior towards other residents within the unit, and she is often non-compliant with care. Psychiatry note for Resident 1, dated June 4, 2026 indicated that the resident was refusing medications, had restless agitation and intrusive behaviors, was combative with care, and inappropriate with a male resident. Her behaviors had increased and she was inappropriately touching a male resident. She became very combative with the staff when they attempted to separate the two residents. She was swearing, combative and threatening staff and other residents. She was sent to the emergency room for psychiatric evaluation and admission. Nursing note for Resident 1, dated June 17, 2026, revealed that she was readmitted to the nursing facility and was screaming at the men on the unit. She refused all care and assessments. She was then found in another resident's room shouting and confrontational. She was making rude comments to a male resident that was wandering around the unit and she had placed her self in his path and lunged at him. She had the male resident agitated and the female resident remained agitated and (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 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required a staff member to stay with her for a one on one for a half hour. Nursing note for Resident 1, dated June 20, 2026, revealed that she was ambulating around the unit yelling at other residents who also wander aimlessly around the unit. Nursing note for Resident 1, dated June 21, 2026, revealed that the resident is increasingly verbally nasty to staff and other residents, yelling at other residents telling them they are fat or ugly, getting in front of them and then screaming at them to get out of her way and cannot be redirected. She swung at another resident and continues to walk the halls. Nursing note for Resident 1, dated June 27, 2026, revealed that she became agitated with another female resident and went up to the resident and scratched her arm. Resident 1 further used her hip to try to make the other resident fall to the floor. The resident received an intra-muscular injection of an anti-psychotic medication due to her increase in violent and aggressive behaviors towards other residents. Nursing note for Resident 1, dated July 1, 2026, revealed that the resident struck another resident in the face after that resident struck her first, and was verbally aggressive with other residents. Nursing note for Resident 1, dated July 2, 2026, revealed that her psychiatric medications were increased due to her increasing behaviors on the unit. Nursing note for Resident 1, dated July 4, 2026, revealed that she had struck another resident in the face and was becoming more agitated. She again required psychiatric medication to calm her behaviors. Observations of Resident 1 on July 9, 2026 at 5:00 p.m. through 5:48 p.m. revealed that she stood in the hallway and would watch all of the other residents that wandered around her in the hallway. She made comments about each of the residents as they walked or wheeled by her. There was no programming on the unit and no behavior plan in place to prevent her from becoming verbally or physically aggressive with the other residents who were all wandering around her. There was no documented evidence that Resident 1's behaviors were assessed to determine if there were any patterns and/or precipitating factors that caused them. There was also no documented evidence that staff monitored the resident's behaviors, and no documented evidence that the interventions on the resident's behavior care plan were revised or that new interventions were developed to address the resident's ongoing behaviors. Interview with the Nursing Home Administrator on July 9, 2026 at 5:28 p.m. revealed that there was no behavior policy, individualized behavior plan or interventions that were put into place to prevent Resident 1 from engaging in further altercations with other residents who wander freely on the secured unit. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to provide appropriate treatment and services for 51 residents who reside on the secured memory impaired unit. Findings include: A review of the facility's census information provided on July 9, 2026, revealed that the secured unit housed 51 residents. A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated May 11, 2026, indicated that the resident was moderately cognitively impaired and had diagnoses that included dementia. The resident's care plan, dated May 27, 2026, revealed that staff were to keep the resident away from other residents when she was restless or agitated. Nursing notes for Resident 1, dated May 15, 2026 through July 9, 2026, revealed that the resident was violent and aggressive with other residents and that she would wander aimlessly around the secured unit getting in the way of the other residents that wander aimlessly around the secured unit. From June 4-17, 2026 the resident was admitted to the psychiatric unit for increased violent and aggressive, as well as sexual behaviors with other residents. After returning to the facility she continued to display violent and aggressive behaviors on the secured unit. Observations of the secured unit on July 9, 2026 from 3:14 p.m. through 4:24 p.m. revealed that there was no programming or activities for the residents on the secured unit. The activity calendar indicated that there was bingo being played on another unit, however, there was nothing scheduled for the secured unit. There were several residents aimlessly wandering the long hallway, there were seven residents sitting in the small area outside the dining room, and seven residents sitting in the dining room or wandering in and out of the dining room. The staff were observed to be providing care to residents in their rooms, or passing medications on the unit. There was no staff available to interact with the residents. A review of the activity calendar for the months of June and July, 2026, revealed that there were days where there were no activities on the secured unit, and days when there was one scheduled activity at 10:30 a.m. on the secured unit. Interview with Activity Aide 6 on July 9, 2026 at 3:53 p.m. revealed that there is usually one activity around 10:30 a.m. some days of the week on the secured unit. He stated that a few of the residents are permitted to attend activities on the other units or in the main dining room, however, only a few may do so and then there is nothing for the other residents to participate in. He stated that when he is able to have an activity on the secured unit the residents enjoy music, singing and dancing and that he is able to get a majority of the residents to participate. Interview with Licensed Practical Nurse 7 on July 9, 2026 at 4:07 p.m., revealed that there are no evening activities for the residents on the secured unit. She stated that the residents mostly wander around the secured unit, or sit in the lounge chairs all evening. She further stated that there are several residents who wander around and have nothing else to do. Interview with the Director of Activities of July 9, 2026 at 5:28 p.m. revealed that she does not have enough staff to have activities or programming on the secured unit everyday. She stated that she recognizes the need for activities/programming, but is in need of staff in order to provide it on the secured unit. She stated that currently there is a 10:30 a.m. activity some mornings, but nothing else the rest of the time. Interview with the Nursing Home Administrator on July 9, 2026 at 5:28 p.m. confirmed that there is no programming or activities on the secured unit and that there should be. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of policies and personnel files, as well as staff interviews, it was determined that the facility failed to complete a professional licensure verification with the Pennsylvania State Board of Nursing prior to hire for two of five employees reviewed (Registered Nurses 4 and 5), failed to complete a Pennsylvania Nurse Aide registry check prior to hire for one of five employees reviewed (Nurse Aide 3) and failed to perform a Pennsylvania criminal background check for two of five employees reviewed (Dietary Aides 1 and 2). Findings include: The facility's abuse policy, dated April 10, 2026, indicated that potential employees will be screened for a history of abuse, neglect, exploitation, or a misappropriation of resident property. Background, reference, and credentials' checks shall be conducted on potential employees contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. The personnel file for Dietary Aide 1 revealed that she was hired on May 26, 2026, and a Pennsylvania criminal background check was completed on July 9, 2026, two months after hire. The personnel file for Dietary Aide 2 revealed that she was hired on May 28, 2026, and there was no documented evidence that a Pennsylvania criminal background check was completed until July 9, 2026, 42 days after hire. The personnel file for Nurse Aide 3 revealed that she was hired on May 11, 2026 and there was no documented evidence that a Pennsylvania nurse aide registry check was completed prior to hire. The personnel file for Registered Nurse 4 revealed that she was hired on June 16, 2026, and there was no documented evidence that a Pennsylvania registered nurse licensure verification was completed prior to hire. The personnel file for Registered Nurse 5 revealed that she was hired on May 12, 2026, and there was no documented evidence that a Pennsylvania registered nurse licensure verification was completed prior to hire. Interview with Nursing Home Administrator on July 9, 2026 at 5:28 p.m. confirmed that the above licensure verifications, nurse aide registry check and criminal background checks were not completed as required. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.		