

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 09/26/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48809</p> <p>Based on a review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to protect the residents rights for one of 44 residents reviewed (Resident 47).</p> <p>Findings include:</p> <p>The facility's policy regarding resident rights, dated October 2023, indicated that the resident had the right to retain and use personal possessions including furnishings and clothing, and the right to be informed, in advance, of changes to the resident's plan of care.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 47, dated August 22, 2024, revealed that the resident was cognitively intact, was understood and was able to understand others, was able to make her needs known, was dependent on staff for her care, and was on a therapeutic diet.</p> <p>Observations of Resident 47's room on September 23, 2024, at 1:27 p.m. revealed that the resident did not have any food items brought in from family in her room. Resident 47 had one eight-ounce can of ginger ale that was half full with a straw and a full 16-ounce Styrofoam water cup with a lid and a straw.</p> <p>Interview with Resident 47 on September 23, 2024, at 1:27 p.m. revealed that on August 20, 2024, a nurse aide took her to the dining room and staff removed all food items (including non-perishable items) from her room without her prior knowledge or permission.</p> <p>Interview with Nurse Aide 1 on September 25, 2024, at 10:52 a.m. revealed that she was asked by the Director of Nursing to remove all food items from the resident's room. The resident was unaware when she was taken to the dining area that her belongings would be gone through and all food items removed.</p> <p>Interview with the Nursing Home Administrator on September 25, 2024, at 11:35 a.m. confirmed that he did not notify the resident prior to items being removed.</p> <p>Interview with Director of Nursing on September 24, 2024, at 2:25 p.m. confirmed that she did not personally inform the resident prior to items being removed.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 201.29(j) Resident Rights.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>31760</p> <p>Based on review of facility policies, investigation reports, and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of 44 residents reviewed (Resident 58).</p> <p>Findings include:</p> <p>The facility's policy regarding abuse and neglect, dated October 2023, indicated that the residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. Neglect was defined as the failure of the facility, its employees, or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated May 2, 2024, revealed that the resident was sometimes understood, could sometimes understand others, and had a diagnosis which included dementia. The resident's care plan, dated September 20, 2023, revealed that the resident was resistive/noncompliant with treatment/care and staff was to leave (if safe to do so) and return later if the resident was resisting care. A care plan, dated September 22, 2023, revealed that the resident required an extensive assist from staff for dressing.</p> <p>A nursing note for Resident 58, dated July 18, 2024, revealed that the resident was assessed related to care concerns.</p> <p>The facility's investigation, dated July 18, 2024, revealed that the resident's wife called in that morning and reported care concerns from July 17, 2024, on the 3:00 p.m. to 11:00 p.m. shift. She stated that she witnessed Agency Nurse Aide 2 providing care to her husband and she felt he was being abused.</p> <p>An investigation statement by the resident's wife, dated July 18, 2024, revealed that when she left last night she thought what should I do? Agency Nurse Aide 2 was absolutely rough, pushed the resident over so hard that he looked scared. When taking his shirt off, she witnessed his arm get caught and his head got stuck, and the nurse aide just tugged him. He tried to hit her because he was scared. She was so rough to the point that she knocked the TV off the stand. She did it right in front of the wife, almost like she wanted to get fired. The wife remembered that another resident was not super happy with her care either.</p> <p>An investigation statement by Agency Nurse Aide 2, dated July 18, 2024, revealed that she assisted Resident 58's wife with p.m. care. His wife assisted with changing his shirt after supper. When Agency Nurse Aide 2 arrived and started rounds, his brief was crooked and his testicles were half out on left side. The resident tried to swing, but his wife calmed him down.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The investigation determined that after reviewing interviews of residents, resident families, and staff members abuse was substantiated. Agency Nurse Aide 2's agency was notified of the investigation and of the outcome. Agency Nurse Aide 2 was placed on the Do Not Return list for the facility. Agency Nurse Aide 2's contract was terminated effective July 22, 2024.</p> <p>An interview with the Director of Nursing on September 25, 2024, at 11:15 a.m. confirmed that abuse was substantiated, and that Agency Nurse Aide 2 was placed on the Do Not Return list for the facility, and her contract with the facility was terminated</p> <p>28 Pa. Code 211.10(d) Resident Care Policies.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>19102</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to notify the state ombudsman and/or the resident and resident's responsible party in writing regarding the reason for transfers/discharge to the hospital for five of 44 residents reviewed (Residents 30, 44, 48, 56, 118).</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 30, dated September 7, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included dementia.</p> <p>Nursing notes for Resident 30, dated July 23, 2024, revealed that the licensed practical nurse was notified by the nurse aide that she heard the resident yelling and when she went back to her room, she saw the resident kneeling on the floor by her bed. The resident tried to adjust herself for comfort, and while doing that they heard two loud pops. The resident stated she had some leg pain. She was aware that her femur (thigh bone) was fractured and that she will be going to the hospital, and she was agreeable. Emergency Medical Services (EMS) was contacted, copies of the resident's chart were created, and a call was made to the emergency department stating that the resident would be admitted, and the plan was for a surgical repair of her femur fracture on February 24, 2024.</p> <p>There was no documented evidence that a written notice of Resident 30's transfer to the hospital was provided to the state ombudsman or the resident and/or the resident's representative regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 44, dated August 29, 2024, revealed that the resident was understood, could understand others, was cognitively intact, and had diagnoses that included respiratory failure (a medical condition where it is difficult to breathe).</p> <p>Nursing notes for Resident 44, dated March 22, 2024, 7:37 p.m., revealed that the resident had difficulty breathing and oxygen was applied. Resident 44 initially refused to go to the emergency room but then requested to be transferred.</p> <p>There was no documented evidence that a written notice of Resident 44's transfer to the hospital was provided to the state ombudsman or the resident and/or the resident's representative regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 48, dated August 12, 2024, revealed that the resident was understood, could understand others, was cognitively intact, and had diagnoses that included respiratory failure (a medical condition where it is difficult to breathe).</p> <p>Nursing notes for Resident 48, dated July 6, 2024, 8:08 p.m., revealed that the resident had difficulty breathing and requested to be transferred to the emergency department.</p> <p>(continued on next page)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documented evidence that a written notice of Resident 48's transfer to the hospital was provided to the state ombudsman or the resident and/or the resident's representative regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 56, dated August 14, 2024, revealed that the resident was understood, could understand others, was moderately cognitively impaired, and had diagnoses that included obstructive uropathy (urine cannot drain through the urinary tract).</p> <p>Nursing notes for Resident 56, dated May 5, 2024, 11:00 p.m., revealed that the resident had uncontrollable shaking, had cool and clammy skin, was diaphoretic (sweating) and pale, and had a blotchy skin rash. The resident complained of severe right groin and testicle pain and was transferred to the hospital. A nursing note, dated May 6, 2024, at 5:40 a.m., revealed that the resident admitted to the hospital with sepsis (occurs when chemicals released in the bloodstream to fight an infection trigger inflammation throughout the body) and a urinary tract infection.</p> <p>There was no documented evidence that a written notice of Resident 56's transfer to the hospital was provided to the state ombudsman or the resident and/or the resident's representative regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 118, dated August 18, 2024, revealed that the resident was cognitively impaired and had diagnoses that included dementia.</p> <p>Nursing notes for Resident 118, dated June 28, 2024, at 9:33 p.m., revealed that the resident was holding pressure to the ring finger on his left hand and he still had bleeding from his wound. The resident was unable to tell what happened, but staff reported that they were trying to get him out of a female resident's room and he may have placed his hand into the wheel spokes or tried to adjust the brakes. The resident had a 2.0 x 2.0 centimeter open area on his finger and the pad of the finger was purple in color and swelling. The provider was notified and recommended sending the resident to the emergency room . At 11:45 p.m. the resident returned to the facility with a splint on his finger and suffered an open fracture.</p> <p>There was no documented evidence that a written notice of Resident 118's transfer to the hospital was provided to the state ombudsman or the resident and/or the resident's representative regarding the reason for transfer.</p> <p>Interview with the Nursing Home Administrator on September 26, 2024, at 12:50 p.m. confirmed that the facility did not provide written notices to the state ombudsman or the residents and/or their representatives when a resident was transferred to the hospital.</p> <p>28 Pa. Code 201.25 Discharge Policy.</p> <p>28 Pa. Code 201.29(f)(g) Resident Rights.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</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 resident-centered care plans were developed and implemented for three of 44 residents reviewed (Residents 4, 47, 111) regarding Post Traumatic Stress Disorder (PTSD), dialysis, and smoking.</p> <p>Findings include:</p> <p>The facility's current policy for care plans revealed that the comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated August 13, 2024, revealed that the resident was cognitively impaired, dependent on staff for daily care tasks, and had diagnoses that included PTSD.</p> <p>A psychological evaluation for Resident 4, dated December 5, 2023, indicated that the resident was diagnosed with PTSD after witnessing his friend's death in a war, his wife committed suicide, and he was physically and verbally abused by his father.</p> <p>There was no documented evidence that a care plan was developed to address Resident 4's care needs related his PTSD.</p> <p>Interview with Director of Nursing on September 25, 2024, at 9:54 a.m. confirmed that Resident 4's care plan did not address his care needs related to his PTSD and it should have.</p> <p>A quarterly MDS assessment for Resident 47, dated August 22, 2024, revealed that the resident was cognitively intact, required extensive assistance from staff for daily care, had diagnoses that included diabetes and kidney disease, received dialysis (a medical procedure that removes waste and excess fluid from the blood when the kidneys are unable to do so), and had a central venous catheter (a connection between the body and a dialysis machine that allows blood to be cleaned and returned to the body).</p> <p>Physician's orders for Resident 47, dated October 11, 2023, revealed that the resident was to be weighed post-dialysis every evening shift every Monday, Wednesday, and Friday.</p> <p>Observations of Resident 47's nightstand on September 23, 2024, at 12:45 p.m. revealed an emergency kit for a central venous catheter.</p> <p>As of September 25, 2024, at 1:45 p.m., there was no documented evidence that a care plan was developed to address Resident 47's care related to her central venous catheter for dialysis.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nursing on September 25, 2024, at 1:45 p.m. confirmed that a care plan was not developed to address the care needs related to Resident 47's central venous catheter for dialysis and should have been.</p> <p>A quarterly MDS for Resident 111, dated August 23, 2024, revealed that the resident was cognitively intact, dependent on staff for some daily care tasks, and had diagnoses that included metastatic lung cancer.</p> <p>A nurse's note for Resident 111, dated July 23, 2024, indicated that the resident was requesting to smoke. Staff reviewed the smoking policy with the resident, and she was able to smoke at the designated smoking times.</p> <p>There was no documented evidence that a care plan was developed to address Resident 111's care needs related her smoking.</p> <p>Interview with Director of Nursing on September 25, 2024, at 9:54 a.m. confirmed that Resident 111's care plan did not address her care needs related to her smoking and it should have.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>19102</p> <p>Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for three of 44 residents reviewed (Residents 44, 90, 109).</p> <p>Findings include:</p> <p>The facility's current policy for care plans indicated that the Interdisciplinary team must review and update the care plan when there has been a change in the resident's condition.</p> <p>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 44, dated August 29, 2024, indicated that the resident was cognitively intact, required supervision from staff for daily care needs, did not have an intravenous access site, and was always continent of urine.</p> <p>The current care plan for Resident 44 revealed that the resident had a potential for complications regarding a Peripherally Inserted Central Catheter (PICC line-a long, thin tube that's inserted through a vein in the arm and passed through to the larger central veins near the heart) insertion site, and complications regarding an indwelling urinary catheter.</p> <p>Physician's orders for Resident 44, dated September 3, 2024, included orders for the PICC line and indwelling urinary catheter to be removed.</p> <p>Observations of Resident 44 on September 25, 2024, at 12:58 p.m. revealed that the resident did not have a PICC line or an indwelling urinary catheter.</p> <p>An interview with Director of Nursing on September 25, 2024, at 2:25 p.m. confirmed that the care plans for Resident 44's PICC line and indwelling urinary catheter were not updated when the devices were removed on September 3, 2024, and should have been.</p> <p>A quarterly MDS assessment for Resident 90, dated August 17, 2024, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and was not receiving any intravenous (IV- administered into a vein) medications.</p> <p>A current care plan for Resident 90 revealed that the resident had a potential for complications regarding a PICC line insertion site.</p> <p>A nursing note, dated March 14, 2024, at 5:34 p.m., revealed that Resident 90's PICC line was removed without any issues.</p> <p>Observations of Resident 90 on September 25, 2024, at 7:45 a.m. revealed that the resident did not have a PICC line.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Director of Nursing on September 26, 2024, at 12:25 p.m. revealed that the care plan for Resident 90 regarding the PICC line was not updated when the device was removed and should have been.</p> <p>A quarterly MDS assessment for Resident 109, dated August 26, 2023, revealed that the resident was sometimes understood, could sometimes understand others, and had a diagnoses that included Alzheimer's disease and dementia. A care plan for the resident, dated August 8, 2024, revealed that she was to be on 15-minute checks due to her behavior of rummaging (picking up and moving other belongings) related to her cognitive impairment and inability to differentiate between personal and other belongings.</p> <p>Review of the Resident 109's clinical record revealed no documented evidence that 15-minute checks were being completed from August 8, 2024, through September 26, 2024.</p> <p>Interview with Nurse Aide 3 on September 26, 2024, at 8:42 a.m. revealed that Resident 109 was not on 15-minute checks currently.</p> <p>Interview with The Director of Nursing on September 26, 2024, at 11:50 a.m. confirmed that Resident 109's care plan should have been revised to reflect that she was no longer on 15-minute checks.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>38012</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide medications as ordered by the physician for two of 44 residents reviewed (Residents 55, 84).</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 55, dated June 7, 2024, revealed that the resident was cognitively intact, dependent on staff for daily care tasks, and had diagnoses that included hypotension (low blood pressure).</p> <p>Physician's orders for Resident 55, dated September 5, 2024, included an order for the resident to receive 2.5 milligrams (mg) of Midodrine two times per day for hypotension and to hold the medication if the systolic blood pressure (top number) is greater than 130. However, the resident's Medication Administration Record (MAR) for September 2024 revealed that staff were not obtaining or recording the resident's blood pressure prior to administering the medication.</p> <p>Interview with the Director of Nursing on September 26, 2024, at 1:15 p.m. confirmed that staff were not documenting Resident 55's blood pressure and therefore would not know if the medication should be held or administered per the parameters.</p> <p>A quarterly MDS for Resident 84, dated August 3, 2024, revealed that the resident was cognitively impaired, dependent on staff for daily care tasks, and had diagnoses that included hypertension (high blood pressure).</p> <p>Physician's orders for Resident 84, dated February 23, 2024, included an order for the resident to receive 12.5 mg of Metoprolol Succinate Extended Release daily and to hold the medication if the systolic blood pressure (top number) is less than 100 or the heart rate is less than 60. However, the resident's Medication Administration Record (MAR) for September 2024 revealed that staff were not obtaining or recording the resident's blood pressure or heart rate prior to administering the medication.</p> <p>Interview with the Director of Nursing on September 26, 2024, at 1:15 p.m. confirmed that staff were not documenting Resident 84's blood pressure or heart rate and therefore would not know if the medication should be held or administered per the parameters.</p> <p>28 Pa. Code 211.12(d)(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>48809</p> <p>Based on review of facility policy, clinical record reviews, and resident and staff interviews, it was determined that the facility failed to ensure a safe environment related to smoking for one of 44 residents reviewed (Resident 46).</p> <p>Findings include:</p> <p>A facility policy for smoking for residents dated, October 2023, revealed that a resident's ability to smoke will be re-evaluated quarterly, upon a significant change (physical or cognitive), and as determined by staff.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 46, dated June 27, 2024, indicated that the resident was usually understood, usually understood others, was cognitively impaired, and required supervision from staff for daily care needs.</p> <p>A care plan for Resident 46, dated September 21, 2024, indicated that she would practice safe smoking.</p> <p>The most current evaluation for smoking for Resident 46, dated March 28, 2024, revealed that the resident was an at-risk smoker and required supervision or physical support to smoke.</p> <p>There was no documented evidence that Resident 46's ability to smoke was evaluated quarterly per the facility's policy.</p> <p>Interview with the Director of Nursing on September 25, 2024, at 12:15 p.m. confirmed that the resident did not have a smoking assessment completed with the quarterly MDS and should have.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>

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 09/26/2024
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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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>19102</p> <p>Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide appropriate care to prevent urinary tract infections for one of 44 residents reviewed (Resident 118) who had an indwelling urinary catheter.</p> <p>Findings include:</p> <p>The facility policy for urinary catheter care, dated October 2023, indicated that the resident's care plan was to be reviewed for any special needs of the resident with a urinary catheter.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 118, dated August 18, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care activities, had an indwelling urinary catheter, and had diagnoses that included obstructive uropathy (urine cannot exit the bladder).</p> <p>Physician's orders for Resident 118, dated June 21, 2024, included an order for a 20 French urinary catheter with a 5 cubic centimeter (cc) balloon to straight gravity drainage for urinary retention.</p> <p>A nursing note, dated September 7, 2024, at 8:08 p.m. revealed that the resident had a urinary tract infection and orders were received to begin 100 milligrams (mg) of Macrobid twice a day for seven days and to encourage fluids and continue to maintain proper Foley catheter care.</p> <p>Nurse aide documentation for Resident 118 for July, August and September 2024 revealed that catheter care was to be provided every shift; however, there was no documented evidence that catheter care was provided during the night shift on July 1, 3, 8, 21, 25, and 28; August 12 and 14; and September 11, 13, 17, 21, and 24, 2024.</p> <p>Interview with the Director of Nursing on September 26, 2024, at 12:25 p.m. confirmed that there was no documented evidence that catheter care was provided on the night shift on the mentioned dates and it should have been done.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>38012</p> <p>Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) for one of 44 residents reviewed (Resident 4).</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 4, dated August 13, 2024, revealed that the resident was cognitively impaired and had diagnoses which included Post Traumatic Stress Disorder. A care plan for the resident, dated July 3, 2024, revealed that the resident was at risk for behaviors related to his mental illness.</p> <p>A psychological evaluation, dated December 5, 2023, for Resident 4 indicated that the resident suffered from PTSD related to having seen his best friend die in a war, his wife committed suicide, and his father was both physically and mentally abusive to him.</p> <p>An interview with Resident 4 on September 23, 2024, at 12:10 p.m. revealed that it was hard for him to watch his friend die in the war and then survive the war himself. He also stated that it was hard to know that his wife killed herself and there was nothing he could do to prevent it. He stated that he felt like it was all his fault.</p> <p>However, there was no documented evidence that the facility completed an assessment for a history of trauma for Resident 4 to identify specific triggers that could re-traumatize the resident.</p> <p>Interview with the Director of Nursing on September 25, 2024, at 9:54 a.m. confirmed that there was no documented evidence of an assessment for a history of trauma being completed for Resident 4.</p> <p>28 Pa. Code 211.12(a)(d)(3)(5) Nursing Services.</p> <p>28 Pa. Code 211.16(a) Social Services.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760</p> <p>Based on review of facility policies, clinical records, and investigation reports, as well as staff interviews, it was determined that the facility failed to provide the necessary services and failed to make certain appropriate treatment and services for dementia were provided to ensure the safety for one of 44 residents reviewed (Resident 109).</p> <p>Findings include:</p> <p>The facility's dementia policy, dated October 2023, revealed that the interdisciplinary team (IDT) will identify and document the resident's condition and level of support needed during care planning and review changes as they arise. Progress or persistent worsening of symptoms and need of increased staff support will be reported to the IDT. The IDT will adjust interventions and the plan depending on the individual's response to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes.</p> <p>The facility's behavior management policy, dated October 2023, revealed that the IDT will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. Interventions will be individualized and part of an overall care environment that supports physical, function and psychosocial needs, and strives to understand, prevent, or relieve the resident's distress or loss of abilities. Interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 109, dated August 26, 2023, revealed that the resident was sometimes understood, could sometimes understand others, and had diagnoses that included Alzheimer's disease and dementia. A care plan for the resident, revised on December 14, 2023, revealed that the resident wanders and paces related to Alzheimer's disease, dementia, and cognitive impairment; wanders in and out of other rooms; often picks up items and moves them throughout the unit. Staff were to allow the resident to wander the third floor and redirect out of other resident's rooms/personal space. A care plan, dated July 31, 2024, revealed that the resident rummages by picking up and moving others belongings due to her inability to differentiate between personal and others belongings. Staff were to distract and redirect as needed, keep her busy with her own belongings, monitor her room as needed, return belongings to others, and provide a rummaging box or other setting for rummaging activities.</p> <p>Nursing notes for Resident 109, dated November 13, 2023, revealed that the resident entered room [ROOM NUMBER] and went through the bathroom into 219, Resident 94's room. He became very angry and hit the resident across the side of her head three to four times with his grabber. Both residents yelled and the nurse aide was close by and came into the room to stop the resident from getting hit anymore. Both residents were started on 15-minute checks until a stop sign was placed on the bathroom door to prevent Resident 109 from entering Resident 94's room.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A psychiatric note for Resident 94, dated November 14, 2023, revealed that the resident was in an altercation on November 13, 2023, when he hit a female resident on the side of her head with his reacher three to four times because he was angry that she went through the adjoining bathroom to get into his room and was getting into his things. The resident was very upset that she came into his room. He feels that he is having increased anxiety due to wanderers on the unit. He stated that he has no one to talk to, so he stays in his room. The resident had a stop sign in front of his door. Another stop sign was put across his neighbor's door. Discussed with the resident that all of the residents on this unit have dementia and most are unaware of their actions. Encouraged the resident to yell for help or ring his call bell if other residents come in his room or if he feels unsafe. Encouraged the resident not to hit the other residents. The resident was adamant that he will defend himself and his belongings. He wants moved to another unit. The resident has a history of dementia, which is one of the reasons he was moved to the dementia unit. He has been having increased depression and anxiety since moving to this unit. The resident does not appear to be adjusting well to the room change. Being on this unit appears to be making his anxiety worse and makes him feel unsafe. The resident could benefit from moving to another unit. He has no history of exiting-seeking behaviors and does not really require a secure dementia unit currently. He does have Ativan ordered as needed for breakthrough anxiety. Continue Ativan (used to treat anxiety) 0.5 mg every six hours as needed for anxiety times 14 days. Recommend moving the resident to another unit in the facility.</p> <p>Nursing notes for Resident 109, dated December 13, 2023, revealed that the resident was assessed post incident. The resident's left lower arm was bandaged at this time, and the resident's upper arm has a reddened scratch to it. The resident was crying and stated, it hurts. The provider was notified, and an x-ray of her left upper extremity was ordered. Staff noted that Resident 94 was yelling earlier and the stop sign was down across his doorway. When staff went to his room he yelled that he grabbed that crazy lady.</p> <p>Facility investigation documents, dated December 13, 2024, revealed that Resident 94 reported that Resident 109 went into his room and took his cellphone and sat in his chair. Resident 94 stated that he took matters into his own hands and grabbed her by the left arm and scratched her. Resident 94 told the social worker that this would happen again if his room was not moved.</p> <p>A statement completed by Nurse Aide 6, dated December 13, 2024, revealed that she came back from break and saw Resident 94's light on. She went to answer it and he yelled that the crazy lady was in his room and took his cell phone. The nurse aide located Resident 109 and there was no cell phone on her. The nurse aide went back and found the cell phone on the floor beside him. He then told the nurse aide that he was going to throw ginger ale at her if he saw her. The nurse aide went up to report what the resident had said to the licensed practical nurse when another care nurse noticed scratches on Resident 109's left arm. The nurse aide cleaned up her left arm and the registered nurse looked at it. Resident 94 also said he was going throw ginger ale at her last night. Nurse Aide 6 was trying to keep her out of his room all day and the stop sign was up, but she goes under it and each time she is seen they call to her and she usually comes.</p> <p>A statement completed by Nurse Aide 5, dated December 13, 2024, revealed that at 3:25 p.m. she had just redirected Resident 109 out of a room because she was in the process of cleaning someone up. She had redirected her from Resident 94's room. She then saw her at 3:45 p.m. when the scratches were discovered.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility investigation documents, dated December 13, 2024, revealed that the licensed practical nurse was made aware by staff that they had witnessed Resident 109 being struck by Resident 70 with an open hand. Resident 70 was sitting in her wheelchair in front of one of the couches in the common area following the evening meal. Resident 109 was seen leaving the dining room and attempted to ambulate through the small space between Resident 70 and the nearby couch. Resident 70 then accused Resident 109 of taking something out of her purse.</p> <p>A nursing note for Resident 109, dated January 6, 2024, revealed that the licensed practical nurse was notified by staff that the resident was found sitting in another resident's room on the floor by the bed on a floor mat.</p> <p>Nursing notes for Resident 109, dated April 22, 2024, revealed that the licensed practical nurse was off the unit collecting medications from the facility's emergency supply and upon returning was informed by staff that they had witnessed an altercation between Resident 109 and Resident 477. Staff heard shouting coming from room [ROOM NUMBER] and upon entering the room witnessed Resident 477 strike Resident 109's left forearm with an open hand. Staff separated both residents and assisted Resident 109 out of the room and to the nurses' station. Resident 477 stated that the resident had entered her room and refused to leave. Fifteen-minute checks were initiated for both residents, and a stop sign was placed across the doorway of room [ROOM NUMBER].</p> <p>Nursing notes for Resident 109, dated June 20, 2024, revealed that the resident was involved in a resident-to-resident altercation. The resident was slapped on the back by Resident 95 because she wandered into her space. Staff were collecting meal trays in the dining room when they witnessed Resident 95 slap Resident 109 across the back. Staff stated that Resident 95 was still eating her meal while Resident 109 was fidgeting with a meal tray sitting next to Resident 95. They heard Resident 95 yelling followed by striking the resident across the back with an open hand. Fifteen-minute checks were initiated for both residents.</p> <p>A statement completed by Nurse Aide 5, dated June 20, 2024, revealed that they had just redirected Resident 109 from Resident 95 at 5:20 p.m.</p> <p>A nursing Note for Resident 109, dated July 27, 2024, revealed that the resident was awake, wandering, and difficult to keep from going in other residents' rooms. Attempts to divert and were ineffective. Foods and drinks were provided with one-to-one, which was effective, but once done eating she went back to walking about.</p> <p>Nursing notes for Resident 109, dated August 7, 2024, revealed that staff advised the licensed practical nurse that they responded to yelling coming from Resident 74's room. Upon entering the room, they noticed the resident sitting on Resident 74's bed. Resident 74 was standing between bed 3 and bed 4 pulling the resident by her hair while continuing to yell get the hell out! A stop sign was placed across door.</p> <p>Nursing notes for Resident 109, dated August 14, 2024, revealed that the resident has not been sleeping for the past two nights and has been going in and out of other residents' rooms. One-to-one needed and diversional activities were attempted, but the resident has a short attention span and wants to keep walking about.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A nursing note for Resident 109, dated August 16, 2024, revealed that the resident continued to be awake and was wandering on the unit, in and out of everyone's room, taking their belongings and blankets. The resident was very disruptive to the unit. One-to-one provided to distract and divert, but her attention span is short.</p> <p>A nursing note for Resident 109, dated August 18, 2024, revealed that the resident continued to be awake, wandering, and disruptive to others. She requires one-to-one most of the time to keep her from going in and waking others.</p> <p>A nursing note for Resident 109, dated September 3, 2024, revealed that the resident continued to be awake and wandering, pacing, picking up everyone's belongings and moving them from room to room, and does not redirect well out of rooms.</p> <p>Interview with Nurse Aide 3 on September 26, 2024, at 8:42 a.m. revealed that Resident 109 will wander in and out of rooms. She indicated that she must watch because the one male resident across from her room will hit her if she would go into his room and that is why there is a stop sign across his door. She indicated that the stop signs seem to help and that she has not been going under them lately. She indicated that they have to watch her because she will go into other residents' rooms and take drinks from their cups. She indicated that she is not currently on 15-minute checks.</p> <p>Interview with Nurse Aide 4 on September 26, 2024, at 9:00 a.m. revealed that Resident 109 will wander in and out of resident rooms and that the residents wonder why she is coming into their rooms and picking up their items. She indicated that the stop signs work most of the time, but there are times that she will duck under the stop signs and go into the resident rooms. She indicated that they try to redirect her, but that will only last a short time.</p> <p>There was no documented evidence that Resident 109's wandering behaviors were assessed/analyzed or that person-centered interventions were revised when they were not effective.</p> <p>Interview with the Director of Nursing on September 26, 2024, at 11:50 a.m. confirmed that staff try and walk with Resident 109; however, she has a short attention span.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>31760</p> <p>Based on review of manufacturer's instructions and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication administration error rate of less than five percent.</p> <p>Findings include:</p> <p>Observations during medication administration on September 25, 2024, revealed that two medication administration errors were made during 25 opportunities for error, resulting in a medication administration error rate of eight percent.</p> <p>Manufacturer's instructions for Fluticasone nasal spray (a medication to treat allergies), dated January 2019, indicated that before using the spray, the user was to blow his/her nose to clear the nostrils, then insert the applicator into a nostril, keeping the bottle upright, close off the other nostril, breathe in through the nose, and while inhaling, press the pump to release the spray.</p> <p>Physician's orders for Resident 60, dated May 9, 2024, included orders for the resident to receive Fluticasone 50 micrograms (mcg), one spray in each nostril daily.</p> <p>Observations during medication administration on September 25, 2024, at 8:06 a.m. revealed that Licensed Practical Nurse 7 administered Resident 60 one spray of the Fluticasone nasal spray into each nostril. However, the resident did not, and Licensed Practical Nurse 7 did not instruct the resident to, blow his nose prior to the administration of the Fluticasone and close off the other nostril during the administration of the Fluticasone.</p> <p>Interview with Licensed Practical Nurse 7 on September 25, 2024, at 8:08 a.m. confirmed that Resident 60 did not blow his nose prior to the administration of Fluticasone and did not close off the other nostril during the administration of Fluticasone.</p> <p>Interview with the Director of Nursing on September 25, 2024, at 9:57 a.m. confirmed that Licensed Practical Nurse 7 should have followed the manufacturer's instructions when administering the Fluticasone to Resident 60.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>38012</p> <p>Based on observations, as well as resident and staff interviews, it was determined that the facility failed to have sufficient dietary staff to enable the main dining room to be open for meal times.</p> <p>Findings include:</p> <p>Observations of the main dining room on September 23, 2024, at 12:18 p.m. revealed that there were no residents eating lunch in the dining room.</p> <p>Interview with Resident 8 on September 23, 2024, at 12:32 p.m. revealed that she would like to eat in the dining room for her meals.</p> <p>Interview with Resident 50 on September 23, 2024, at 11:45 a.m. revealed that she would like to go the dining room for the conversation and socialization with others during her meals.</p> <p>Interview with Resident 15 on September 23, 2024, at 11:49 a.m. revealed that she would like to go to the dining room for her meals.</p> <p>Interview with Resident 71 on September 23, 2024, at 11:53 a.m. revealed that she would like to eat in the dining room so that she could get a hot cup of coffee, but that she was told there was not enough staff to open the dining room.</p> <p>Interview with Resident 111 on September 23, 2024, at 11:53 a.m. revealed that she would eat in the dining room if it was open.</p> <p>Interview with Resident 120 on September 23, 2024, at 11:53 a.m. revealed that she would like to eat in the dining room.</p> <p>Interview with the Dietary Manager on September 23, 2024, at 9:45 a.m. revealed that she was planning to get the dining room open for the residents in the near future but that the residents were not able to eat in there now due to a lack of staff.</p> <p>Interview with the Nursing Home Administrator on September 26, 2024, at 9:13 a.m. confirmed that the dining room is closed because there are not enough dietary staff. He stated that he was aware that the residents wanted the dining room open for meals, especially lunch.</p> <p>28 Pa. Code 201.18(e)(6) Management.</p> <p>28 Pa. Code 201.20(b) Staff Development.</p> <p>28 Pa Code 211.6(c) Dietary Services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to prepare and store ice under sanitary conditions for one of three ice machines (second floor kitchenette) and failed to maintain a sanitary refrigerator on the first floor kitchenette.</p> <p>Findings include:</p> <p>A facility policy for resident personal food storage, dated [DATE], revealed that all food and beverage must be labeled and dated with the resident's name and date, otherwise it shall be discarded.</p> <p>Observations of the ice machine in the second floor kitchenette revealed that the drain pipe coming from the machine extended down from the machine and into the floor drain grate with a clear tube over the drain pipe directly into the drain grate. There was no air gap between the end of the ice machine's drain pipe and the floor drain.</p> <p>Observations of the refrigerator in the first floor kitchenette on [DATE], at 10:47 a.m. revealed a dark, removable substance in the bottom of the freezer, a full carton of orange sherbet that had expired, nine undated and unlabeled popsicles, and one popsicle that was undated, unlabeled, and open to air.</p> <p>Interviews with the Maintenance Director on [DATE] at 12:22 p.m. confirmed that the drain pipe coming from the ice machine in the second floor kitchenette was in direct contact with the floor drain because of the clear tube that was installed over the pipe to prevent splash, that there was no air gap, and that there should have been an air gap between the end of the pipe and the floor drain.</p> <p>Interview with Nursing Home Administrator on [DATE], at 1:42 p.m. confirmed that the expired sherbet and unlabeled and undated popsicles should have been thrown out and the freezer should have been free of the dark, removable substance.</p> <p>28 Pa. Code 207.4 Ice Containers and Storage.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>		

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 09/26/2024
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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>31760</p> <p>Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.</p> <p>Findings include:</p> <p>The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending October 5, 2023, and complaint investigation surveys ending December 1, 2023; February 5, 2024; and May 2, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending September 26, 2024, identified repeated deficiencies related to providing an environment free from abuse, the development of comprehensive care plans, revision of comprehensive care plans, providing quality care, providing a safe environment free of accident hazards, indwelling urinary catheters (a thin tube that is inserted into the bladder to drain urine), and appropriate food preparation and serving.</p> <p>The facility's plans of correction for deficiencies regarding providing an environment free from abuse, cited during the survey ending December 1, 2023, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F600, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding providing an environment free from abuse.</p> <p>The facility's plan of correction for a deficiency regarding the development of comprehensive care plans, cited during the survey ending October 5, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding the revision of comprehensive care plans.</p> <p>The facility's plan of correction for a deficiency regarding a failure to update residents' care plans, cited during the survey ending October 5, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding updating residents' care plans.</p> <p>The facility's plan of correction for a deficiency regarding quality care, cited during the survey ending October 5, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality care.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's plans of correction for deficiencies regarding providing a safe environment free of accident hazards, cited during the surveys ending October 5, 2023; February 5, 2024; and May 2, 2024, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding safety and accident-free environments.</p> <p>The facility's plan of correction for deficiencies regarding indwelling urinary catheters, cited during the survey ending October 5, 2023, revealed that bowel/bladder incontinence, catheter, and urinary tract infections would be monitored by QAPI. The results of current survey, cited under F690, revealed that the QAPI committee was ineffective in maintaining compliance with indwelling urinary catheters.</p> <p>The facility's plan of correction for a deficiency regarding appropriate food preparation and serving, cited during the survey ending October 5, 2023, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F812, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding food preparation and serving.</p> <p>Refer to F600, F656, F657, F684, F689, F690, F812.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>48809</p> <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that each resident was offered and/or received the influenza immunizations for one of 44 residents reviewed (Resident 14).</p> <p>Findings include:</p> <p>The facility's policy regarding influenza (flu) vaccines, dated October 2023, revealed that the Infection Preventionist will promote and administer seasonal influenza vaccine.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated August 3, 2024, revealed that the resident was usually understood, could usually understand, was cognitively impaired, and was dependent on staff for her daily care tasks. Section O0250 A of the MDS (Influenza Vaccination) revealed that the resident did not receive the influenza vaccine in this facility for this year's influenza vaccination season due to being offered but declining the vaccine.</p> <p>Review of Resident 14's clinical record revealed that the resident received the annual influenza vaccine on October 11, 2017; October 8, 2018; October 10, 2019; October 7, 2020; November 4, 2021; and October 26, 2022. There was no documented evidence that the resident was offered the influenza vaccine for the 2022-2023 flu season.</p> <p>Interview with the Director of Nursing on September 25, 2024, at 1:29 p.m. confirmed that there was no documented evidence that Resident 14 was offered the seasonal influenza vaccine for 2022-2023 flu season.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		