

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
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 08/14/2025
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observations and staff interviews, it was determined that the facility failed to provide a dining experience based upon resident's preference for 5 of 50 residents reviewed (Residents 46, 69, 81, 83, 95). Findings include: Observations of Resident 46 on August 11, 2025, at 12:35 p.m. revealed that the resident was eating lunch in her room at her bedside table. Interview with Resident 46 on August 11, 2025, at 12:35 p.m. revealed that the main dining room has been closed since the previous week, and the resident prefers to eat in the main dining room and not in her room. She was unaware why the main dining room is not open. Observations of Resident 69 on August 11, 2025, at 12:35 p.m. revealed that the resident was eating lunch in her room sitting on her bed at her bedside table. Interview with Resident 69 on August 11, 2025, at 12:35 p.m. revealed that the resident prefers to eat in the main dining room, but it has been closed since the previous week. She believes it has to do with not having enough staff. Observations of Resident 81 on August 11, 2025, at 12:40 p.m. revealed that the resident was eating lunch in her room. Interview with Resident 81 on August 11, 2025, at 12:40 p.m. revealed that the resident always eats in the main dining room but hasn't been allowed to since it has been closed for several days. Residents were not told a reason why only that they were not allowed to eat in the main dining room. Observations of Resident 83 on August 11, 2025, at 12:49 p.m. revealed that the resident was eating lunch in her room. Interview with Resident 83 on August 11, 2025, at 12:49 p.m. revealed that the resident preferred to eat in the main dining room but hasn't been able to for several days because there was not enough nursing staff available to have it open. Observations of Resident 95 on August 11, 2025, at 12:41 p.m. revealed that the resident was eating lunch in her room. Interview with resident 95 on August 11, 2025, at 12:41 p.m. revealed that the resident prefers to eat in the main dining room, which was closed, and she was told it was due to not being able to safely open it. Interview with Nurse Aide 1 on August 13, 2025, at 9:15 a.m. revealed that the main dining rooms on the first floor have not been opened since the previous week due to not having enough nursing staff. Interview with Nurse Aide 4 on August 13, 2025 at 9:30 a.m. revealed that they were told that the main dining room would be closed, and they believe it was due to not having enough staff since nursing is required to be in the main dining room during service. Interview with the Dietary Director on August 13, 2025, at 12:32 p.m. confirmed that the main dining room has been closed since Monday August 11, 2025 because they could not safely open it due to a shortage of nursing staff. The Dietary Director also stated that residents should be able to eat where they prefer. 28 Pa. Code 207.2(a) Administrator's responsibility.		

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment in residents' rooms for six of 50 residents reviewed (Residents 23, 24, 40, 48, 90, 105). Findings include: Observations of Resident 23's room on August 11, 2025 at 2:31 p.m. revealed that the STOP sign on her door used to prevent wandering residents from entering her room, was tattered, torn, and stained. Observations of Resident 24's room on August 11, 2025 at 2:33 p.m. revealed that the STOP sign on her door used to prevent wandering residents from entering her room, was tattered, torn, and stained. Observations of Resident 40's room on August 11, 2025 at 2:34 p.m. revealed that the STOP sign on her door used to prevent wandering residents from entering her room, was tattered, torn, and stained. Observations of Resident 48's room on August 11, 2025 at 2:37 p.m. revealed that the STOP sign on his door used to prevent wandering residents from entering his room, was tattered, torn, and stained. Observations of Resident 90's room on August 11, 2025 at 2:44 p.m. revealed that the STOP sign on her door used to prevent wandering residents from entering her room, was tattered, torn, and stained. Observations of Resident 105's room on August 11, 2025 at 2:38 p.m. revealed that the STOP sign on her door used to prevent wandering residents from entering her room, was tattered, torn, and stained. Interview with the Director of Housekeeping on August 14, 2025 at 9:56 a.m. revealed that the STOP signs were dirty/stained and had holes in them. She stated that they needed replaced, but that the order for new ones was not submitted due to the facility not paying the bill with the supplier. She stated that once the bill was settled she would order more and they would be replaced. 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 207.2(a) Administrator's responsibility.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure that proper care to prevent infection was provided for one of 50 residents reviewed (Resident 23). Findings include: A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated May 19, 2025, indicated that the resident had severe cognitive impairment, required extensive assistance with daily care tasks, and had intermittent urinary catheter procedures. A nursing note for Resident 23, dated February 19, 2025, revealed that the resident's urine sample obtained earlier in the week was not labeled and needed redrawn. Nursing note dated February 21, 2025 revealed that the urine sample could not be flexed and therefore, needed redrawn again. A nursing note dated February 25, 2025 revealed that the urinary results were inconclusive and that the urine sample would need obtained again. Since the resident was symptomatic the physician ordered an antibiotic without having urinary sample test results. A nursing note for Resident 23, dated April 17, 2025 revealed that the resident was ordered an antibiotic for a urinary tract infection, however, there was no indication that a urine sample was obtained or cultured. A nursing note, dated April 25, 2025, revealed that Resident 23 had just finished an antibiotic, however, the provider ordered a urine sample to be recollected since the culture and sensitivity (to determine which antibiotic would kill the bacteria) was not run on the urine as ordered. A nursing note, dated April 27, 2025, revealed that the urine sample showed bacteria and another antibiotic was ordered, however, the culture and sensitivity was not run as ordered again. A nursing note on April 28, 2025 revealed that another urine sample was obtained and sent to the lab so that they could obtain a culture and sensitivity. A nursing note, dated April 30, 2025 revealed that the sensitivity was run and the physician ordered an additional seven days of antibiotics. Interview with the Director of Nursing on August 14, 2025 at 11:14 a.m. confirmed that Resident 23's urinary tract infections were not treated timely due the urinary samples not being tested according to physician's orders in February and April, 2025. This resulted in the resident receiving multiple straight catheter procedures to obtain her urine, as well as receiving multiple courses of antibiotics without confirming that the bacteria was susceptible to the antibiotic. 42 CFR 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI. 28 Pa. Code 211.12(d)(1) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide showers as scheduled for 5 of 50 residents reviewed (Residents 17, 71, 77, 86, 100) and failed to have sufficient staff to have the first floor main dining room open for 5 of 50 residents reviewed (Residents 46, 69, 81, 83, 95). Findings include: An annual Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 17, dated May 5, 2025, revealed that the resident was cognitively intact and required maximum assistance from staff for personal care needs. The current care plan for Resident 17 revealed she is to receive her showers on Tuesdays and Fridays on evening shift. Review of Resident 17's bathing records for May and June 2025 revealed that the resident received one shower in the last 34 days. She did not refuse any showers. An annual MDS assessment for Resident 71, dated, April 7, 2025, revealed that the resident was cognitively intact and required moderate assistance with bathing. The current care plan for Resident 71 revealed that she is to receive her showers on Mondays and Thursdays during the day shift. Review of Resident 71's bathing records for July revealed that on July 31, 2025, she received a bed bath instead of her preferred shower. Interview with Resident 71 on August 11, 2025, at 10:14 a.m. revealed that she prefers showers to bed baths, and she was not aware of why she didn't receive showers all the time. A Quarterly MDS for Resident 77 dated August 5, 2025, revealed that the resident was cognitively impaired and required maximum assistance from staff for showering. The current care plan for Resident 77 revealed that he is to receive showers on Tuesdays and Fridays on the evening shift. Review of Resident 77's bathing records for July and August revealed that on July 1, 4, 11, 18, and 25, 2025, and August 8 and 12, 2025 he received a bed bath instead of his preferred showers. Interview with Resident 77 on August 14, 2025, at 9:02 a.m. revealed that he prefers to receive a shower to a bed bath and that there has not been enough staff to provide him with his preferred showers. A Quarterly MDS for Resident 86 dated June 23, 2025, revealed that the resident was cognitively intact and was dependent on staff for her showering needs. The current care plan for Resident 86 revealed that her preferred shower days are Mondays and Thursdays during the day. Review of Resident 86's bathing records for July revealed that on July 7, 2025, she received a bed bath instead of a shower. Interview with Resident 86 on August 14, 2025, at 9:10 a.m. revealed that she prefers showers to baths, and they do not have enough staff to provide her with the care she should be receiving. A quarterly MDS for Resident 100, dated July 29, 2025, revealed that he is cognitively intact, and required moderate assistance from staff for showers. The current care plan for Resident 100 revealed that his shower days are Mondays and Fridays in the evening. Review of Resident 100's bathing records for June, July, and August, 2025 revealed that on June 4, 11, 16, 18; July 4, 11; and August 8, 2025, he received bed baths instead of showers. Interview with Resident 100 on August 11, 2025, at 10:27 a.m. revealed that the facility is very short staffed, and he is unable to receive his preferred showers. It is very important to him because he does use his electric wheelchair to go out into the community and he does not get as clean from a bed bath, and he is concerned that he has an odor when he does not receive his showers. Interview with Nurse Aide 1 on August 11, 2025, at 10:22 a.m. revealed that they do not have enough staff to provide residents with the necessary care. They are not able to give residents their preferred showers and many times can only give them a quick bed bath. Nurse Aide 1 also stated that the evening shift is worse than daylight shift, and that they are never able to complete showers on the evening shift. Interview with Nurse Aide 2 on August 11, 2025, at 10:42 a.m. revealed that there is not enough staff for them to provide necessary care to residents including their preferred showers. Interview with Nurse Aide 3 on August 11, 2025, at 11:20 a.m. revealed that they do have enough staff to complete the necessary care for residents, including making sure they receive their preferred showers. Interview with Nurse Aide 4 on August 12, 2025, at (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:29 a.m. revealed that they do not have enough staff to complete care and residents are not receiving the care they need. Interview with the Director of Nursing on August 13, 2025, at 1:02 p.m. indicated that she had no input regarding having enough staff to provide showers to residents. An interview with a group of residents on August 12, 2025 at 1:30 p.m. revealed that the dining room has been closed due to a lack of nursing staff. The residents stated that they prefer to eat in the dining room for the socialization, however, they were told by the nursing staff that they do not have enough staff to keep the dining room open. Observations of Resident 46 on August 11, 2025, at 12:35 p.m. revealed that the resident was eating lunch in her room at her bedside table. Interview with Resident 46 on August 11, 2025, at 12:35 p.m. revealed that the main dining room has been closed since the previous week, and the resident prefers to eat in the main dining room and not in her room. They were unaware why the main dining room is not open. Observations of Resident 69 on August 11, 2025, at 12:35 p.m. revealed that the resident was eating lunch in her room sitting on her bed at her bedside table. Interview with Resident 69 on August 11, 2025, at 12:35 p.m. revealed that the resident prefers to eat in the main dining room, but it has been closed since the previous week. They were not told, but they believe it has to do with not having enough staff. Observations of Resident 81 on August 11, 2025, at 12:40 p.m. revealed that the resident was eating lunch in her room. Interview with Resident 81 on August 11, 2025, at 12:40 p.m. revealed that the resident always eats in the main dining room but hasn't been allowed to since it has been closed for several days and the residents were not given a reason why. Observations of Resident 83 on August 11, 2025, at 12:49 p.m. revealed that the resident was eating lunch in her room. Interview with Resident 83 on August 11, 2025, at 12:49 p.m. revealed that the resident preferred to eat in the main dining room but hasn't been able to for several days because it was closed due to not having enough nursing staff available. Observations of Resident 95 on August 11, 2025, at 12:41 p.m. revealed the resident eating lunch in her room. Interview with Resident 95 on August 11, 2025, at 12:41 p.m. revealed that the resident prefers to eat in the main dining room, and was told it was due to not having enough nursing staff to safely open it. Interview with Nurse Aide 1 on August 13, 2025, at 9:15 a.m. revealed that the main dining rooms on the first floor have not been opened since the previous week due to not having enough nursing staff. Interview with Nurse Aide 4 on August 13, 2025 at 9:30 a.m. revealed that they were told the main dining room would be closed, and they believe it was due to not having enough staff since they require nursing staff to be in the main dining room during service. Interview with the Dietary Director on August 13, 2025, at 12:32 p.m. confirmed that the main dining room has been closed since Monday August 11, 2025 because there has not been enough nursing staff to safely open the main dining room on the first floor.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record reviews and staff interviews, it was determined that the facility failed to respond to a pharmacy recommendation for one of 50 residents reviewed (Resident 46) and failed to provide a rationale for not referring the resident to psychiatric care per pharmacist's recommendations (R8). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 46, dated August 14, 2025, revealed that the resident was cognitively intact and required moderate assist from staff for daily care needs. Pharmacy medication regimen review reports for Resident 46 dated January 31, 2025, March 26, 2025, April 29, 2025, June 29, 2025, and July 30, 2025 provided to the facility, included recommendations for the physician; however there was no documented evidence that they were addressed by the physician. An interview with the Director of Nursing on August 13, 2025, at 2:22 p.m. confirmed that the above pharmacy consultant reports were not addressed by the physician. An admission MDS assessment for Resident 8, dated May 30, 2025, revealed that the resident was cognitively intact, dependent on staff for daily care needs, had diagnoses that included diabetes, and received insulin (to low blood sugar levels). A pharmacy note for Resident 8 dated May 19, 2025 revealed that the resident should be referred to psychiatry for his behaviors. The medication regimen review for Resident 8 was addressed by the physician on May 22, 2025, however, it did not include any rationale for not referring the resident to psychiatry. Interview with the Director of Nursing on August 13, 2025, at 12:00 p.m. confirmed that the medical director did not provide a rationale as to why Resident 8 was not referred to psychiatry.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to store and serve food in accordance with professional standards for food service safety. Findings include: The facility's dietary policy regarding personal hygiene, dated October 15, 2024, revealed that staff were to cover all hair, including facial hair with a restraint, either with a hairnet, cap, or hat. Observations in the kitchen on August 14, 2025 at 8:01 a.m. revealed Dietary Aide 6 at the dishwasher working with the sanitized dishes without a beard restraint. Interview with the Dietary Director on August 14, 2025, at 11:15 a.m. confirmed that Dietary Aide 6 should have been wearing a beard restraint/guard while in the kitchen. The facility's food labeling policy, dated October 15, 2024, revealed that each food item, once opened, was to be securely closed, labeled and dated before being returned to the refrigerator or freezer. Observations in the main kitchen on August 11, 2025, at 9:02 a.m. revealed an opened and undated three-quarter full gallon container of potato salad in the refrigerator, an opened and undated one-quarter full bag of breakfast sausages in the main freezer, and an opened and undated one-quarter full bag of egg noodles in the pantry. Interview with the Dietary Director on August 11, 2025, at 9:21 a.m. confirmed that the above items should have been dated when they were opened for use. 28 Pa. Code 211.6(f) Dietary services.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on a review of a list of nurse aides currently employed by the facility, including their hire dates and training hours, as well as staff interviews, it was determined that the facility failed to ensure that nurse aides had 12 hours of in-service training annually for four of four nurse aides reviewed (Nurse Aide 6, Nurse Aide 7, Nurse Aide 2, and Nurse Aide 8). Findings include: A list of nurse aides provided by the facility revealed that based on their months and dates of hire: Nurse Aide 6 should have received at least 12 hours of in-service training between May 31, 2024, and May 31, 2025. However, there was no documented evidence that she received the 12 hours of training as required. Nurse Aide 7 should have received at least 12 hours of in-service training between December 13, 2023, and December 13, 2024. However, there was no documented evidence that she received the 12 hours of training as required. Nurse Aide 2 should have received at least 12 hours of in-service training between July 10, 2024, and July 10, 2025. However, there was no documented evidence that she received the 12 hours of training as required. Nurse Aide 8 should have received at least 12 hours of in-service training between April 21, 2024, and April 21, 2025. However, there was no documented evidence that she received the 12 hours of training as required. Interview with the Nursing Home Administrator on August 14, 2024, at 1:30 p.m. confirmed that there was no documented evidence that the above nurse aides received the 12 hours of in-service training as required. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 201.19(7) Personnel Policies and Procedures.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician was notified timely about a change in condition for one of 50 residents reviewed (Resident 58). Findings include: The facility's policy regarding changes in condition, dated October 15, 2024, indicated that the nurse would notify the resident's attending physician when there was a change in the resident's medical, mental condition and/or status. A nurse will notify the attending physician when there was refusal of treatment or medications two or more consecutive times. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated May 25, 2025, revealed that the resident was cognitively intact, was understood, could understand, was independent with care needs, used insulin medication (manages blood glucose levels), and had diagnoses that included diabetes mellitus (disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal levels of glucose in the blood). A care plan for Resident 58, dated September 4, 2018, indicated he was insulin dependent and staff were to administer medications per physician order. Physician's orders for Resident 58, dated February 27, 2025, included an order for the resident to receive Regular Insulin Concentrate 500 units per milliliter (ml) (a short-acting insulin) subcutaneously daily: 160 units before breakfast, 50 units before lunch and 125 units before supper. An order administration note date August 11, 2025, at 9:10 a.m. and 2:03 p.m. indicated that the regular insulin was not administered because it was unavailable. There was no documented evidence that the physician was notified about the resident's second missed dose of insulin. Interview with the Assistant Director of Nursing on August 13, 2025, at 1:03 p.m. confirmed that she was made aware that the medication was not available on the morning of August 11, 2025, however she was not aware that Resident 58 also missed his lunch dose. Therefore, the physician was not notified when the resident missed his second dose of insulin at lunch time. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, as well as staff interviews, it was determined that the facility failed to notify the resident's representative in writing regarding the reason for transfer to the hospital and to ensure that a bed-hold notice was provided to the resident's responsible party for two of 50 residents reviewed (Residents 22 and 46). Findings Include: A nursing note for Resident 22 dated, April 11, 2025, at 3:47 a.m. revealed that the resident was moaning in pain. The facility attempted to contact her son three times without a response, and new orders were given by the medical doctor to send Resident 22 to the emergency room. Review of Resident 22's clinical record revealed no documented evidence that that resident representative was notified in writing of the transfer to the hospital, and there was no documented evidence that a bed hold notice was provided. A nursing note for Resident 46 dated, July 22, 2025, revealed that the resident had a fall and was transferred to the emergency room with complaints of pain in her right shoulder. Review of Resident R46's clinical record revealed no documented evidence that the resident representative was notified in writing of the transfer to the hospital, and there was no documented evidence of a bed hold notice was provided. Review of documentation provided by the Nursing Home Administrator on May 8, 2025, at 10:04 a.m. revealed the Office of the State Long Term Care Ombudsman was not made aware of Resident R86's facility-initiated emergency transfers to the hospital as required. Interview on August 14, 2025, at 3:45 p.m. with the Nursing Home Administrator confirmed that there was no documented evidence in either resident's clinical records of a written notification to the resident representative regarding the transfer to the hospital, and there was no documentation of a bed hold notice being provided. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management		

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that physician's orders for enteral tube feedings (feeding through a tube inserted directly into the stomach) was followed for one of 50 residents reviewed (Resident 7). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated July 20, 2025, indicated that the resident was a quadriplegic (paralysis affecting all four limbs) required enteral feedings due to a decreased appetite and needed assistance from staff for care. Physician's orders for Resident 7, dated January 10, 2025, included an order for the resident to receive Osmolite 1.5 (a liquid nutritional product) (may substitute Diabetisource) via feeding tube (enteral nutrition-a way to deliver liquid nutrition through a flexible tube surgically placed in the stomach or digestive system) at a rate of 90 milliliters per hour, with a start time of 8:00 p.m. to run for 11 hours, (for a total of 990 milliliters). A review of Resident 7's Medication Administration Records (MAR) for August 11, 2025, revealed that Resident 7 did not receive his tube feeding as ordered that evening. A nursing note for Resident 7 on August 11, 2025, at 5:37 p.m. revealed that the Osmolite 1.5 was not available. The Director of Nursing called the pharmacy and was informed that the Osmolite 1.5 would come on the night run; however, it did not arrive. Interview with Resident 7 on August 13, 2025, at 12:37 p.m. stated that he was aware that he did not receive his tube feeding the evening of August 11, 2025, and reported that he had a bowl of cereal (Resident 7 able to take nourishment by mouth but has a decreased appetite). Interview with the Director of Nursing on August 13, 2025, at 1:59 p.m. stated that she was unaware that Resident 7's Osmolite 1.5 was not delivered and was not notified that Resident 7 missed his 11 hour tube feeding on the evening of August 11, 2025. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on a review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to ensure that it was free from significant medication errors for one of 50 residents reviewed (Resident 58). Findings include: A facility policy regarding diabetes protocol, dated October 15, 2024, indicated that the physician would help individuals with elevated blood sugar and confirmed diabetes and that insulin medication given to a resident shall be prescribed by the physician. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated May 25, 2025, revealed that the resident was cognitively intact, was understood, could understand, was independent with care needs, used insulin medication (manages blood glucose levels), and had diagnoses that included diabetes mellitus (disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal levels of glucose in the blood). The current care plan for Resident 58 indicated that he was insulin dependent and staff were to administer medications per physician's order. Interview with Resident 58 on August 12, 2025, at 1:30 p.m., indicated that the facility ran out of his insulin and he missed two doses and his blood sugar had risen. Physician's orders for Resident 58, dated February 27, 2025, included an order for the resident to receive Regular Insulin Concentrate (a short-acting insulin) subcutaneously (injected under the skin) daily before meals. The resident was to receive 160 units of Regular Insulin Concentrate before breakfast, 50 units before lunch, and 125 units before supper. Review of the Medication Administration Record (MAR) for Resident 58, dated August 2025, revealed that on August 11, 2025, at 7:00 a.m. the resident had a blood sugar of 178 milligrams per deciliter (mg/dl) and was not administered 160 units of Regular Insulin Concentrate as ordered; August 11, 2025, at 12:00 p.m. the resident had a blood sugar of 309 mg/dl and was not administered 50 units of Regular Insulin Concentrate as ordered. Interview with the Director of Nursing on August 13, 2025, at 1:03 p.m. confirmed that Resident 58's medication was not available and the resident did not receive his scheduled doses as noted above. 28 Pa Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, manufacturer's instructions and clinical records, as well as observations and staff interviews, it was determined that the facility failed to date an opened insulin pen injector for one of 50 residents reviewed (Resident 18). Findings include: The policy for medication storage and labeling, dated October 15, 2024, indicated that when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. Manufacturer's instructions for Tresiba insulin (an ultra long acting insulin that helps control blood sugar for up to 42 hours) indicated that after the first opening it may be kept at room temperature for up to 8 weeks (56 days). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 18, dated July 25, 2025, indicated that the resident was alert and oriented, required assistance from staff for daily care needs, and had diagnoses that included diabetes mellitus (a disease that occurs when your blood sugar is too high). Physician's orders for Resident 18, dated July 31, 2025, included an order for the resident to receive 64 units of Tresiba insulin (controls the amount of sugar in the blood) subcutaneously (under the skin) in the afternoon for diabetes mellitus. Observations of Medication Cart 2 on August 12, 2025, revealed an opened and undated Tresiba insulin pen labeled with Resident 18's name. Interview with Licensed Practical Nurse 5 on August 12, 2025, at 12:20 p.m. confirmed that the Tresiba insulin pen for Resident 18 should have been dated once the seal had been broken. Interview with Director of Nursing on August 13, 2025, at 10:08 a.m. confirmed that the Tresiba insulin pen should have been dated once the seal had been broken. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on clinical record reviews and observations, as well as resident and staff interviews, it was determined that the facility failed to ensure that drink preferences were honored for 2 of 50 residents reviewed (Residents 71, 101). Findings include: An interview with Resident 71 on August 11, 2025, at 10:13 a.m. revealed that she wanted to have soda as a drink choice, either for meals or for a snack. The resident said that they were told they could purchase their own soda from the vending machines in the building, or they could have someone bring soda in for them, but it would no longer be supplied by the facility. She was informed that she would be provided a ginger ale if she was sick. Interview with Resident 101 on August 13, 2025, at 12:08 p.m. revealed that he would like to have soda as a drink of choice. He is currently having to spend his own money out of pocket, separate from what the facility gets paid each month, for soda because he would like something besides ginger ale if he were sick. He would like different sodas as a choice for either meals or a snack. Interview with the Dietary Manager on August 13, 2025, at 12:10 p.m. confirmed that the facility has regular and diet ginger ale if a resident is sick; however, she is not permitted to order soda for the residents on a regular basis. She revealed that the decision came from her corporate office that she could no longer order soda due to its cost. She also indicated that she is aware that residents continue to request soda as a drink of choice for some meals and snacks. 28 Pa. Code 201.29(j) Resident Rights.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 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. Findings include: The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending September 26, 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 August 14, 2025, identified repeated deficiencies related to quality of care; bowel/bladder incontinence, catheter, and urinary tract infection; and food procurement, storage, preparation, service and sanitation. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending September 26, 2024, 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 F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care. The facility's plan of correction for a deficiency regarding bowel/bladder incontinence, catheter and urinary tract infection (UTI), cited during the survey ending on September 26, 2024, 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 F690, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding bowel/bladder incontinence, catheter, and urinary tract infection. The facility's plan of correction for a deficiency regarding food procurement, storage, preparation, service and sanitation, cited during the survey ending September 26, 2024, 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 F812, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding food procurement, storage, preparation, service and sanitation. Refer to F684, F690, & F81228 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.		