

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

Printed: 10/09/2026
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 07/23/2026
NAME OF PROVIDER OR SUPPLIER Mountain Laurel Healthcare and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Leonard Street Clearfield, PA 16830	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility policy, Resident Council meeting minutes, as well as resident, staff interviews and observations, it was determined that the facility failed to make ongoing efforts to resolve grievances presented by the Resident Council. Findings include: A facility policy regarding resident and family grievances dated April 10, 2026, indicated that grievances may be voiced verbally during resident or family council meetings. The staff member receiving the grievance would record the nature and specifics of the grievance on the designated grievance form. The Grievance Official would take steps to resolve the grievance. Resident Council meeting minutes, dated June 15, 2026, revealed that residents voiced concern about call bell response time being longer than ten minutes causing residents to have accidents. A review of the grievance logs for June and July 2026 revealed no documented evidence that a grievance form was created or investigated regarding the group's concern about untimely call bell response. Interview with a group of Residents on July 21, 2026, at 2:30 p.m. revealed that some of their concerns get a response back, while other do not. Staffing continues to be a problem, and the agency staff sit and play on their phones instead of providing care and answering call bells. Interview with the Nursing Home Administrator on July 22, 2026, at 11:37 a.m. confirmed that the residents voiced concerns about call bell wait times being too long at the Resident Council meeting on June 2026, and that as of July 22, 2026, the concern from Resident Council had not been investigated. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1)(4) Management. 28 Pa. Code 201.29(a) Resident rights.		

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 homelike environment for the residents in the facility's second floor dining room. Findings include: The facility's policy regarding homelike environment, dated April 10, 2026, revealed the facility will provide a safe, clean, comfortable, and homelike environment. Observations of the second floor dining room during lunch on July 23, 2026, at 12:27 p.m. revealed four empty wheelchairs stored along the walls of the dining room during lunch hour. Interview with Nurse Aide 6, on July 23, 2026, at 12:30 p.m. confirmed that the wheelchairs should be stored in the closet adjacent to the dining room, and she proceeded to relocate the empty wheelchairs into the storage closet. Interview with the Nursing Home Administrator on July 23, 2026, at 12:45 p.m. confirmed that empty wheelchairs should not be stored in the dining room. Observations on July 23, 2026, at 9:14 a.m. revealed that the wallpaper in the second-floor dining room was peeling off the wall below the windows. Interview with the Director of Maintenance on July 23, 2026 at 9:30, revealed that the wall in the second-floor dining room was on the list of repairs and he was aware that it was a problem. Interview with the Director of Nursing on July 23, 2026, at 9:35 a.m. confirmed that the wall in the dining room needed repaired. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on a review of facility policies and clinical records, as well as staff interviews, it was determined the facility failed to ensure a resident's medication regimen was free from unnecessary psychotropic medications for one of 87 residents reviewed (Resident 59). Findings included: The facility's policy regarding medication administration, dated April 10, 2026, indicated that medications were to be administered by licensed nurses or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 59, dated May 11, 2026, revealed that the resident was cognitively impaired, had behaviors of rejecting care and wandering, received antidepressant and antipsychotic medications, and had medical diagnoses that included anxiety, depression, and dementia. Physician's orders for Resident 59, dated June 26, 2026, included an order for the resident to receive 10 mg of Olanzapine (antipsychotic medication) two times a day, and an order, dated June 28, 2026, included orders for the resident to receive 2 milligrams (mg) of Haldol (antipsychotic medication) two times a day. A nursing note, dated July 2, 2026, revealed that a verbal order was received from the psychiatry provider to increase the resident's Haldol to three times a day and make Olanzapine taper to a bedtime dose ending on July 6th. Physician's orders, dated July 2, 2026, included orders for the resident to receive 2mg of Haldol three times a day, and 10 mg of Olanzapine twice a day for seven days and then give 10 mg of Olanzapine at bedtime. A psychiatry note for Resident 59, dated July 7, 2026, revealed that on July 2, 2026 verbal orders were given for Haldol dosing and Olanzapine taper parameters. A review of the Medication Administration Record (MAR) revealed that the transcription of the orders resulted in doses that differed from the intentions. The Olanzapine taper parameters had been entered in a manner that resulted in higher doses being administered than the 10 mg bedtime dose intended at the stage of the taper. A review of Resident 59's Medication Administration Record (MAR) for July 2026 revealed that the resident received 2mg of Haldol three times a day from July 2 through 7, 2026, and received 10 mg of Olanzapine twice a day from July 2 through 7, 2026 and 10 mg of Olanzapine at bedtime from July 3 through 5, 2026. An interview with the Assistant Director of Nursing on July 23, 2026, at 2:38 p.m. confirmed that Resident 59 did not receive the taper of Olanzapine as ordered by the physician, which resulted in a medication error of receiving more Olanzapine than intended. Pa. Code 211.12(d)(3)(5) Nursing Services.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on review of the Resident Assessment Instrument User's Manual and clinical records, the Centers for Medicare & Medicaid Services (CMS) Minimum Data Set (MDS) validation report, as well as staff interviews, it was determined that the facility failed to ensure that the Care Area Assessment Process of comprehensive Minimum Data Set assessments and comprehensive assessments were completed in the required time frame for 16 of 87 residents reviewed (Residents 9, 57, 83, 97, 98, 129, 152, 153, 157, 159, 162, 163, 165, 170, 171, 172). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that for admission MDS assessments, the assessment completion date, and the Care Area Assessment (CAA - the process of completing an in-depth assessment of triggered, potentially problematic care areas) completion date (Item V0200B2) were to be no later than the resident's admission date plus 13 calendar days and there must be an MDS every 92 days. A comprehensive MDS assessment for Resident 9 revealed that the ARD was June 28, 2026. The MDS assessment was dated as completed on July 13, 2026, which was one day late. A comprehensive MDS assessment for Resident 57 revealed that the ARD was June 27, 2026. The MDS assessment was dated as completed on July 13, 2026, which was three days late. A comprehensive MDS assessment for Resident 83 revealed that the ARD was July 7, 2026. The MDS assessment was dated as completed on July 14, 2026, which was one day late. A comprehensive MDS assessment for Resident 97 revealed that the ARD was June 1, 2026. The MDS assessment was dated as completed on June 15, 2026, which was one day late. A comprehensive MDS assessment for Resident 98 revealed that the ARD was June 23, 2026. The MDS assessment was dated as completed on July 9, 2026, which was six days late. A comprehensive MDS assessment for Resident 129 revealed that the ARD was June 8, 2026. The MDS assessment was dated as completed on June 15, 2026, which was one day late. A comprehensive MDS assessment for Resident 152 revealed that the ARD was May 5, 2026. The MDS assessment was dated as completed on May 19, 2026, which was one day late. A comprehensive MDS assessment for Resident 153 revealed that the ARD was May 8, 2026. The MDS assessment was dated as completed on May 26, 2026, which was five days late. A comprehensive MDS assessment for Resident 157 revealed that the ARD was May 1, 2026. The MDS assessment was dated as completed on May 15, 2026, which was one day late. A comprehensive MDS assessment for Resident 159 revealed that the ARD was May 14, 2026, 2026. The MDS assessment was dated as completed on May 28, 2026, which was one day late. A comprehensive MDS assessment for Resident 162 revealed that the ARD was May 13, 2026. The MDS assessment was dated as completed on May 28, 2026, which was two days late. A comprehensive MDS assessment for Resident 163 revealed that the ARD was May 13, 2026. The MDS assessment was dated as completed on May 28, 2026, which was two days late. A comprehensive MDS assessment for Resident 165 revealed that the ARD was May 26, 2026. The MDS assessment was dated as completed on June 9, 2026, which was one day late. A comprehensive MDS assessment for Resident 170 revealed that the ARD was May 5, 2026. The MDS assessment was dated as completed on May 19, 2026, which was one day late. A comprehensive MDS assessment for Resident 171 revealed that the ARD was May 4, 2026. The MDS assessment was dated as completed on May 19, 2026, which was two days late. A comprehensive MDS assessment for Resident 172 revealed that the ARD was May 2, 2026. The MDS assessment was dated as completed on May 19, 2026, which was four days late. Interview with the (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing Home Administrator on July 23, 2026 at 11:15 a.m. confirmed that the above comprehensive MDS assessments were not completed in the required time frames. 28 Pa. Code 211.5(f) Clinical records.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record reviews, as well as resident and staff interviews, it was determined that the facility failed to implement an individualized care plan for dental needs for eight of 87 residents reviewed (Residents 4, 25, 56, 59, 129, 135, 162, 171). Findings include: A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated June 24, 2026, indicated that the resident was cognitively intact, required assistance for daily care, and was a diabetic. A physician's order for Resident 4, dated June 17, 2026, revealed that the resident was medicated with Insulin Glargine (long-acting insulin, and an order dated June 18, 2026, revealed that the resident was ordered Jardiance (anti diabetic medication). There was no documented evidence that a care plan was developed to address Resident 4's care needs related to her diabetes. A comprehensive MDS assessment for Resident 25, dated June 7, 2026, indicated that the resident was slightly cognitively impaired, required assistance for daily care, and medicated with an antipsychotic medication, antidepressant medication, and an anticonvulsant medication. There was no documented evidence that a care plan was developed to address Resident 25's care needs related to her psychosis, antiseizures, and depression. A quarterly MDS assessment for Resident 56, dated May 26, 2026, revealed that the resident was cognitively intact, and received an anti-depressant and an anti-psychotic medication. Physician's orders for Resident 56, dated May 9, 2026, included an order for the resident to receive 30 milligrams (mg) of Mirtazapine (anti-depressant) at bedtime, and an order, dated June 24, 2026, included an order for the resident to receive 20 mg of Olanzapine (anti-psychotic) at bedtime. The resident's Medication Administration Record (MAR) for July 2026 revealed the resident was currently receiving Mirtazapine and Olanzapine. There was no documented evidence that a care plan was developed to address Resident 56's care needs related to the use of anti-depressant or anti-psychotic medications. An admission MDS assessment for Resident 59, dated May 11, 2026, revealed that the resident was cognitively impaired, and received an anti-depressant and an anti-psychotic medication. Physician's orders for Resident 59, dated June 17, 2026, included an order for the resident to receive 20 mg of Citalopram (anti-depressant) one time a day, and an order, dated July 7, 2026, included an order for the resident to receive 2 mg of Haldol (anti-psychotic) twice a day. The resident's MAR for July 2026 revealed the resident was currently receiving Citalopram and Haldol. There was no documented evidence that a care plan was developed to address Resident 59's care needs related to the use of anti-depressant or anti-psychotic medications. A comprehensive MDS assessment for Resident 129, dated June 8, 2026, indicated that the resident was cognitively intact, required assistance for daily care, and was a diabetic. A physician's order for Resident 129, dated June 1, 2026, included an order for the resident to receive 15 milligrams (mg) Buspirone (anti-anxiety medication) two times daily. Physician's order, dated June 15, 2026, included an order for the resident to receive 50 mg Seroquel (anti-psychotic medication). There was no documented evidence that a care plan was developed to address Resident 129's care needs related to her anxiety or psychosis. A comprehensive MDS assessment for Resident 129, dated June 8, 2026, indicated that the resident was cognitively intact, required assistance for daily care, and was a diabetic. A physician's order for Resident 129, dated June 1, 2026, included an order for the resident to receive 15 milligrams (mg) Buspirone (anti-anxiety medication) two times daily. Physician's order, dated June 15, 2026, included an order for the resident to receive 50 mg Seroquel (anti-psychotic medication). There was no documented evidence that a care plan was developed to address Resident 129's care needs related to her anxiety or psychosis. An interview with the Nursing (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Home Administrator on July 23, 2026, at 9:39 a.m. revealed that there was no care plan in place regarding Residents 4, 29, 125's individualized needs and there should have been. A quarterly MDS assessment for Resident 135, dated June 30, 2026, revealed that the resident was cognitively impaired, and received an anti-depressant and an anti-psychotic medication. Physician's orders for Resident 135, dated November 12, 2025, included an order for the resident to receive 100 mg of Sertraline (anti-depressant) at bedtime, and an order dated June 27, 2026, included an order for the resident to receive 25 mg of Seroquel (anti-psychotic) twice a day. The resident's MAR for July 2026 revealed the resident was currently receiving Sertraline and Seroquel. There was no documented evidence that a care plan was developed to address Resident 135's care needs related to the use of anti-depressant or anti-psychotic medications. An admission MDS assessment for Resident 162, dated May 20, 2026, revealed that the resident was cognitively impaired, had diagnoses that included dementia, and did not receive an anti-depressant or an anti-psychotic medication. Physician's orders for Resident 162, dated June 23, 2026, included an order for the resident to receive 50 mg of Zoloft (anti-depressant) one time a day, and an order dated July 15, 2026, included an order for the resident to receive 0.5 mg of Haldol (anti-psychotic) three times a day. The resident's MAR for July 2026 revealed the resident was currently receiving Zoloft and Haldol. There was no documented evidence that a care plan was developed to address Resident 162's care needs related to the use of anti-depressant or anti-psychotic medications. An admission MDS assessment for Resident 171, dated May 19, 2026, revealed that the resident was cognitively impaired and received an anti-convulsant medication. Physician's orders for Resident 171, dated May 5, 2026, included an order for the resident to receive 100 mg of Neurontin (anti-convulsant) twice a day for neuropathy (nerve pain). The resident's MAR for July 2026 revealed the resident was currently receiving Neurontin. There was no documented evidence that a care plan was developed to address Resident 171's care needs related to the use of anti-convulsant medications. Interview with Nursing Home Administrator on July 23, 2026, at 9:56 a.m. confirmed that the care plans for Residents 56, 59, 135, 162, and 171 did not have a care plan to address their use of anti-depressant, anti-psychotic, or anti-convulsant medications and should have. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policies and clinical record review, 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 three of 87 residents reviewed (Resident 7, 25, and 129). Findings include: The facility's policy regarding Trauma Informed Care, dated April 10, 2026, revealed that the facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/ or re-traumatization. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated February 16, 2026, revealed that the resident was understood, could understand, was moderately cognitively impaired, required assistance from staff for daily care needs, was taking antipsychotic, antianxiety, and antidepressant medication, and had a diagnosis that included PTSD. A care plan for Resident 7 dated September 24, 2024, indicated that he was a survivor of trauma. He was a veteran of Vietnam War, lost his wife to suicide, and had a history of physical and verbal abuse from his father. An interview with Resident 7 on July 21, 2026, at 8:36 a.m. revealed that he had anxiety due to his service in Vietnam, he lost his best friend, and he mostly has problems at night with his PTSD. A PTSD trauma assessment dated [DATE], indicated that he has intrusive memories and flashbacks as well as upsetting dreams and nightmares. There was no documented evidence that the facility identified Resident 7's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring,. Interview with the interim Director of Nursing and Regional Consultant on July 22, 2026, at 1:30 p.m. revealed that she believed Resident 7 current care plan does not address triggers or his nightmares and flashbacks. A comprehensive MDS assessment for Resident 25, dated June 7, 2026, indicated that the resident was cognitively impaired, required assistance for daily care, and had diagnoses that included anxiety, depression, schizophrenia, and PTSD. Resident 25's care plan, dated May 31, 2026, indicated that the resident had PTSD, however, there was no documented evidence that the facility identified Resident 25's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring, and there was not documented evidence of a care plan for her PTSD. A comprehensive MDS assessment for Resident 129, dated June 8, 2026, indicated that the resident was cognitively intact and required assistance for daily care. Nursing note for Resident 129, dated June 7, 2026, revealed that the resident was upset that a nurse aide had grabbed her arm and yanked on it, and that she was crying in pain. Nursing note for Resident 129, dated June 8, 2026, revealed that the resident was experiencing occasional flashbacks related to a past sexual abuse incident. There was no documented evidence that the facility identified Resident (continued on next page)		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of personnel files, as well as staff interviews, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed at least annually for five of five nurse aides reviewed (Nurse Aide 1, Nurse Aide 2, Nurse Aide 3, Nurse Aide 4, and Nurse Aide 5). Findings include: Review of Nurse Aide 1's personnel file revealed that she was hired October 29, 2015. There was no evidence that Nurse Aide 1 had a performance evaluation completed since 2021. Review of Nurse Aide 2's personnel file revealed that she was hired March 20, 2014. There was no evidence that Nurse Aide 2 had a performance evaluation completed since 2021. Review of Nurse Aide 3's personnel file revealed that she was hired August 18, 2021. There was no evidence that Nurse Aide 3 had a performance evaluation completed since 2021. Review of Nurse Aide 4's personnel file revealed that she was hired October 16, 2012. There was no evidence that Nurse Aide 4 had a performance evaluation completed since 2021. Review of Nurse Aide 5's personnel file revealed that she was hired November 15, 2011. There was no evidence that Nurse Aide 5 had a performance evaluation completed since 2021. Interview with the Nursing Home Administrator on July 22, 2026 at 10:58 a.m. revealed that there have been no annual performance evaluations since 2021. Interview with the Director of Human Resources on July 22, 2026 at 12:08 p.m. revealed that there have been no annual performance evaluations since 2021. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.18(e)(1) Management.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, and a test tray, as well as resident and staff interviews, it was determined that the facility failed to serve food that was palatable. Findings include: Review of the posted menus for the lunch meal on Wednesday, July 22, 2026, revealed that residents were to receive a ham steak, mashed potatoes with gravy, green beans, ice cream, and a beverage. A test tray for the lunch meal on B wing on July 22, 2026, revealed that the cart left the kitchen at 12:38 p.m. arrived on the nursing unit at 12:40 p.m., and the last resident was served at 12:47 p.m. The test tray was tasted at 12:47 p.m., and the mashed potatoes were bland, thin in texture, and not palatable. Interview with Resident 44 on July 20, 2026, at 7:30 p.m. revealed that she does not like the taste of the food and feels as though the selection is limited. Interview with Resident 53 on July 20, 2026, at 8:00 p.m. revealed that she does not like the taste of the food. Interview with Resident 113 on July 20, 2026 at 7:42 p.m. revealed that he disliked some the food and that it was rarely cooked properly. Interview with Resident 129 on July 20, 2026 at 8:32 p.m. revealed that she disliked the food, that her chicken was raw., her vegetables are either mushy or raw, and no one in the kitchen listens to her complaints. Interview with Resident 155 on July 20, 2026 at 7:58 p.m. revealed that she disliked the food, it was rarely cooked properly, the meats were either over cooked and tough or undercooked and raw, and that sometimes its cold when it arrives to her room. Interview with the Dietary Manager on July 22, 2026, at 12:48 p.m. confirmed that the mashed potatoes were bland, thin in texture, and not palatable. 28 Pa. Code 211.6(b) Dietary services.		

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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 manufacturer's recommendations, observations, and staff interviews, it was determined that the facility failed to ensure that the dishwashing temperatures were at proper temperatures to ensure sanitary dishwashing conditions. Findings include: Manufacturer's instructions for the main kitchen high-temperature dishwasher, a CMA Dish Machine EST-44H, recommended the wash cycle temperature range between 150 to 160 degrees Fahrenheit. Also in accordance with the U.S. Department of Health and Human Services, Public Health Services, Food and Drug Administration Food Code for High Temperature Dishwasher heat sanitization of 150-165 degrees Fahrenheit for wash cycle temperature. Observations in the main kitchen on July 23, 2026, at 10 a.m. revealed that the wash cycle temperature was only 132 degrees Fahrenheit. On July 23, 2026, at 10 a.m., Dietary Manager confirmed that this temperature was not the correct temperature for a high-temperature wash cycle. Interview with the Dietary Manager on July 23, 2026, at 10 a.m. confirmed that the dishwashing cycle was only registering as 132 degrees Fahrenheit. She confirmed that it should register at least 150 degrees Fahrenheit. Dietary Manager confirmed that the thermostat was not set correctly, and this was adjusted. 28 Pa. Code 201.18(e) (2.1) Management. 28 Pa. Code 211.6(f) Dietary Services.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide the required notice to the resident or the resident's representative following the end of their Medicare coverage for three of three residents reviewed (Residents 10, 14, 46) who remained in the facility for long-term care. Findings include: An quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 10, dated June 1, 2026, indicated that the resident was severely cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included metabolic encephalopathy (brain dysfunction caused by systemic metabolic disturbances or chemical imbalances). A Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, completed by the facility, revealed that Medicare coverage for Resident 10 started on March 18, 2026, and that his last covered day was June 1, 2026. The form indicated that the facility-initiated discontinuation from Medicare Part A coverage and that the resident's benefit days were not exhausted. Resident 10 signed the Beneficiary Protection Notification himself, however he is severely cognitively impaired and could not understand the form. Resident 10 remained the facility for long-term care. There was no documented evidence that Residents 10 was provided with an Advance Beneficiary Notice of Non-coverage (ABN - a notice given to Medicare beneficiaries to convey that Medicare is not likely to provide coverage in a specific case). A Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, completed by the facility, revealed that Medicare coverage for Resident 14 started on January 27, 2026, and that his last covered day was March 5, 2026. The form indicated that the facility-initiated discontinuation from Medicare Part A coverage and that the resident's benefit days were not exhausted. Resident 14 remained the facility for long term care. There was no documented evidence that Residents 14 was provided with an ABN of Non-coverage. An quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 46, dated May 20, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included dementia (syndrome characterized by a decline in cognitive function). A Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, completed by the facility, revealed that Medicare coverage for Resident 46 started on February 14, 2026, and that her last covered day was March 4, 2026. The form indicated that the facility-initiated discontinuation from Medicare Part A coverage and that the resident's benefit days were not exhausted. There was no documentation that Resident 46 was aware of the Beneficiary Protection Notification form, or that her Power of Attorney was aware. Resident 46 remained the facility for long term care, and was unaware that she was now private pay. There was no documented evidence that Residents 47 was provided with an ABN of Non-coverage. Interview with the Nursing Home Administrator on July 22, 2026, at 10:45 a.m. confirmed that an ABN notice was not provided to Residents 10, 14, or 46 as required and no Beneficiary Protection Notification Review form was not provided to Residents 10 or 46. 28 Pa. Code 201.18(e)(1) Management.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on review of the Resident Assessment Instrument Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that quarterly Minimum Data Set assessments were completed within the required time frame for seven of 87 residents reviewed (Residents 56, 74, 85, 96, 119, 130, 141). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that the assessment reference date (ARD - the last day of the assessment's look-back period) of a quarterly MDS assessment must be no more than 92 days after the ARD of the most recent assessment of any type, and the assessment was to have a completion date (Section Z0500B) that was no later than the ARD plus 14 calendar days. A quarterly MDS assessment for Resident 56 had an ARD of May 26, 2026, but it was not completed (Section Z0500B) until June 10, 2026, which was two days late. A quarterly MDS assessment for Resident 74 had an ARD of June 24, 2026, but it was not completed (Section Z0500B) until July 9, 2026, which was two days late. A quarterly MDS assessment for Resident 85 had an ARD of June 28, 2026, but it was not completed (Section Z0500B) until July 13, 2026, which was two days late. A quarterly MDS assessment for Resident 96 had an ARD of June 24, 2026, but it was not completed (Section Z0500B) until July 9, 2026, which was two days late. A quarterly MDS assessment for Resident 119 had an ARD of June 24, 2026, but it was not completed (Section Z0500B) until July 9, 2026, which was two days late. A quarterly MDS assessment for Resident 130 had an ARD of June 3, 2026, but it was not completed (Section Z0500B) until June 18, 2026, which was two days late. A quarterly MDS assessment for Resident 141 had an ARD of June 24, 2026, but it was not completed (Section Z0500B) until July 9, 2026, which was two days late. Interview with the Nursing Home Administrator on July 23, 2026 at 11:15 a.m. confirmed that the above comprehensive MDS assessments were not completed in the required time frames. 28 Pa. Code 211.5(f) Clinical records.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's baseline care plan included information regarding the resident's immediate care needs for one of 87 residents reviewed (Residents 155). Findings include: Resident 155's physician orders, dated July 15, 2026, revealed that the resident had a urostomy (a surgical procedure that creates a new path for urine to leave the body when the bladder is removed), and that she medicated with Diltiazem (high blood pressure medication), Lasix (water pill), Apixaban (blood thinner), glipizide (anti-diabetic medication), Sertraline (anti-depressant medication), and Clonazepam (anti-anxiety medication). An admission note for Resident 155 dated July 15, 2026 at 5:00 p.m. revealed that the resident arrived at the facility at 5:00 p.m., was alert and oriented, had anxiety and depression and was crying, bladder cancer with bladder removal and urostomy in place, atrial fibrillation (irregular heart beat treated with a blood thinner), high blood pressure, and diabetes, There was no documented evidence that a baseline care plan was developed or individualized for Resident 155's care and treatment needs related to her urostomy, irregular heartbeat, water pill, blood thinner, diabetes, depression or anxiety. Interview with the Assistant Director of Nursing on July 23, 2026 at 1:16 p.m. confirmed that the resident's baseline care plan did not include care and treatment needs required for her urostomy, irregular heartbeat, water pill, blood thinner, diabetes, depression or anxiety. 28 Pa. Code 211.12(d)(1) Nursing Services		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify a provider's orders for one of 80 residents reviewed (Resident 136). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. A quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 136, dated May 9, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included Type II diabetes mellitus (condition defined by persistently high levels of sugar (glucose) in the blood). Physician's orders for Resident 136, dated June 22, 2026, included an order for the resident to receive Humulin R U-500 (a type of insulin) to be injected per sliding scale: if blood sugar 0-300 give 0 units; 301-450 give 40 units; 451 or more call the provider; 0-300 give 0 units; 301-450 give 5 units; 451 give 7 units and call the provider. The facility failed to clarify which sliding scale should be followed for administration. Interview with the Director of Nursing on July 22, 2026, at 12:32 p.m. confirmed that Resident's 136 medication order should have been clarified with the physician prior to administering the medication, and it was not. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that pressure ulcer care/prevention treatments were provided as ordered for one of 80 residents reviewed (Resident 9). Findings include: A wound management policy, dated April 10, 2026, indicated that clinical staff will follow medical physician's orders for the treatment plan. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated June 28, 2026, revealed that the resident was cognitively intact, required extensive assistance with daily care tasks, was at risk for pressure ulcer (skin impairment caused by pressure) development, a stage IIV (a deep, severe skin wound featuring full-thickness skin loss where subcutaneous fat is visible, but muscle, tendon, and bone are not exposed) pressure ulcer and had one stage IV (most severe form of pressure injury, involving full-thickness tissue loss with exposed muscle, tendon, or bone) pressure ulcer. A physician's order for Resident 9, dated July 15, 2026, included an order to cleanse area with soap and water, pat dry. Apply skin prep to wound. Cut black foam too size and loosely pack tunnel of right buttocks at 2 o'clock (approximate location of area that needs packed) and cover wound bed, cover with transparent dressing, set to 125 millimeters of mercury (mmHG) continuous vacuuming suction. Bridge wounds together above the anus to maintain good seal. Observations of wound care for Resident 9 on July 21, 2026, at 11:01 a.m. revealed that Licensed Practical Nurse 7 bridged the wound together above and below the anus, however the wound care order specifically stated to bridge above and not below. An interview with Licensed Practical Nurse 7 immediately following the completion of the treatment revealed that she thought that it was necessary to bridge above and below the anus. An interview with the Certified Wound Care Registered Nurse 8 from the wound care center where Resident 9 receives specialized wound care weekly on July 21, 2026, at 2:30 p.m. revealed that the staff should have only bridged the wound above the anus. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on facility policy, clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure a safe environment for three of 87 residents reviewed (Residents 133, 169, and 171). Findings include: A facility policy regarding resident falls dated April 10, 2026, indicated that residents who had a fall were to be assessed by nursing staff. A quarterly minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 133, dated June 19, 2026, revealed that the resident was severely cognitively impaired, had wandering behaviors, required assistance for daily care needs, and had a diagnosis of dementia. The resident's care plan, dated March 15, 2026, revealed that the resident had a potential for falls due to impaired mobility and balance. Observations of Resident 133 on July 20, 2026, at 7:27 p.m. revealed him to be laying on the floor on his right side, head near the top of the bed, knees bent fetal. Nurse Aide 10 confirmed that Resident 133 was on the floor, she entered the room and pulled him up to a sitting position and left the room. Nurse Aide 10 came back with Nurse Aide 12, and they physically assisted Resident 133 to stand. Nurse Aide 12 stated that she had provided incontinence care to Resident 133 approximately 45 minutes ago, and she lowered him to the floor because he wanted to be on the floor and that he was ambulatory. Interview with Licensed Practical Nurse 11 on July 20, 2026, at 7:39 p.m., revealed that she was not informed that Resident 133 was found on the floor, and did not assess him. Interview with Registered Nurse 13 on July 20, 2026, at 8:20 p.m., revealed that she was not informed that Resident 133 was found on the floor. She saw him downstairs with staff and informed the staff member that Resident 133 could not be downstairs. Registered Nurse 13 assessed Resident 133 and started neurological checks. Nurse Aide 12 reported that she had changed Resident 133 then lowered him to the floor. Nurse Aide 12 did not notify staff that she had lowered the resident to the floor. It was not until this surveyor found him on the floor and notified the staff. The registered nurse was not informed of the fall. A witness statement dated July 20, 2026, by Nurse Aide 10 indicated that she and Nurse Aide 12 assisted Resident 133 off the floor. Nurse Aide 10 indicated that Resident 133 did not fall and that he was lowered to the floor earlier by another staff member. A witness statement dated July 20, 2026, by Nurse Aide 12 indicated that she changed Resident 133 and was helping him into bed when he started sitting on the floor. I asked him if that's where he wanted to be and Resident 133 said yes. I told him I would come back and check on him then went into another room. An interview with the interim Director of Nursing on July 22, 2026, at 1:32 p.m. confirmed that Resident 133 was not assessed by a registered nurse after being found on the floor and that the resident should not have been assisted off the floor before being assessed. The witness statements were inconsistent. Nurse Aide 12 reported that she lowered the resident to the floor after providing care on July 20, 2026, at 6:45 p.m. However, the Licensed Practical Nurse or the Registered Nurse on duty were informed that Resident 133 was lowered to the floor. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 169, dated May 19, 2026, revealed that the resident was cognitively impaired, was dependent on staff for wheelchair use, and had diagnoses that included dementia. Observations of Resident 169 on July 22, 2026, at 8:49 a.m. revealed that the resident was sitting in her wheelchair in the hallway outside of her room and her left foot was off of the wheelchair footrest, positioned behind the footrest. Nurse Aide 14 began pushing the resident from the hallway outside of the resident's room to the end of the hallway near the elevator and dining room, with the resident's foot sliding on the floor. An interview with Nurse Aide 14 at that time revealed that she was not aware that the resident's left foot was (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positioned off of the left wheelchair footrest and was sliding on the floor. An interview with the Director of Nursing on July 23, 2026, at 10:43 a.m. confirmed that Nurse Aide 14 should not have pushed Resident 169 down the hallway while her left foot was positioned behind the wheelchair footrest and sliding on the floor. The facility's policy regarding resident falls, dated April 10, 2026, indicated that the unit manager/designee would notify the staff of the residents at risk for falls and any interventions that were put into place. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 171, dated May 19, 2026, revealed that the resident was cognitively impaired, was dependent on staff for daily care needs, and had diagnoses that included dementia. A nursing note dated July 14, 2026, at 2:35 a.m. revealed that Resident 171 was found on the floor beside her bed. The bed was put in a low position and fall mats were placed on both sides of the bed. The resident's care plan was updated on July 14, 2026, to include fall mats on both sides of the bed. Observations on July 23, 2026, at 2:39 p.m. revealed that Resident 171 was in bed without fall mats on either side of her bed. Interview with Licensed Practical Nurse 15 on July 23, 2026, at 2:44 p.m. confirmed that Resident 171 was to have fall mats down on each side of her bed when she was in bed. 28 Pa. Code 211.12(d)(5) Nursing services.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to respond to a pharmacy recommendation for two of 87 residents reviewed (Residents 7, 13) and failed to ensure that monthly pharmacy medication reviews were completed for one of 87 residents reviewed (Resident 56). Findings include: A facility policy regarding medication regime review dated April 10 2026, indicated that each resident was reviewed at least once a month by a licensed pharmacist and the facility staff shall act upon all recommendations according to procedures for assessing medication regimen review irregularities A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated February 16, 2026, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and was taking antipsychotic, antianxiety, and antidepressant medication. Pharmacy medication regimen review reports for Resident 7 dated February 25, 2026, provided to the facility, included recommendations for the physician to consider a gradual does reduction of Ziprasidone 20 milligrams (mg) (antipsychotic medication), Venlafaxine 112.5 mg (antidepressant medication), and Lorazepam 0.5 mg (antianxiety medication) ; however there was no documented evidence that they were addressed by the physician. A quarterly MDS assessment Resident 13 dated January 2, 2026, revealed that the resident was severely cognitively impaired and required assistance from staff for daily care needs, and was taking antipsychotic, antianxiety, and antidepressant medication. Pharmacy medication regimen review reports for Resident 7 dated March 30, 2026, provided to the facility, included recommendations for the physician to consider a gradual does reduction of Risperidone 1.5 mg (antipsychotic medication) and Citalopram mg (antidepressant medication); however there was no documented evidence that they were addressed by the physician. An interview with the interim Director of Nursing on July 23, 2026, at 9:55 a.m. confirmed that the above pharmacy consultant reports for Resident 7 and 13 were not addressed by the physician. A quarterly MDS for Resident 56, dated May 26, 2026, revealed that the resident was cognitively intact, and received antidepressant, anticoagulant, and antipsychotic medications. Review of Resident 56's clinical record revealed no documented evidence that the pharmacist performed a monthly review of medications in May 2026. Interview with the Assistant Director of Nursing on July 23, 2026, at 1:16 p.m. confirmed that a monthly pharmacy review for Resident 56 was not completed for the month of May and should have been. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.		

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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 plan of correction for the State Survey and Certification (Department of Health) survey ending August 14, 2025, as well as complaint surveys ending March 19, 2026 and April 28, 2026, revealed that the facility developed plans of corrections that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending July 23, 2026, identified repeated deficiencies related to clean, homelike environment, pressure ulcer development/prevention, drug regime reviews, food store/prepare/serve safely, and infection control. The facility's plan of correction for a deficiency regarding clean/homelike environment, cited during the survey ending August 14, 2025, 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 F584, revealed that the QAPI committee was ineffective in correcting deficient practices related to the clean/homelike environment. The facility's plan of correction for a deficiency regarding pressure ulcer development/prevention, cited during a complaint survey ending March 19, 2026, 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 F686, revealed that the QAPI committee was ineffective in correcting deficient practices related to pressure ulcer development/prevention. The facility's plan of correction for a deficiency regarding drug regime reviews, cited during the survey ending August 14, 2025, 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 F756, revealed that the QAPI committee was ineffective in correcting deficient practices related to drug regime reviews. The facility's plan of correction for a deficiency regarding food store/prepare/serve safely, cited during the survey ending August 14, 2025, 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 QAPI committee was ineffective in correcting deficient practices related to food store/prepare/serve safely. The facility's plan of correction for a deficiency regarding infection control, cited during a complaint survey ending April 28, 2026, 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 F880, revealed that the QAPI committee was ineffective in correcting deficient practices related to infection control. Refer to F584, F686, F756, F812, F880 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Mountain Laurel Healthcare and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Leonard Street Clearfield, PA 16830	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to use proper infection control practices during incontinent care for one of 80 residents reviewed (Resident 9). Findings include: The facility's policy regarding enhanced barrier precautions (EBP), dated April 10, 2026, revealed that EBP may be indicated for residents with wounds, and the health care worker must wear the appropriate personal protective equipment (PPE), including gown and gloves, when providing care. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated June 28, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, had limited range of motion to his lower extremity, and had a stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle). Observations on July 21, 2026, at 11:01 a.m. revealed that Resident 9 had a sign outside his room indicating that he was on enhanced barrier precautions, however, there was no Personal Protective Equipment (PPE, gloves, gowns, face shields, etc.) visible outside or inside the residents room. Licensed Practical Nurse 9 and Licensed Practical Nurse 7 entered the resident's room to perform wound care. The licensed nurses proceeded to provide wound care for the resident by removing the old dressing, cleansing the wound, and dressing the clean wound. The licensed practical nurses did not wear gowns while performing wound care per the facility's EBP policy. Interview with Licensed Practical Nurse 9 on July 21, 2026, at 12:39 p.m. confirmed that she did not have on a gown while performing wound care, and that both LPNs should have worn gowns during care. Interview with the Director of Nursing on July 21, 2026, at 10:09 a.m. and 2:50 p.m. confirmed that LPN 9 and LPN 7 should have worn gowns when performing wound care. 28 Pa. Code 211.12(d)(1) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 and/or the pneumococcal immunizations for four of 87 residents reviewed (Residents 1, 4, 113, 171). Findings include: The facility's influenza and pneumonia vaccination policies, dated April 10, 2026 revealed that all residents would be offered the influenza and pneumonia vaccines. A quarterly Minimum Data Set (MDS) assessments (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated July 6, 2026, revealed that the resident was admitted to the facility on [DATE] and that her pneumonia vaccine was not up to date and that she was not offered the pneumonia vaccine. There was no documented evidence that the facility offered or administered the pneumonia vaccine to Resident 1. A quarterly Minimum Data Set (MDS) assessments (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated June 24, 2026, revealed that the resident was admitted to the facility on [DATE] and that her pneumonia vaccine was not up to date and that she was not offered the pneumonia vaccine. There was no documented evidence that the facility offered or administered the pneumonia vaccine to Resident 4. A comprehensive MDS assessment for Resident 113, dated June 30, 2026, revealed that the resident was cognitively intact, was admitted to the facility on [DATE], that his pneumonia vaccine was not up to date, and that he was not offered the pneumonia vaccine. There was no documented evidence that Resident 113 was offered the pneumonia vaccine. An admission MDS assessments for Resident 171, dated May 19, 2026, revealed that the resident was admitted to the facility on [DATE], and that her pneumonia vaccine was not up to date and that she was not offered the pneumonia vaccine. There was no documented evidence that the facility offered or administered the pneumonia vaccine to Resident 171 Interview with the Nursing Home Administrator on July 23, 2026, at 9:42 a.m. revealed that Residents 1, 4, 113, and 171 were not offered the pneumonia vaccine and they should have been. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		