STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395542	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Top Rehabilitation & Healthcare Center	185 South Mountain Boulevard Mountain Top, PA 18707

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, investigation documentation provided by the facility, and resident and staff interviews, it was determined the facility the facility failed to protect one of four sampled residents (Resident 1) from neglect by not providing the care and services necessary to prevent a fall from bed. This deficiency is cited at past noncompliance.Findings include:A review of the facility's Resident Abuse policy, last revised July 2025, revealed the facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in the policy. A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses, which included chronic respiratory failure with hypoxia (long-term inability of the lungs to adequately oxygenate the blood and/or remove carbon dioxide) and diabetes. A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated June 23, 2025, indicated the resident had a BIMS (brief interview for mental status) score of 12 (8-12 indicates moderately cognitively impaired), and required staff assistance for all aspects of toileting hygiene, and required staff provide assistance to roll the resident from left side to right side. A review of the resident's care plan for decreased ADLs (activities of daily living) self-care performance initially dated October 23, 2024, indicated the resident required extensive assistance for personal hygiene (which would include incontinence care) and the assistance of two staff for bed mobility. Review of investigation documentation provided by the facility revealed on July 16, 2025, 5:00 AM Resident 1 was found on the floor on the right side of the bed between the right side of the bed and the divider curtain in the room. The bed was not in the lowest position. The resident had a raised bluish/purple area the size of a golf ball slightly raised above the bridge of the nose on the forehead. The resident verbally complained of her head hurting. During interview with Resident 1 on July 22, 2025, at approximately 11:00 AM the resident could not remember the details of the fall but did recall that she was on her side in bed because she needed incontinence care after a bowel movement, the nurse aide left to obtain washcloths, and she rolled out of bed and landed on her face. Review of information submitted by the facility revealed the physician was contacted following the fall and an order was received to transfer the resident to the emergency room for a CT scan (computerizes tomography an imaging test that helps to detect diseases and injuries). The CT scan revealed an acute fracture of the bony nasal septum (break in the nose that separates the nasal passages). The facility identified that the resident was an assist of two for bed mobility. Employee 1 (nurse aide) was gathering supplies when the resident rolled from the bed to the floor. Employee 1 confirmed that she left Resident 1 on her side in the bed while she went to the bathroom to get washcloths, and the resident rolled off the side of the bed. Employee 1 (nurse aide) was educated and suspended upon investigation. An interview with the Director of Nursing (DON) on July 22, 2025, at approximately 12:30 PM confirmed that Resident 1 should not have been left alone during care which resulted in the resident rolling out of bed onto the floor. This deficiency is cited as past non-compliance. The facility's corrective action plan was to transport Resident 1 to the emergency room. The facility investigated and determined the resident was left unattended in bed by Employee 1 (nurse aide) ultimately leading to the resident falling out of bed. The facility's corrective action plan included current alert and oriented residents with a status of assist of two for bed mobility were interviewed to ensure repositioning and care was being performed per the residents' plan of care/Kardex (a system for organizing and accessing resident information). An audit was completed of current residents' bed mobility/Kardex to ensure accuracy. Skin checks were performed on residents with assist times two for bed mobility by the licensed nurse to ensure there were no new skin observations related to bed mobility or care. To prevent this from reoccurring nursing staff were re-educated to following the care plan/Kardex for resident care and the facility Abuse and Neglect Policy. To monitor and maintain ongoing compliance the DON or designee will audit five random resident care interactions to ensure the plan of care is being followed for bed mobility staff assistance and bed positioning, five days a week times one week, then three days per week times one week, then weekly times one month. The facility's corrections were completed on July 20, 2025, which was verified during the survey of July 22, 2025. 28 Pa. Code 211.12 (d)(1)(5) Nursing Services