

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: 395542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Mountain Top Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of select facility policies and procedures, and staff and resident interviews, the facility failed to provide Resident 34, who was dependent on staff for activities of daily living (ADLs), with the care and services necessary to maintain proper personal hygiene and grooming, including nail care and monitoring of a contracted hand. As a result of this failure, the resident developed an open wound to the palm that required treatment and caused pain. This deficient practice resulted in actual harm for one of 29 residents reviewed (Resident 34). Findings include: A review of the facility policy entitled Bath, Shower/Tub last reviewed by the facility on February 2, 2026 indicates it is the policy of the facility to provide residents with a bath/shower to promote cleanliness, provide comfort to the resident, to observe the condition of the resident's skin, to provide residents with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. Step 20 indicates the staff is to dry the resident from head to waist before assisting him or her from the tub or shower. The staff is then instructed to observe the resident's skin for any rashes, reddened areas, skin discoloration, etc. A review of the facility procedure entitled, Fingernails/Toenails, Care of last reviewed by the facility on February 2, 2026, revealed the purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections. In preparation staff are to review the resident's care plan to assess for any special needs of the resident. The procedure is outlined as follows: Place the equipment on the bedside stand or overbed table. Arrange supplies so they can be easily reached. Wash and dry hands thoroughly. Fill wash basin one-half full of warm soapy water. Allow the first hand to soak in the warm soapy water for approximately 5 minutes. Encourage the resident to exercise his or her fingers while they are soaking. Rinse the hand that has been in the soapy water with clear, warm water. Dry the hand with a towel. Gently, remove the dirt from around and under each nail with an orange stick (small wooden tool made from orange wood to clean underneath the nails). Trim fingernails in an oval shape. Smooth the nails with a nail file or emery board, then repeat the procedure to the other hand. The facility policy guides staff to document the following: The date and time that the nail care was given, the name and title of the individual administering the nail care, the condition of the resident's nails, any redness or irritation of the skin on the hands, breaks or cracks in the skin, pain, any difficulties cutting the resident's nails, any problems or complaints made by the resident with his/her hands, and documentation of refusal or reason why the intervention was not completed. A review of the clinical record revealed Resident 34 was admitted to the facility on [DATE], with diagnoses including reduced mobility and chronic obstructive pulmonary disease (a progressive lung disease that causes airflow limitation and shortness of breath). A review of Resident 34's Annual MDS Assessment (Minimum Data Set, a federally mandated standardized assessment process completed periodically to plan resident care) dated November 12, 2025, revealed the resident was totally dependent on staff assistance for bathing and required moderate assistance of staff members for personal hygiene, which can include combing hair, shaving, brushing teeth, applying makeup, and washing/drying face and hands. The MDS revealed the resident was cognitively intact as evidenced by (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 395542	Facility ID: 395542 If continuation sheet Page 1 of 36

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F 0677 Level of Harm - Actual harm Residents Affected - Few	a BIMS score of 15 (Brief Interview for Mental Status is a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognitively intact). A review of Resident 34's clinical record revealed a history of contracted right and left hands (a condition in which fingers are fixed in a bent position, commonly toward the palm, due to tightening of tissue beneath the skin). An orthopedic evaluation dated December 9, 2025, confirmed flexion contractures (chronic, often painful condition where a joint, most commonly the knee, hip, or finger, becomes stiff and stuck in a bent or flexed position, resisting active or passive straightening) of digits three through five of both hands. Resident 34's care plan, initiated January 11, 2025, identified self-care deficits and required two staff members to assist with bathing due to shortness of breath, weakness, and cognitive impairment. The goal of this focus was that the resident will accept assistance during bathing or showering. The plan included bilateral carrot splints (a cylindrical device placed in the palm to separate fingers, reduce skin breakdown, and promote hygiene) to both hands at night. The care plan also documented the resident preferred showers. A revised care plan dated March 18, 2025, directed staff to check nail length and trim and clean nails on bath days and as necessary. A physician order dated February 8, 2025, required a weekly licensed nurse skin inspection every Saturday evening during the 3:00 PM to 11:00 PM shift. A review of Resident 34's December 2025 Treatment Administration Record (TAR) revealed a skin inspection on Saturday December 13, 2025, was completed; however, the clinical record did not contain documentation describing the results of those assessments. The record did not reflect assessment of the contracted fingers or nail condition. The TAR for January 2026, revealed a skin inspection was signed off as completed on January 3, 2026, January 10, 2026, January 24, 2026, and January 31, 2026. The clinical record did not have a full assessment of the skin documented. The clinical record could not support any documentation of results of the skin inspection. A review of Resident 34's clinical record indicated that from December 1, 2025, to the end of survey February 20, 2026, the resident did not exhibit any behaviors related to refusing assistance with care. A review of the Documentation Survey Reports for November 2025 through February 2026 revealed the facility failed to document required shift skin observations for Resident 34 on the following dates and shifts: November 1, 2025-night shiftNovember 6, 2025-night shiftNovember 8, 2025-day shiftNovember 8, 2025-night shiftNovember 9, 2025-day, evening, and night shiftsNovember 19, 2025-night shiftNovember 23, 2025-day shiftNovember 30, 2025-night shiftJanuary 4, 2026-night shiftJanuary 6, 2026-evening shiftJanuary 9, 2026-night shiftFebruary 5, 2026-day shiftFebruary 6, 2026-night shiftFebruary 8, 2026-night shiftFebruary 11, 2026-night shiftFebruary 15, 2026-night shift Additional review revealed that on documented shifts, staff consistently recorded no new skin issues; however, the clinical record did not contain evidence that staff assessed the contracted fingers or the palm area where the injury later developed. An interview with Resident 34 conducted on February 17, 2026, at 12:34 PM revealed the resident prefers showers over bed baths, Resident 34 stated that when staff are busy, they give her a bed bath because it is quicker than providing her with a shower, due to her needing mechanical lift assistance for transfers. A review of the Documentation Survey Reports for November 2025, December 2025, January 2026, and February 2026 revealed the facility provided Resident 34 with bed baths on the following dates, despite documentation in the care plan that the resident preferred showers: November 1, 2025; November 5, 2025; November 15, 2025; November 19, 2025; November 26, 2025; December 6, 2025; December 10, 2025; December 13, 2025; January 7, 2026; January 10, 2026; January 24, 2026; January 31, 2026; February 7, 2026; February 11, 2026; February 14, 2026; and February 18, 2026. Review of the Documentation Survey Reports revealed staff provided Resident 34 with a shower three times in November 2025, four times in December 2025, three times in January 2026, and one time in February 2026. Between November 2025 and the survey end date, the facility scheduled Resident 34 to receive 32 showers. The facility provided only 11 of the 32 scheduled showers. The clinical record did not contain documentation that Resident 34 refused showers on the dates bed baths were provided. A review of Resident 34's clinical record from (continued on next page)		

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F 0677 Level of Harm - Actual harm Residents Affected - Few	November 2025 through the survey end date did not contain documentation that staff provided nail care as required by facility policy and the resident's care plan. An interview with Resident 34 on February 18, 2026, at 9:00 AM, revealed Resident 34 stated that when staff provided showers, they washed the tops of her hands but did not wash underneath her contracted fingers. Resident 34 stated that her contractures are painful, and that the right hand was more painful than the left and had worsened recently. Resident 34 stated she informed staff that her hands were painful and that staff don't do much with my hands. She stated that therapy provided carrot splints to be inserted at nighttime. She reported she could not independently insert the splint into her right hand and that staff did not assist her by lifting her fingers to place the splint between her fingers and palm as directed. The clinical record contained no documentation of nail care from November 2025 through the survey end date of February 20, 2026. An observation on February 19, 2026, at 2:38 PM with the assistance of Employee 4, LPN (licensed practical nurse), Employee 4, separated the resident's contracted fingers on her right hand, the surveyor observed a strong foul odor, thickened and elongated mycotic (common fungal infections causing nails to become thick, brittle, and yellow or white, often separating from the bed) fingernails, and the middle fingernail curling into the palm of the contracted hand. An open skin area was identified in the mid-palm region. Measurement of the open area revealed 1.2 cm in greatest width where the nail had embedded. Following identification of the open area and fungal involvement to the palm of Resident 34's right hand on February 19, 2026, the facility obtained physician orders dated February 20, 2026, directing staff to cleanse the palms of both hands with soap and water and apply antifungal powder twice daily. These orders initiated medical treatment for skin breakdown and infection that developed while the resident was dependent on staff for hygiene and nail care. Interview with the Director of Physical Therapy (PT) on February 20, 2026, at 9:32 AM revealed therapy evaluated Resident 34 on January 20, 2026, due to bilateral hand contractures. The Director of PT stated that during the January 20, 2026, assessment, the skin of both hands was intact. Review of the physical therapy documentation dated January 20, 2026, revealed therapy instructed nursing staff to apply bilateral carrot splints to the resident's hands at night. The documentation reflected nursing staff acknowledgment and signature that education was provided. The education included instructions to monitor skin integrity and report any concerns to therapy as indicated. During an interview on February 20, 2026, at 1:00 PM Resident 34 stated staff had not provided nail care and that her fingernails had grown long enough to dig into her palm. The resident stated she used her teeth to tear off the elongated portion of the nail because it was digging into her hand. The resident stated staff washed under her contracted fingers earlier that morning. Resident 34 stated, Staff have never paid this much attention to me before. They usually tell me I have anxiety and leave me alone. The clinical record did not demonstrate that staff consistently provided nail care, routinely inspected the contracted hand for skin integrity, ensured consistent application of bilateral carrot splints as recommended by therapy on January 20, 2026, or timely identified developing skin breakdown. Therapy documented that the skin was intact on January 20, 2026. On February 19, 2026, an open area measuring 1.2 cm in greatest width was identified on the resident's palm. Resident 34 required staff assistance with activities of daily living due to bilateral hand contractures. The facility did not demonstrate consistent implementation of care plan interventions to maintain proper grooming, nail care, and hand hygiene for this dependent resident. As a result of the facility's failure to consistently provide necessary ADL assistance and monitor skin integrity, Resident 34 developed an open skin area on the palm caused by elongated fingernails pressing into the contracted hand. The open area required cleansing and treatment, and the resident reported pain. This failure resulted in actual harm to the resident, as evidenced by the development of a measurable open wound (1.2 cm), the need for clinical treatment, and the resident's report of pain. During an interview conducted on February 20, 2026, at 1:50 PM, the Nursing Home Administrator and Director of Nursing reviewed these findings. The facility did not provide documentation demonstrating consistent provision of required care and services or timely identification of the resident's hand injury. 28 Pa. Code 211.5(f) (continued on next page)		

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Clinical records. 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12(a)(c)(d)(5) Nursing services.		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility policies, and staff interviews, the facility failed to ensure a resident who entered the facility with existing pressure-related skin damage received necessary care and services to prevent additional pressure injuries and prevent worsening of existing wounds. This failure resulted in actual harm, unstageable to Stage 4 pressure areas, for one of 29 residents reviewed (Resident 11.) Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States, Clinical Practice Guidelines, indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of a facility policy entitled Prevention of Pressure Injuries, last reviewed by the facility on February 2, 2026, revealed it is the facility's policy to use a standardized pressure injury screening tool to determine and document resident risk factors for developing pressure injuries, inspect skin on a daily basis when performing or assisting with personal care or activities of daily living (ADLs), establish and implement a nutritional care plan for any resident at risk of malnutrition, monitor the resident for weight loss and intake of food and fluids, and select appropriate support surfaces and pressure redistribution interventions based on the resident's risk factors. A pre-admission external provider wound note dated October 7, 2025, indicated recommendations for Resident 11 to be repositioned every two hours and to utilize pillows or wedges to offload pressure while in bed. A clinical record review revealed Resident 11 was admitted to the facility on [DATE], with diagnoses that included pressure-induced deep tissue damage of the sacrum (damage to the skin and underlying tissue caused by prolonged pressure, often over bony prominence) and chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated October 16, 2025, revealed that Resident 11 was severely cognitively impaired with a BIMS score of 4 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00 to 7 indicated severe cognitive impairment). A care plan initiated November 6, 2025, identified risk for impaired skin integrity related to impaired cognition and interventions implemented directed staff to turn and reposition as needed, consult dietitian as needed, and elevate heels off the mattress. A second care plan initiated November 19, 2025, identified altered nutritional status and underweight condition for age and directed staff to provide feeding/dining assistance, monitor weight, notify physician and dietitian of significant changes, and refer to occupational therapy and speech pathology services for evaluation and treatment as needed. A physician order dated October 9, 2025, required offloading heels (keeps heels elevated off bed or surface so no weight rests on them, which prevents reduced blood flow and helps avoid pressure injuries) while in bed every shift for heel protection. The facility discontinued the order November 1, 2025, when Resident 11 was hospitalized from [DATE], through November 3, 2025, and did not renew the order upon readmission November 3, 2025. A review of the documentation survey (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	reports (record of interventions and tasks implemented) and treatment administration record for November 1, 2025, through January 2026, revealed no documented evidence that Resident 11's heels were elevated off the mattress as indicated in the plan of care. Clinical records also contained no documentation staff implemented routine turning and repositioning interventions to reduce Resident 11's risk of developing pressure injuries from November 2025 through January 2026. Staff documented repositioning only as a non-pharmacological intervention before administering pain medication rather than as a scheduled preventive intervention. A Braden Scale assessment (a standardized clinical assessment that measures risk of pressure injury based on sensory perception, moisture, activity, mobility, nutrition, and friction) dated December 20, 2025, indicated moderate risk for pressure injury. Clinical record review revealed Resident 11 experienced clinically significant, unplanned weight loss following admission. The resident lost more than 5 percent of body weight within 30 days and a total of 10 percent within four months. A body mass index of 19.5 kg/m² indicated the resident was underweight for advanced age. Although the registered dietitian (RD) initiated protein supplementation, the facility did not document consistent weight monitoring and did not implement additional nutritional interventions despite continued decline. Unplanned weight loss and undernutrition reduce subcutaneous tissue and muscle mass that normally cushion bony prominences such as the heels. Loss of protective tissue increases susceptibility to pressure-related tissue damage. A progress note dated January 8, 2026, at 5:09 PM documented therapy staff identified Resident 11 had open draining wounds on both heels. The left heel measured 3.5 cm by 1.5 cm, and the right heel measured 5.0 cm by 3.5 cm with moderate sanguineous drainage, meaning blood-tinged fluid. Staff applied treatment, elevated heels, and notified the physician and representative. A progress note dated January 13, 2026, at 1:50 PM documented evaluation by an external wound care provider. The provider noted protective heel boots at bedside and nursing staff reported the resident refused to wear them. The provider recommended protective heel boots when out of bed and heel offloading while in bed. The clinical record from admission October 9, 2025, through January 13, 2026, contained no documented evidence staff implemented heel boots and no documentation that the Resident 11 refused to wear them. A pressure injury, also called a pressure ulcer or bedsore, is damage to skin and underlying tissue caused by prolonged pressure that reduces blood flow, usually over bony areas such as heels or the sacrum. Stages indicate severity: Stage 3: Full thickness skin loss with visible fat tissue. Stage 4: Full thickness tissue loss exposing muscle, tendon, or bone. Unstageable: Depth cannot be determined because dead tissue covers the wound. A review of external wound care provider notes dated January 13, 2026, through February 17, 2026, revealed that Resident 11's bilateral heel injuries were assessed as: January 13, 2026, right heel- unstageable measuring 6.0 cm x 3.3 cm x 0.1 cm January 20, 2026, right heel- unstageable measuring 3.0 cm x 3.0 cm x 0.1 cm January 27, 2026, right heel- unstageable measuring 3.4 cm x 3.2 cm x 0.1 cm February 3, 2026, right heel- unstageable measuring 2.5 cm x 3.0 cm x 0.2 cm February 10, 2026, right heel- unstageable measuring 3.0 cm x 3.0 cm x 0.2 cm February 17, 2026, right heel- unstageable measuring 2.5 cm x 2.5 cm x 0.2 cm January 13, 2026, left heel- unstageable measuring 2.0 cm x 4.0 cm x 0.1 cm January 20, 2026, left heel- unstageable measuring 1.6 cm x 1.5 cm x 0.1 cm January 27, 2026, left heel- unstageable measuring 1.5 cm x 1.5 cm x 0.1 cm February 3, 2026, left heel- unstageable measuring 1.1 cm x 1.1 cm x 0.1 cm February 10, 2026, left heel- stage 4 measuring 1.0 cm x 1.1 cm x 0.1 cm February 17, 2026, left heel- stage 3 measuring 0.9 cm x 0.7 cm x 0.1 cm This documentation demonstrates progression from unstageable tissue damage to a Stage 4 pressure injury, indicating full thickness tissue loss exposing deeper structures. Clinical records reviewed through survey completion date of February 20, 2026, contained no documented evidence staff implemented the external wound care provider's January 13, 2026, recommendations for heel boots or heel offloading. During wound care observation February 20, 2026, at 10:58 AM, Employee 1, Licensed Practical Nurse (LPN) measured the right heel wound at 2.5 cm x 2.0 cm x 0.1 cm with a pink/red wound bed with slough (a type of soft, moist, dead tissue, typically yellow, tan, gray, or white in (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policies, physician orders, weight records, MDS assessments, and staff and resident interviews, it was determined the facility failed to ensure residents maintain acceptable parameters of nutritional status to the extent possible. The facility failed to reassess and adjust enteral nutrition and oral intake in response to significant progressive weight loss for one resident (Resident 31), resulting in actual harm as evidenced by a 36.8 pound (21.1 percent) unplanned weight loss in two months. The facility further failed to timely monitor weights and implement interventions for one resident (Resident 11), resulting in continued significant weight loss and development of bilateral unstageable pressure injuries and failed to obtain ordered monthly weights for one resident (Resident 15). These failures occurred for 3 of 29 residents reviewed. Findings include: Review of the facility Enteral Nutrition Policy (tube feeding, liquid nutrition delivered through a tube into the gastrointestinal tract) last reviewed February 2, 2026, indicated that adequate nutritional support through enteral nutrition is provided to residents as ordered. The dietitian with input from the provider and nurse estimates calorie, protein, and fluid needs, determines whether the resident's current intake is adequate to meet his or her nutritional needs, recommends special food formulations, and calculates fluids to be provided (beyond free fluids in formula). The dietitian monitors residents who are receiving enteral nutrition and makes appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. Review of the facility Weighing and Measuring the Resident Policy last reviewed February 2, 2026, indicated that the purpose of the policy is to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of nutritional status and medical condition of the resident, and to provide a baseline height in order to determine the ideal weight for the resident. Weight is usually measured upon admission and monthly during the resident's stay. Report significant weight loss or gain to the nurse supervisor. Notify the nurse supervisor if the resident refuses the procedure. The threshold for significant unplanned and undesired weight loss will be based on: 1 month, 5 percent weight loss is significant, greater than 5 percent is severe3 months, 7.5 percent weight loss is significant, greater than 7.5 percent is severe6 months, 10 percent weight loss is significant, great than 10 percent is severe. A review of a facility policy entitled Nutritional Assessment, last reviewed by the facility on February 2, 2026, revealed it is the facility's policy to conduct a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, for each resident. The registered dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. The policy indicated individualized care plans will be developed that address or minimize to the extent possible the resident's risk of nutritional complications. A clinical record review revealed Resident 31 was admitted to the facility on [DATE], with diagnoses including cerebral infarction (stroke caused by disrupted blood flow to the brain), left-sided hemiplegia (paralysis on the left side of the body), and dysphagia (difficulty swallowing). Physician orders for Resident 31 dated November 17, 2025, directed NPO (nothing by mouth) and Isosource 1.5 at 60 ml/hour (milliliters per hour) continuously via PEG tube (percutaneous endoscopic gastrostomy, a feeding tube inserted through the abdominal wall into the stomach when oral intake is not adequate) with 250 cc (cubic centimeters) water flush every six hours. A review of Resident 31's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 23, 2025, revealed that Resident 31 was moderately cognitively impaired with a BIMS score of 12 (Brief Interview for (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 through 12 indicates moderate cognitive impairment). Review of Resident 31's weight record revealed an initial documented weight on November 20, 2025, (three days after admission) was 169.6 pounds. The resident's height was 5 feet 5 inches. The resident's calculated ideal body weight range was noted to be 144 to 174 pounds. A review of Resident 31's clinical record revealed that on November 24, 2025, staff documented in an SBAR note (Situation, Background, Assessment, Recommendation, a structured communication tool used to report changes in condition) that the resident exhibited edema (swelling caused by excess fluid), fever, and unresponsiveness. The physician ordered transfer to the hospital. The hospital admitted the resident with diagnoses of adult failure to thrive (overall decline in physical functioning and nutritional status) and bilateral pleural effusions (collection of fluid around both lungs that can impair breathing). Resident 31 returned to the facility on December 4, 2025, weighing 174 pounds. Physician orders dated December 4, 2025, directed NPO (nothing by mouth), Isosource 1.5 at 60 ml/hour continuously via PEG tube, 250 cc water flush every six hours, and weekly weights for four weeks. On December 5, 2025, the Registered Dietitian (RD) calculated Resident 31's daily needs as 2059 to 2401 calories, 82 to 102.9 grams of protein, and 2059 to 2401 milliliters of fluid. The RD documented that the current feeding regimen met estimated needs and recommended increasing the feeding rate to 80 ml per hour for 18 hours daily and adding 30 cc liquid protein mixed with 60 cc water via PEG tube for additional nutritional support. A physician order dated December 6, 2025, was implemented for liquid protein 30 cc mixed with 60 cc water via PEG tube daily and on December 8, 2025, implemented Isosource 1.5 ml at 80 ml/hr for 18 hours via PEG begin at 6:00 PM and off at 12:00 PM. Despite these interventions, the resident experienced progressive and severe weight loss as follows: December 4, 2025, 174 poundsDecember 10, 2025, 160.4 pounds (13.6 pound or 7.8 percent significant weight loss in 6 days, no reweight completed, no evidence of physician or RD notification)December 17, 2025, 158.6 pounds December 24, 2025, 146.6 pounds (27.4 pounds or 15.7 percent significant weight loss in 20 days, no evidence of physician or RD notification) December 31, 2025, 144.4 poundsJanuary 4, 2026, 145.2 pounds February 12, 2026, 137.2 pounds, reweight taken and noted as 137.2 pounds (36.8 pounds or 21.1 percent significant weight loss in 2 months and 7 days)February 19, 2026, 138 pounds. On February 2, 2026, nursing staff documented that Resident 31 returned from a video fluoroscopy (an X-ray test used to evaluate how a person swallows food and liquids). The results showed no aspiration (food or liquid entering the airway) and no penetration (food or liquid entering the upper airway but not passing below the vocal cords). Staff notified speech therapy of the results. On the same date, February 2, 2026, the physician ordered a puree diet (foods blended or mashed into a smooth, pudding-like consistency that requires no chewing) with lemon ice on each tray. A review of Resident 31's clinical record revealed no documented evidence that the Registered Dietitian (RD) reevaluated the resident's tube feeding regimen or overall nutritional needs in response to the resident's significant and progressive weight loss between December 5, 2025, and February 10, 2026. During this period, the resident's weight continued to decline substantially. The record contained no documentation that the facility identified this ongoing significant weight loss in accordance with facility policy thresholds or acted promptly to address it. The record lacked documentation that the RD reassessed the adequacy of calories, protein, fluids, or the overall nutritional support plan during this period of rapid decline. On February 10, 2026, eight days after the physician ordered the puree diet, the RD documented awareness that Resident 31 had started a puree diet with thin liquids. The resident reported feeling full from the tube feeding and stated he did not want to eat some meals. The RD reduced the tube feeding to overnight administration at 85 ml/hour for 12 hours from 6:00 PM to 6:00 AM daily, providing 1,530 calories per day. The RD documented that staff would continue to monitor PO intake (PO, meaning by mouth/oral) and weights. On February 12, 2026, after Resident 31's weight reached 137.2 pounds, the RD documented that the resident triggered for significant weight loss within one month. The RD noted (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	minimal oral intake and increased the tube feeding to 90 ml/ hour for 12 hours and increased liquid protein to three times daily to promote nutritional adequacy and weight recovery. The revised tube feeding provided 1,620 calories per day. The RD initiated weekly weights at that time and continue to motor PO intakes and tube feeding tolerance. During an interview on February 19, 2026, Resident 31 stated he did not like puree foods and was not eating much of the diet. He reported his usual weight was at least 165 pounds and expressed concern that he had lost too much weight. The resident's representative confirmed that speech therapy was working with him to improve oral intake and introduce foods that were not pureed. During an interview on February 20, 2026, at 9:00 AM the RD confirmed he began employment on January 26, 2026, and stated that Resident 31's tube feeding, oral intake, and weights are now being monitored to prevent additional weight loss and ensure the resident's nutritional needs are met to the extent possible. The RD confirmed there was no documented evidence that the resident's nutritional needs were reevaluated between December 5, 2025, and February 10, 2026, despite significant weight loss during that period. During an interview on February 20, 2026, at 11:00 AM the Director of Nursing was unable to provide documentation demonstrating the facility timely monitored and reassessed Resident 31's nutritional needs to prevent significant weight loss and maintain nutritional parameters to the extent possible for the resident who was dependent on tube feeding to meet his nutritional needs. The facility's failure to timely identify, reassess, and adjust enteral and oral nutritional interventions in response to documented significant and progressive weight loss resulted in actual harm to Resident 31, as evidenced by a severe 36.8 pound (21.1 percent) unplanned weight loss, reflecting significant nutritional decline in two months. Clinical record review revealed Resident 11 was admitted to the facility on [DATE], with diagnoses that included pressure-induced deep tissue damage of the sacrum (damage to the skin and underlying tissue caused by prolonged pressure, often over bony prominence) and chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). A review of an admission Minimum Data Set assessment dated [DATE], revealed that Resident 11 is severely cognitively impaired with a BIMS score of 4; a score of 0 to 7 indicates severe cognitive impairment. A clinical record review revealed a care plan indicating Resident 11 was at risk for altered nutritional status and was underweight for his age, initiated on November 19, 2025. Interventions implemented to ensure Resident 11 would not have significant weight change included providing feeding and dining assistance as needed, periodically obtaining the resident's weights, evaluating and reporting to the registered dietitian, physician, and family when significant weight changes occur, and referring to occupational therapy and speech pathology services for evaluation and treatment as needed. A clinical record review revealed a care plan indicating Resident 11 has an activities of daily life (ADL) self-care performance deficit initiated on November 6, 2025. Interventions implemented to ensure Resident 11's ADL needs would be met included supervision-level assistance while eating, initiated on November 6, 2025. Resident 11 weighed 154.0 pounds on October 9, 2025, upon admission), and 144.0 pounds on November 4, 2025, reflecting a 6.49 percent weight loss, or 10 pounds, in 30 days. A loss greater than 5 percent in one month constitutes significant weight loss. There was no documented evidence that the facility notified the registered dietitian or that the registered dietitian was aware Resident 11 had significant weight loss until 15 days later on November 19, 2025. A nutritional risk assessment dated [DATE], at 4:45 PM documented that Resident 11 was underweight for advanced age with a body mass index (BMI a numerical value calculated by weight and height that estimates whether body weight is underweight normal or overweight) of 19.5 kg/m2 (kilogram per square meter). Significant weight loss was noted with a 6.5 percent loss over three to four weeks. The assessment indicated Resident 11 was independent with setup provided for meals, with assistance from staff at times. The RD initiated liquid protein twice daily to support weight stabilization and planned continued monitoring and remain available for any nutrition-related needs and concerns. The clinical record did not indicate the physician was notified about Resident 11's significant weight loss as measured on November 4, 2025. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident 11 weighed 144.8 pounds on December 1, 2025. The facility did not document a weight for January 2026, despite facility policy requiring monthly weights. On February 5, 2026, Resident 11 weighed 138.6 pounds, representing a 10 percent loss or 15.4 pounds in less than four months. The clinical record contained no evidence that staff attempted to obtain or document the resident's weight between December 1, 2025, and February 5, 2026, a period of 66 days. The clinical record contained no documented evidence that the facility identified this continued significant weight loss in accordance with facility policy thresholds. The record lacked documentation that staff implemented additional dietary interventions despite ongoing weight decline from December 2025 through February 2026. A progress note dated January 22, 2026, at 4:10 PM documented that a significant weight change could not be determined at that time. The note documented that Resident 11 had bilateral unstageable pressure injuries on his heels. An unstageable pressure injury is a wound covered by dead yellow, tan, brown, or black tissue that prevents visualization of the depth of the wound. The RD documented that the current nutrition plan was appropriate to meet the resident's needs for weight stability or gain and wound healing and indicated she would continue to monitor and remain available for any nutrition-related needs or concerns. Despite the RD documenting that a significant weight loss could not be determined on January 22, 2026, the facility had not obtained a current weight since December 1, 2025. The record contained no evidence that staff attempted to obtain a weight at that time to evaluate the resident's nutritional status. Resident 11's clinical record also lacked documentation that the facility implemented timely interventions after identifying the weight of February 5, 2026, weight. The facility did not initiate further evaluation until February 16, 2026, when speech-language pathology assessed the resident for swallowing dysfunction (difficulty swallowing safely or effectively). An occupational therapy Discharge summary dated [DATE], documented that Resident 11 required moderate assistance with eating, meaning staff provided 50 to 74 percent of the effort required to complete the task. A prior evaluation dated November 4, 2025, documented that the resident required only minimal assistance, meaning staff provided 25 percent or less physical support. such as guiding the utensil, stabilizing a plate, or helping with opening packaging). The clinical record revealed that the resident's care plan did not reflect the updated need for increased assistance with meals. A meal intake review from January 26, 2026, through February 18, 2026, indicated five meals that the resident was documented as independent or setup only and consumed less than 50 percent of the meal. Specifically, Resident 11 consumed 0 to 25 percent of dinner on January 26, 2026, and 26 to 50 percent of meals on January 31, 2026 (dinner), February 1, 2026 (dinner), February 13, 2026 (breakfast), and February 18, 2026 (lunch). The clinical record contained no documentation explaining why staff did not provide additional assistance with meals despite reduced intake and documented therapy recommendations. Following surveyor inquiry, the facility updated the resident's care plan on February 19, 2026, to reflect the need for assistance of one staff member during meals to ensure activities of daily living (basic self-care tasks such as eating) were met. During an interview on February 20, 2026, at 11:50 AM the Nursing Home Administrator was unable to provide documented evidence that the facility implemented timely interventions after identifying Resident 11's significant weight loss of 10 percent in less than 4 months on February 5, 2026. The Nursing Home Administrator was also unable to explain the 66-day lapse in weight monitoring from December 1, 2025, through February 5, 2026, despite the resident developing bilateral unstageable pressure injuries. The facility did not provide documentation demonstrating that the resident's weight loss was unavoidable. A review of the clinical record revealed that Resident 15 has diagnoses including Huntington's disease (an inherited neurological disorder that causes progressive breakdown of nerve cells in the brain, leading to cognitive decline, movement disorders, and functional deterioration). A physician's order dated August 6, 2025, directed staff to obtain monthly weights to monitor for changes in Resident 15's nutritional status. A review of Resident 15's weight record on February 18, 2026, revealed documented weights of 170.2 pounds on October 7, 2025, 169.2 pounds on November 6, 2025, and 176 pounds on December 6, 2025. The facility did not document a weight for January 2026 or February (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	2026, despite the active physician order and facility policy requiring monthly weight monitoring. After surveyor inquiry, staff obtained a weight of 166.2 pounds on February 20, 2026. During an interview on February 19, 2026, at 1:00 PM the Nursing Home Administrator confirmed the facility did not obtain or document Resident 15's January 2026 monthly weight as required. The facility did not provide documentation demonstrating that staff monitored the resident's weight in accordance with physician order and policy to identify potential nutritional decline in a resident with a progressive neurological condition. Refer F68628 Pa Code 211.5 (f) Medical records 28 Pa Code 211.10 (a)(c)(d) Resident care policies 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing Services		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on a review of clinical records and resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes and enhances each resident's dignity and quality of life by failing to respond in a timely manner to residents' requests for assistance, including experiences reported by 5 out of 6 residents during a resident group interview (Residents 19, 58, 64, 80, and 101). Findings include: During a resident group interview on February 19, 2026, at 10:00 AM, five out of six alert and oriented residents (Residents 19, 58, 64, 80, and 101) indicated that they have concerns about long wait times for care. One out of the six residents in attendance indicated that she is independent and does not need to ring her call bell for staff assistance. During the group interview, Resident 64 indicated that he often waits 30 minutes to an hour for staff to assist him when he rings his call bell for assistance. He explained that this has been an ongoing concern. During the group interview, Resident 101 indicated that she usually waits 30 minutes for staff to respond to her needs for care. Resident 101 explained that she gets frustrated when staff come into her room, turn her call bell off, and do not provide care, because they often do not return until she rings the call bell again for assistance. During the group interview, Resident 80 indicated that she experiences long wait times for care but was unable to provide information on how long she waits. She explained that there is not enough staff to get her up on the day shift, so she has staff on the night shift assist her out of bed and get ready for the day at 5:30 AM. During the group interview, Residents 19 and 58 indicated that they wait 30 minutes for staff to respond to their call bell for assistance. They indicated they know staff are busy providing care for residents throughout the facility but are frustrated with the long wait times they experience for care. During an interview on February 20, 2026, at 11:30 AM, the above information was reviewed with the nursing home administrator (NHA). The NHA was unable to explain why residents are reporting untimely staff responses to residents' requests for assistance and care. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(4) Nursing services.		

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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 observation and resident and staff interviews, it was determined the facility failed to provide housekeeping and maintenance services to maintain a clean and orderly environment in resident areas in two of two shower rooms. Findings included: Interview with Resident 7, a cognitively intact resident, on February 18, 2026, at 11:30 AM revealed a concern with the floor in the shower room being black. Resident 7 also stated that the shower room often has a foul odor. Observation of the Unit 2 shower room on February 18, 2026, at 11:40 AM revealed a faded, heavily worn floor with a 14 inch by 7 inch black oval area on the floor leading into the shower stall and peeled paint on the floor of the shower stall (first stall located closest to the entry door of the shower room). There was a two inch by one inch piece of plastic laminate missing from the front corner of the sink area in the shower room. Observation of the Unit 1 shower room on February 18, 2026 at 1:30PM revealed the shower floor to have a build up of what appeared to be soap scum on the shower floor, the shower floor was observed to be lined with anti-slip strips black in color, with a total of 14 strips in place, 7 of the 14 strips were lifted on the sides and not intact. The anti-slip strips appeared to be worn and not in place, defeating the purpose of the anti-slip action. Two of the strips appeared to have black hair attached to the sides of the strips that were lifting up. An observation of the bariatric shower bed (a padded bed used to assist in showering dependent bariatric/large residents) located in the Unit 1 bathroom revealed the shower bed was dry and visibly not in use, the shower bed was observed to have a buildup of powder in the corners of the bed. Interview with the Nursing Home Administrator (NHA) on February 18, 2026, at 2:00 PM confirmed the black on the floor was an epoxy (resin and hardener used as a protective coating on floors) that was used to repair the floor in the past, did not match the floor color, and was not applied in a manner to maintain a homelike interior. The NHA confirmed the facility's environment should be kept in good repair and maintained in a clean and homelike manner. Interview with the Director of Nursing on February 19, 2026, at 10:00 AM reviewed the above findings of the facility's failure to ensure both shower rooms were homelike, clean, and maintained. 28 Pa Code 201.18(e)(2.1) Management		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and resident and staff interviews, it was determined the facility failed to provide person-centered care as prescribed to meet the current clinical needs and failed to follow physician orders for the management of a Central Venous Catheter (CVC) and Peripherally Inserted Central Catheter (PICC) line for two of 29 sampled residents (Residents 3 and 75). Findings include: A review of the facility policy entitled Central Venous Catheter Care and Dressing Changes, last reviewed February 2, 2026, indicated the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. Change the dressing if it becomes damp, loosened, or visibly soiled, at least every seven days, and immediately if the dressing or site appears compromised. For PICCs (peripherally inserted central catheter, a thin, flexible tube that is inserted into a large vein to the heart to deliver medications and other therapies into the bloodstream), measure arm circumference and compare to baseline when clinically indicated to assess for edema (swelling caused by fluid accumulation) and possible deep-vein thrombosis (a blood clot in a deep vein). The policy required staff to report signs and symptoms of complications to the physician, supervisor, and oncoming shift. A review of the facility policy entitled Administration Set/Tubing Changes, last reviewed February 2, 2026, revealed it is the policy to change the primary or secondary intermittent (IV tubing used to deliver medications that are not running continuously) administration sets every twenty-four hours or if suspected contamination of tubing has occurred and label the tubing with the date, time, and initials. Place a sterile end cap (a protective sterile cover placed on IV tubing to prevent contamination) on the primary and/or secondary intermittent tubing when it is disconnected from the catheter. A review of the facility policy entitled Administering Medications, last reviewed February 2, 2026, revealed it is the policy that medications are administered in a safe and timely manner and as prescribed. A review of the clinical record of Resident 3 revealed the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of an Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 26, 2026, revealed that Resident 3 had moderately impaired cognition with a BIMS score of 12 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 to 12 indicates cognition is moderately impaired). A review of outside hospital documentation revealed that Resident 3 had a central venous catheter (a sterile, flexible tube inserted into a large vein, typically in the chest, to administer medications directly into the bloodstream) was inserted into the resident's right chest on January 30, 2026. Physician orders dated February 1, 2026, directed staff to maintain a PICC line and keep an emergency kit (sterile materials and clamps to stop bleeding and cap the catheter to reduce the risk of air entering the bloodstream) at the bedside. An additional physician order dated February 1, 2026, directed staff to change the central venous line dressing and caps every seven days and as needed. A physician order dated February 10, 2026, directed staff to administer Ampicillin (an antibiotic medication used to treat bacterial infections) 2 grams intravenously every six hours until March 10, 2026, for a bacterial infection related to a right knee prosthetic (implanted artificial joint) infection. On February 18, 2026, at 11:00 AM, observation of Resident 3 revealed the central line in the right chest had no dressing in place (a sterile dressing protects the catheter insertion site from environmental contamination and reduces infection risk). Resident 3 stated the dressing had fallen off, did not know how long it had been off, (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and had not notified staff. At that time, observation of the IV pole revealed an empty antibiotic bag attached to IV tubing that was not labeled with a date, time, or initials. The tubing was hanging freely without a sterile end cap on the distal end. Employee 3, Licensed Practical Nurse (LPN), confirmed these observations. A review of the clinical record of Resident 75 revealed the resident was admitted to the facility on [DATE], with diagnoses that included cauda equina syndrome (a rare surgical emergency caused by severe compression of nerve roots at the base of the spinal cord) and osteomyelitis (a bone infection). A review of an admission MDS dated [DATE], revealed that Resident 75 had moderately impaired cognition with a BIMS score of 11 (a score of 8 to 12 indicates cognition is moderately impaired). Outside hospital documentation dated January 30, 2026, revealed a PICC line was inserted in the resident's right arm. Physician orders dated January 30, 2026, directed staff to change the PICC dressing and caps every seven days and as needed. Observation on February 18, 2026, at 12:30 PM, in the presence of Employee 3, LPN, revealed the PICC dressing was dated February 8, 2026. The dressing should have been changed on February 15, 2026, in accordance with the seven-day requirement. Employee 3 acknowledged the dressing was overdue. A second observation on February 19, 2026, at 9:00 AM, revealed the dressing remained dated February 8, 2026, and had not been changed. A review of the February 2026 Treatment Administration Record (TAR) revealed the dressing change scheduled for February 15, 2026, was not signed and left blank. A physician order for Resident 75 dated November 8, 2025, directed staff to administer Cefepime HCL (a broad-spectrum intravenous antibiotic used to treat serious bacterial infections) 100 grams intravenously three times daily until March 5, 2026. A review of Resident 75's February 2026 Medication Administration Record (MAR) revealed the following doses were left blank and not signed as administered: February 7, 2026, at 10:00 PM, February 11, 2026, at 2:00 PM, February 12, 2026, at 2:00 PM, February 13, 2026, at 10:00 PM, February 16, 2026, at 10:00 PM. Blank entries on the MAR indicate the facility did not document administration of ordered IV antibiotics. A physician order for Resident 75, dated January 30, 2026, directed staff to measure and document the circumference of the upper arm at the PICC insertion site every evening shift. Measuring arm circumference identifies swelling that may indicate infection or thrombosis. A review of the February 2026 MAR revealed: Arm circumference measured 22 centimeters from February 1, 2026, through February 6, 2026. February 7, 2026, was left blank. Measurements remained 22 centimeters from February 8 through February 15, 2026. February 16, 2026, was left blank. February 17, 2026, measured 22 centimeters. February 18, 2026, measured 25 centimeters. February 19, 2026, was left blank. Following surveyor inquiry, Employee 3 measured the resident's arm circumference on February 20, 2026, at 10:40 AM, and obtained a measurement of 27 centimeters. This reflected a 5-centimeter increase from the documented baseline of 22 centimeters. Employee 3 stated she was unsure why there was a discrepancy in measurements, why the increase was not investigated, and why the physician was not notified. During interviews on February 19 and February 20, 2026, the Director of Nursing reviewed and confirmed the above findings regarding Resident 3's central venous catheter and Resident 75's PICC line management. The facility failed to follow its own policies and physician orders related to sterile dressing maintenance, tubing changes, antibiotic administration, monitoring of catheter sites, documentation, and physician notification. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on a review of scheduled facility mealtimes, select facility policy, and resident and staff interviews, it was determined the facility failed to consistently provide snacks as desired by residents, including experiences reported by six out of six residents during a group interview (Residents 6, 19, 58, 64, 80, and 101). Findings include: A review of the facility policy titled Dining Options for Meal Service, last reviewed by the facility on February 2, 2026, revealed it is the facility policy that meals will be served regularly according to the community schedule of dining times, with no more than 14 hours between the time the evening meal is offered and the breakfast meal is offered. The policy indicates that an HS snack (evening snack) must be offered to all residents. A review of the facility's scheduled mealtimes revealed that the time between dinner and breakfast the next day exceeds 14 hours. Specifically, residents eating in the dining room are scheduled to receive dinner at 5:00 PM. Breakfast is served in resident rooms with: Nursing Unit 2 resident rooms 80 to 93 are scheduled to receive breakfast at 7:15 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 15 minutes. Nursing Unit 1 resident rooms 1 to 36 are scheduled to receive breakfast at 7:30 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 30 minutes. Nursing Unit 2 resident rooms 60 to 78 are scheduled to receive breakfast at 7:45 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 45 minutes. Nursing Unit 1 resident rooms 37 to 57 are scheduled to receive breakfast at 8:00 AM. The scheduled time between dinner and breakfast the next day is 15 hours. During a resident council interview on February 19, 2026, at 10:00 AM, six out of six residents (Residents 6, 19, 58, 64, 80, and 101) indicated that a snack is not offered between dinner and breakfast the following day. Resident 6 explained that only one nurse offers snacks to residents in the evening, and she is not a regular nurse. Residents 19, 58, 64, 80, and 101 explained that they are not offered evening snacks. During an interview on February 20, 2026, at approximately 11:30 AM, the above information was reviewed with the nursing home administrator (NHA). The NHA was not able to provide documented evidence that snacks were consistently offered to residents in the evening. The NHA confirmed it is the facility's policy to offer residents nourishing snacks in the evening. 28 Pa. Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.		

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NAME OF PROVIDER OR SUPPLIER Mountain Top Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 185 South Mountain Boulevard Mountain Top, PA 18707	
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of clinical records, and select facility policy and staff interview, it was determined the facility failed to ensure that self-administration of medications was clinically appropriate for one of the 29 residents sampled (Resident 58). Findings include: A review of facility policy titled Self-Administration of Medications, last reviewed by the facility February 2, 2026, revealed residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and care plan. A clinical record review revealed Resident 58 was admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease(a progressive lung disease, primarily caused by smoking, that causes long-term breathing problems like chronic cough, wheezing, and shortness of breath) and emphysema (a chronic, progressive obstructive lung disease caused primarily by smoking, which destroys the alveoli (air sacs) and reduces lung elasticity, trapping air and limiting oxygen intake). A review of a Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 26, 2025, revealed that Resident 58 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A clinical record review revealed a physician's order for Resident 58 to receive Deep Sea Nasal Solution, directed to take 1 spray in both nostrils one time a day for a dry nose. The clinical record revealed a physician's order for Resident 58 to receive Trelegy Ellipta Inhalation Aerosol Powder Breath inhaler, to be administered 1 puff orally one time a day for COPD. During an observation on February 18, 2026, at 12:15 PM, Resident 58 was observed ambulating in her room. On the bedside table the Trelegy inhaler and the deep-sea nasal solution and a tube of hydrocortisone cream 1% was observed. An interview with Resident 58 conducted at the time of observation revealed the staff leave her medications for her and when she is finished, she walks the medication back to the medication cart so the medication can be stored. The interview revealed the hydrocortisone cream was given to the resident from her dermatologist and that she does not return the cream to the cart, that it is always at her bedside and she uses it on her skin when she feels she needs to. A clinical record review failed to reveal documented evidence indicating Resident 58 was assessed and deemed clinically appropriate and safe to self-administer her own medications. In addition, the clinical record did not reveal an order for hydrocortisone cream 1%. A review of the clinical record did not reveal any outpatient visits that could confirm an order for the hydrocortisone cream. During an interview on February 18, 2026, at 1:30 PM, with Employee 6, Registered Nurse, it was confirmed Resident 58 did not have an active order to self-administer medication. The interview revealed the resident should not have had the medications left at the bedside and did not have an active order for self-administration of medication. An interview with the Director of Nursing conducted on February 19, 2026, at 10:00AM reviewed the above findings of the facility's failure to assess Resident 58 to ensure she could safely self-administer medications as required in the facility policy. 28 Pa Code: 211.9 (a)(1) Pharmacy services. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa Code 211.12 (d)(1)(5) Nursing services.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, and staff interviews, the facility failed to ensure residents' rights to formulate and have advance directives implemented. The facility failed to maintain accurate and consistent documentation of residents' resuscitation status by failing to revise a comprehensive care plan to reflect the resident's current code status (Resident 3), ensure physician orders reflected the resident's documented resuscitation wishes (Resident 75), and obtain and maintain a completed Physician Orders for Life-Sustaining Treatment (POLST) form consistent with a physician's Do Not Resuscitate (DNR) order (Resident 103), for 3 of 29 residents reviewed. Findings include: A review of a facility policy titled Advance Directives, last reviewed by the facility on February 2, 2026, revealed it is the facility policy that the resident has the right to formulate an advance directive, including the right to accept or decline or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Further review revealed that a Physicians Orders for Life-Sustaining Treatment (POLST) paradigm form is designed to improve resident care by creating a portable medical order form that records residents' treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency. A review of a facility policy titled Do Not Resuscitate Order, last reviewed by the facility on February 2, 2026, revealed it was the facility policy that in addition to the advance directive or Do Not Resuscitate order (DNR a medical order directing that cardiopulmonary resuscitation, a life-saving procedure performed when the heart or breathing stops, should not be attempted with a goal of allowing a natural death), state-specific forms may be used to specify whether to administer CPR in case of a medical emergency, and state-specific forms include a POLST form. A review of the clinical record of Resident 3 revealed the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of an Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated [DATE], revealed that Resident 3 had moderately impaired cognition with a BIMS score of 12 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 to 12 indicates cognition is moderately impaired). A review of the Resident 3's comprehensive care plan, initiated [DATE], and most recently revised February 13, 2026, identified the resident's code status (overall medical directive that specifies what life sustaining interventions should be initiated if a resident experiences a cardiac or respiratory arrest when breathing stops or the heart stops beating) as DNR, with an established goal that the resident's code status preference would be honored. However, a review of a physician's order for Resident 3 dated [DATE], identified an order for Full Code status, indicating CPR should be attempted in the event of cardiopulmonary arrest. Further review of a POLST form dated [DATE], indicated the resident elected CPR/Attempt Resuscitation in the event of cardiopulmonary arrest. The facility did not revise Resident 3's comprehensive care plan to reflect the resident's Full Code status until February 19, 2026, following surveyor inquiry. As a result, the care plan did not accurately reflect the resident's most current resuscitation preference for over two months. A review of the clinical record of Resident 75 revealed the resident was admitted to the facility on [DATE], with diagnoses that included cauda equina syndrome (a rare surgical emergency caused by severe compression of nerve roots at the base of the spinal cord) and diabetes. A review of an admission MDS dated [DATE], revealed that Resident 75 had moderately impaired cognition with a BIMS score of 11 (a score of 8 to 12 indicates cognition is (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moderately impaired). A review of Resident 75's clinical record revealed a completed and signed POLST dated February 9, 2026. The POLST indicated the resident elected CPR/Attempt Resuscitation status, and CPR was to be performed in the event of cardiopulmonary arrest. A review of Resident 75's current physician orders through the end of the survey on February 20, 2026, did not identify any physician order addressing code status. The facility did not ensure that physician orders reflected the resident's elected Full Code status as documented on the POLST, resulting in the absence of a corresponding medical order in the record. A review of the clinical record of Resident 103 revealed the resident was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (brain damage that results from a lack of blood) and depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time). A review of an admission MDS assessment dated [DATE], revealed that Resident 103 had moderately impaired cognition with a BIMS score of 11 (a score of 8 to 12 indicates cognition is moderately impaired). A review of Resident 103's current physician orders revealed an order dated [DATE], in the electronic health record and identified the resident's code status as DNR, indicating CPR was not to be performed in the event of cardiopulmonary arrest. However, review of Resident 103's POLST dated [DATE], revealed the form was incomplete. Section A, which requires documentation of whether the resident elects CPR or DNR status, was left blank. The facility did not ensure the POLST form was completed to reflect the physician's DNR order. On February 20, 2026, following surveyor inquiry, the facility obtained an updated POLST reflecting DNR status, signed by Resident 103's representative. On February 20, 2026, at 10:00 AM, the Director of Nursing confirmed the above findings for Residents 3, 75, and 103. The facility failed to maintain consistent, accurate, and complete documentation of residents' resuscitation preferences across care plans, physician orders, and POLST forms. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.5 (f)(i) Medical records. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, investigative documentation provided by the facility, and staff interviews, the facility failed to protect one of 21 sampled residents (Resident 34) from neglect when staff did not implement the resident's individualized care plan intervention requiring the assistance of two staff members for all bed mobility. This deficiency is cited as past noncompliance. Findings include: A review of a facility policy titled Abuse, Neglect, and Exploitation, last reviewed by the facility on February 2, 2026, revealed it is the facility's policy to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies that prohibit and prevent abuse and neglect. The policy defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. A review of the clinical record revealed that Resident 34 was admitted to the facility on [DATE], with diagnoses, which included reduced mobility, and chronic obstruction pulmonary disorder (is a progressive, irreversible lung disease characterized by long-term airway obstruction and inflammation). A review of Resident 34's Annual MDS Assessment (Minimum Data Set, a federally mandated standardized assessment process completed periodically to plan resident care) dated November 12, 2025, revealed the resident was totally dependent on staff assistance for bathing and required moderate assistance of staff members for personal hygiene, upper and lower body dressing, toileting hygiene, rolling left and right in bed, sitting up in bed, and required assistance lying down in bed. The MDS revealed the resident was cognitively intact as evidenced by a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognitively intact). A review of the individualized care plan initiated January 11, 2025, revealed Resident 34 had an activities of daily living self-care deficit related to shortness of breath and weakness. Activities of daily living are routine personal care tasks such as bathing, dressing, toileting, and mobility. The care plan intervention required the assistance of two staff members for all bed mobility. A review of a Task List Report (a report that indicates the date when interventions were added to the Kardex, a quick reference for staff that includes a summary of resident required care information) revealed Resident 34 was to be an assistance level of two (employees) for all care on March 25, 2025. A progress note dated September 20, 2025, at 11:15 AM documented Resident 34 experienced a fall from bed. Upon arrival, the nurse observed the resident lying prone (face down position) on the floor next to the left side of the bed. The nurse documented that the resident required a four-person assist to be rolled and noted a 3 centimeter (cm) by 3 cm laceration (a tear or cut in the skin) above the left eyebrow. A facility-provided investigative document dated September 20, 2025, included a written statement from Employee 8, Nurse Aide. Employee 8 documented she responded to the resident's call bell and placed the resident on a bedpan. After completion, Employee 8 asked the resident to roll over. The statement indicated the resident rolled off the bed onto the floor. Employee 8 documented she was aware the resident required assistance of two staff members but proceeded alone because no other staff member was available at that time. During an interview on February 18, 2026, at 1:00 PM, Resident 34 stated she requested assistance to use the bathroom. She stated that when Employee 8 asked her to roll over, she responded that she was on the edge of the bed. The resident stated Employee 8 indicated she would roll her, and she subsequently rolled off the bed onto the floor, hitting her head. A review of progress notes revealed Resident 34 was transferred to the emergency department and returned on September 20, 2025, at 5:30 PM with sutures in place to the forehead. A progress note dated September 21, 2025, at 10:32 AM documented bruising to the fourth and fifth fingers of the left hand measuring 9 cm by 5 cm and bruising to the left eye. A progress note dated September 25, 2025, (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 1:26 PM documented the resident was transferred again to the emergency department for continued pain, and diagnostic evaluation confirmed a fracture of the left hand. Telephone contact attempts to Employee 8 Nurse Aide on February 19 and February 20, 2026, were unsuccessful. A review of Employee 8's personnel file revealed she signed an attestation on September 9, 2025, acknowledging completion of orientation, which included training on the facility's abuse and neglect policy, safe bed mobility procedures, safe transfer and lift techniques, and documentation requirements within the electronic health record. During an interview on February 19, 2026, at 12:45 PM, the Director of Nursing confirmed the facility investigation determined Employee 8 did not follow Resident 34's care plan requiring assistance of two staff members for bed mobility. The Director of Nursing confirmed Employee 8 was immediately removed from the staffing schedule pending investigation and subsequently reassigned to a transportation position without direct resident care responsibilities. The deficient practice was cited as past noncompliance. The facility implemented corrective actions immediately following the incident. The resident was assessed and transferred for medical evaluation. Employee 8 was immediately suspended pending investigation outcome. The facility reviewed all residents' records to confirm current bed mobility assistance levels and ensure care plans and Kardex entries accurately reflected required assistance levels. The facility completed skin inspections for residents requiring two-person assistance with bed mobility. Nursing staff received re-education on adherence to individualized care plans and the facility's Abuse and Neglect policy. To sustain compliance, nursing administration initiated random audits of five resident care interactions to verify that staff performed bed mobility according to individualized care plans and Kardex instructions. Audits were conducted daily for one week, biweekly for two weeks, and weekly for one month. Audit results were reported to the facility's Quality Assurance and Performance Improvement Committee for review and follow-up. The facility achieved compliance with this requirement on September 24, 2025. This deficiency is cited as past noncompliance. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing services.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interviews, it was determined that the facility failed to develop and implement a comprehensive care plan that reflected the resident's current medical status and required interventions for one of 29 residents sampled (Resident 3). Findings include: A review of Resident 3's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe), diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces), and congestive heart failure (CHF, a condition in which the heart doesn't pump blood as well as it should). A review of an Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated [DATE], revealed that Resident 3 had moderately impaired cognition with a BIMS score of 12 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 to 12 indicates cognition is moderately impaired). A review of a physician's order for Resident 3 dated [DATE], revealed an order for full code status indicating CPR should be attempted in the event of cardiopulmonary arrest. A review of a POLST form (Physicians Orders for Life-Sustaining Treatment form designed to improve resident care by creating a portable medical order form that records residents' treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency) for Resident 3 dated [DATE], revealed that the resident had elected CPR/Attempt Resuscitation status. (CPR (cardiopulmonary resuscitation) is to be performed in the event of cardiopulmonary arrest (if breathing stops or if the heart stops beating). A review of the Resident 3's comprehensive care plan, initiated [DATE], and most recently revised February 13, 2026, identified the resident's code status (overall medical directive that specifies what life sustaining interventions should be initiated if a resident experiences a cardiac or respiratory arrest when breathing stops or the heart stops beating) as DNR, with an established goal that the resident's code status preference would be honored. Resident 3's care plan failed to include updated goals, interventions, or monitoring related to the resident's full code status. A physician's order dated [DATE], directed oxygen administration at 4 liters (L) via nasal cannula continuously related to COPD. A review of Resident 3's comprehensive plan of care, initiated on [DATE], and most recently revised on February 13, 2026, failed to include updated goals, interventions, or monitoring related to the resident's continuous oxygen therapy. A physician's order dated [DATE], directed a fluid restriction of 1800 ml (milliliters) per day, with 290 ml allotted for nursing during the day, 290 ml for nursing during the evening, 290 ml for nursing during the night, and 840 ml for dietary. A review of Resident 3's care plan revealed a focus on impaired cardiovascular status due to COPD and CHF, initiated on [DATE], and last revised on February 13, 2026, with interventions to reflect a 2200 ml fluid restriction. Resident 3's care plan failed to include updated goals, interventions, or monitoring related to the resident's fluid restriction. A physician's order dated [DATE], directed to give Apixaban (generic for Eliquis, an anticoagulant ,blood thinning medication) 5 mg, one tablet every morning and at bedtime. A review of Resident 3's comprehensive plan of care, initiated on [DATE], and most recently revised on February 13, 2026, failed to include updated goals, interventions, or monitoring related to the resident's anticoagulant therapy. A physician's order dated [DATE], directed to give Humalog insulin (a rapid acting insulin medication used to lower blood sugar) subcutaneously before meals and at bedtime per sliding scale related to diabetes. A review of Resident 3's comprehensive plan of care, initiated on [DATE], and most recently revised on February 13, 2026, failed to include updated goals, interventions, or monitoring related to the resident's (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diabetes and insulin therapy. A review of outside hospital paperwork revealed that Resident 3 had a central venous catheter (a thin, flexible tube that is inserted into a large vein to the heart to deliver medications and other therapies into the bloodstream) inserted in their right chest on [DATE]. A physician's order dated February 1, 2026, revealed an order for a PICC line (a thin, flexible tube that is inserted into a large vein to the heart to deliver medications and other therapies into the bloodstream) and to maintain an emergency kit at the bedside. A physician's order dated February 10, 2026, directed to give Ampicillin (an antibiotic medication) 2 gm intravenously (IV, through a vein) every six hours until [DATE], for a bacterial infection due to a right knee prosthetic infection. A review of Resident 3's comprehensive plan of care, initiated on [DATE], and most recently revised on February 13, 2026, failed to include updated goals, interventions, or monitoring related to the resident's PICC line and IV antibiotic therapy. Following surveyor inquiry, Resident 3's care plan was updated to reflect the resident's current plan of care related to oxygen therapy, PICC line therapy, anticoagulant therapy, code status, diabetes and insulin therapy, and fluid restriction on February 19, 2026. During an interview on February 19, 2026, at 2:00 PM the Director of Nursing confirmed the facility failed to review and revise Resident 3's care plan to accurately reflect the resident's current medical condition, risks, and required treatments. 28 Pa. Code 211.12(d)(3)(5) Nursing services		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interview, it was determined the facility failed to ensure licensed nurses accurately administered prescribed medication consistent with professional standards of practice for one of 29 sampled residents (Resident 31). Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates the registered nurse was to carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. Review of the facility policy titled Administering Medications last reviewed by the facility on February 2, 2026, revealed that medications are administered as prescribed and in a safe and timely manner. Medications are administered in accordance with prescriber orders. A clinical record review revealed that Resident 31 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (stroke, caused by disrupted blood flow to the brain) and left sided hemiplegia (paralysis or severe weakness on the left side of the body). Review of a physician's order dated December 5, 2025, revealed an order for Midodrine HCL (hydrochloride) 5 mg one tablet via PEG tube (Percutaneous endoscopic gastrostomy is an endoscopic medical procedure in which a tube is passed into the patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) before meals for hypotension, hold medication for systolic blood pressure greater than 100 mmHg (systolic blood pressure is the top number in the blood pressure reading representing the pressure in the arteries when the heart beats and pumps blood). Review of the Medication Administration Record (MAR) for December 2025, January 2026, and February 1, 2026 through 18, 2026, revealed that Midodrine was administered 15 times outside of the physician ordered parameters, as evidenced by the following documented blood pressure readings at the time of administration: December 10, 2025, 4:00 PM BP 112/68 mm/Hg (millimeters of hemoglobin)December 12, 2025, 11:00 AM BP 122/70 mm/HgDecember 17, 2025, 7:00 AM BP 102/60 mm/HgDecember 18, 2025, 11:00 AM BP 122/94 mm/HgDecember 20, 2025, 11:00 AM BP 102/76 mm/HgDecember 21, 2025, 7:00 AM BP 120/60 mm/HgDecember 26, 2025, 7:00 AM BP110/76 mm/HgJanuary 5, 2026, 11:00 AM BP 115/63 mm/HgJanuary 9, 2026, 11:00 AM BP112/89 mm/HgJanuary 20, 2026, 11:00 AM BP 111/62 mm/HgJanuary 22, 2026, 7:00 AM BP 102/74 mm/HgJanuary 23, 2026, 11:00 AM BP 104/56 mm/HgFebruary 9, 2026, 11:00 AM BP 108/58 mm/HgFebruary 10, 2026,11:00 AM BP109/68 mm/HgFebruary 17, 2026, 7:00 AM BP 118/78 mm/Hg These administrations occurred despite the physician's explicit hold parameters to hold medication for a systolic reading of greater than 100 mm/Hg During an interview on February 20, 2026, at 9:45 AM, the director of nursing acknowledged that nursing staff did not follow acceptable standards of nursing practice related to medication administration. 28 Pa. Code 211.5(f)(ii)(ix) Medical records. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records and staff and resident interview, it was determined the facility failed to consistently implement appropriate interventions based on individual resident needs to promote resident safety and prevent potential hazards for one resident out of 29 sampled residents. (Resident 18). Findings include: A review of clinical records revealed that Resident 18 was admitted to the facility on [DATE], with diagnosis to include major depressive disorder (a serious, common mood disorder causing persistent sadness, loss of interest, and functional impairment in daily life) and anxiety (response to stress that becomes a disorder when it causes persistent, excessive fear or worry disproportionate to the situation) A review of Resident 18's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 23, 2025, revealed that Resident 18 was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). Review of the resident's comprehensive plan of care, initially dated October 20, 2025, revealed the resident required assistance of two staff members for activities of daily living (ADLs). ADLs refer to basic self care tasks such as bathing, transferring, toileting, dressing, eating, and personal hygiene. The care plan indicated the resident required assistance with bathing, transfers, personal hygiene, and eating set up, including the use of lidded cups for liquids. The care plan also identified that Resident 18 had the potential to exhibit mood and behavioral symptoms, including tearfulness, accusatory behavior toward staff, ordering non approved medications, and gifting staff, related to her diagnosis of depression. Interventions included administering medications as ordered, approaching the resident calmly, allowing expression of feelings, and offering emotional support. An additional care area, initiated October 20, 2025, identified use of psychotropic medications. Psychotropic medications are drugs that affect mood, perception, or behavior and may carry risks of side effects that impair judgment, coordination, or impulse control. The care plan directed staff to monitor for adverse effects, including confusion, dizziness, unsteadiness, impaired thinking, worsening depression, irritability, aggression, and suicidal ideations. On February 18, 2026, at 9:45 AM, observation revealed Resident 18 lying in bed with a pair of scissors placed on her bedside table within immediate reach. During interview at that time, the resident stated she used the scissors to open mail when staff were not available. The resident declined photographs of the scissors and became tearful, and the interview concluded. Review of the clinical record revealed no documentation that the facility assessed Resident 18's ability to safely possess or use scissors. The record contained no interdisciplinary assessment evaluating risks associated with sharp objects, despite the resident's psychiatric diagnoses, documented behavioral symptoms, use of psychotropic medications, and need for extensive assistance with ADLs. The record also lacked documentation that the resident had scissors in her possession or that staff implemented safety interventions related to sharp objects. The record did not demonstrate that the facility evaluated whether unrestricted access to scissors constituted an accident hazard Interview with Employee 7, Nurse Aide, revealed that when the facility determines a resident can safely use scissors, staff typically secure them in the resident's nightstand to prevent access by other residents. Employee 7 stated she previously attempted to lock the scissors in Resident 18's nightstand; however, the resident refused and became tearful. Employee 7 confirmed that, as observed, the scissors remained accessible on the bedside table. Interview with the Nursing Home Administrator and Director of Nursing on February 19, 2026, at 2:00 PM, confirmed that no documented assessment had been completed to determine Resident 18's ability to safely use or possess scissors. As of the end of survey on February 20, 2026, the facility did not provide evidence (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of an interdisciplinary assessment, physician consultation, behavioral evaluation, or care plan revision addressing the resident's access to scissors or alternative safety measures such as supervised use or provision of safety scissors (cutting instruments designed with rounded or blunt tips to reduce the risk of puncture injury). 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.12(a)(c)(d)(5) Nursing services.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to evaluate the clinical necessity of an indwelling urinary catheter for one resident out of 29 sampled (Resident 16). Findings included: A review of a facility policy entitled Urinary Catheter Care, last reviewed February 2, 2026, indicated that nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is placed and remove the catheter as soon as it is no longer needed. A review of Resident 16's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and morbid obesity (a chronic disease that's characterized by a body mass index of 40 or higher, or a body mass index of 35 or higher with obesity-related health issues). A review of a Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 29, 2026, revealed that Resident 16 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information, a score of 13 to 15 indicates cognition is intact). A review of admission physician orders dated November 14, 2025, included an order for insertion and maintenance of a Foley catheter (an indwelling urinary catheter, which is a flexible tube inserted through the urethra into the bladder to continuously drain urine), size 16 French (French is the unit of measurement used to describe the external diameter of a catheter; a 16 French catheter measures approximately 5.3 millimeters in diameter), with a 10 cubic centimeter (cc) balloon (a small inflatable balloon at the catheter tip that is filled with sterile water once inside the bladder to hold the catheter in place), attached to a straight drainage bag to gravity drainage (a urine collection bag that passively drains urine from the bladder by gravity without suction). The indication for the catheter was obstructive uropathy with urinary retention (obstructive uropathy is a blockage that impedes urine flow through the urinary tract; urinary retention is the inability to empty the bladder completely). A review of the admission nursing evaluation dated November 14, 2025, assessed Resident 16 as experiencing urinary incontinence (involuntary loss of urine), despite the presence of a physician order for an indwelling Foley catheter at the time of admission. A review of a facility document titled Foley Catheter Justification, dated December 9, 2025, indicated that staff are not to insert or maintain a urinary catheter unless valid medical justification exists and must discontinue the catheter as soon as it is no longer clinically warranted. The form documented that Resident 16 had a bladder outlet obstruction (a blockage at the base or neck of the bladder that reduces or prevents urine flow), and staff determined to continue the Foley catheter. A review of physician and Certified Registered Nurse Practitioner progress notes dated November 2025, December 2025, January 2026, and February 2026 through the survey end date of February 20, 2026, failed to document ongoing clinical evaluation of the continued need for the indwelling Foley catheter. The progress notes did not reference a past medical history of obstructive uropathy with urinary retention or provide assessment findings supporting continued catheter use. During an interview conducted on February 19, 2026, at 9:00 AM, Resident 16 stated that she was hospitalized in early November 2025 for respiratory failure (a condition in which the lungs cannot adequately exchange oxygen and carbon dioxide). She stated hospital staff inserted the Foley catheter when she was intubated (placement of a tube into the trachea, or windpipe, to maintain an open airway and provide mechanical breathing support). Resident 16 stated she had not previously experienced urinary retention and had not required catheterization before that hospitalization. She expressed a desire to have the Foley catheter removed so she could feel more normal, particularly if discharged home. A review of outside hospital documentation dated (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	November 2025, titled Post Acute Placement Packet, which accompanied the referral for admission, did not include a diagnosis of obstructive uropathy or urinary retention. Resident 16's clinical record failed to contain documented, clinically acceptable justification for the continued placement and use of the indwelling Foley catheter and failed to demonstrate timely reassessment of the catheter's ongoing necessity. During an interview on February 19, 2026, at 2:30 PM the aforementioned information was reviewed with the Director of Nursing and confirmed there was no physician documentation to clinically support the use of the indwelling Foley catheter for Resident 16 related to obstructive uropathy with retention. 28 Pa. Code 211.10 (a)(c) Resident care policies.28 Pa. Code: 211.12 (c)(d)(3)(5) Nursing Services.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, and staff interview, it was determined the facility failed to ensure staff administered a narcotic pain medication in accordance with the physician's order for one of 21 residents reviewed for medication administration, Resident 64. Findings include: According to the US Department of Health and Human Services, Interagency Task Force, Executive Summary Draft Final Report May 6, 2021, for Pain Management Best Practices the development of an effective pain treatment plan after proper evaluation to establish a diagnosis with measurable outcomes that focus on improvements including quality of life (QOL), improved functionality, and Activities of Daily Living (ADLs). Achieving excellence in acute and chronic pain care depends on the following: An emphasis on an individualized patient-centered approach for diagnosis and treatment of pain is essential to establishing a therapeutic alliance between patient and clinician. Acute pain can be caused by a variety of different conditions such as trauma, burn, musculoskeletal injury, neural injury, as well as pain due to surgery/procedures in the perioperative period. A multi-modal approach that includes medications, nerve blocks, physical therapy and other modalities should be considered for acute pain conditions. A multidisciplinary approach for chronic pain across various disciplines, utilizing one or more treatment modalities, is encouraged when clinically indicated to improve outcomes. Review of a facility policy, last reviewed February 2, 2026, revealed staff are responsible to implement medication regimens as ordered by the physician. The policy indicated staff must administer medications as ordered, monitor the resident's response, and document administration and effectiveness. A review of Resident 64's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses, which included vascular headaches (intense, throbbing, or pulsating pains caused by the constriction, swelling, or inflammation of blood vessels in the head), and idiopathic peripheral autonomic neuropathy (damage to nerves outside the brain and spinal cord that may affect automatic body functions). Review of a physician order, initially dated January 9, 2026, revealed Resident 64 was prescribed Oxycodone 5 milligrams (mg), a narcotic pain medication used to treat moderate to severe pain, to be administered one tablet by mouth every four hours PRN (as needed) for severe pain rated 8 to 10. The order specified use of a pain scale in which 0 to 3 indicates mild pain, 4 to 7 indicates moderate pain, and 8 to 10 indicates severe pain. A review of Resident 64's January 2026 Medication Administration Record (MAR) revealed staff administered Oxycodone 5 milligrams 47 times. Of those 47 administrations, 23 doses were given when the documented pain rating did not meet the physician ordered parameter of 8 to 10. Staff administered the medication outside of ordered parameters on the following dates and times: January 9, 2026, at 8:01 PM for a pain scale of 7. January 11, 2026, at 7:05 PM for a pain scale of 7. January 16, 2026, at 8:33 AM for a pain scale of 7. January 16, 2026, at 1:00 PM for a pain scale of 7. January 16, 2026, at 7:30 PM for a pain scale of 7. January 17, 2026, at 9:22 AM for a pain scale of 7. January 19, 2026, at 12:53 PM for a pain scale of 7. January 19, 2026, at 7:05 PM for a pain scale of 7. January 20, 2026, at 7:05 PM for a pain scale of 1. January 21, 2026, at 7:02 PM for a pain scale of 7. January 23, 2026, at 9:13 AM for a pain scale of 6. January 23, 2026, at 7:03 PM for a pain scale of 6. January 26, 2026, at 10:12 AM for a pain scale of 5. January 26, 2026, at 6:49 PM for a pain scale of 7. January 27, 2026, at 7:05 PM for a pain scale of 7. January 28, 2026, at 7:41 AM for a pain scale of 5. January 29, 2026, at 9:04 AM for a pain scale of 7. January 29, 2026, at 7:06 PM for a pain scale of 7. January 30, 2026, at 8:40 AM for a pain scale of 7. January 30, 2026, at 1:29 PM for a pain scale of 6. January 30, 2026, at 8:02 PM for a pain scale of 0. January 31, 2026, at 9:15 AM for a pain scale of 0. January 31, 2026, at 10:43 PM for a pain scale of 5. Review of the February 2026 Medication Administration Record revealed staff administered Oxycodone 5 milligrams 24 times. Of those 24 administrations, 14 doses were given when the documented pain rating did not meet the physician ordered parameter of 8 to 10. Staff administered the medication outside of ordered parameters on the following dates and times: February 2, 2026, at (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7:31 PM for a pain scale of 4. February 3, 2026, at 7:53 PM for a pain scale of 7. February 5, 2026, at 8:47 AM for a pain scale of 7. February 5, 2026, at 1:23 PM for a pain scale of 5. February 6, 2026, at 7:58 AM for a pain scale of 6. February 6, 2026, at 6:59 PM for a pain scale of 6. February 9, 2026, at 7:09 PM for a pain scale of 7. February 11, 2026, at 7:07 PM for a pain scale of 7. February 12, 2026, at 7:05 PM for a pain scale of 6. February 13, 2026, at 7:59 AM for a pain scale of 4. February 15, 2026, at 9:22 AM for a pain scale of 6. February 16, 2026, at 7:07 PM for a pain scale of 7. February 18, 2026, at 7:05 PM for a pain scale of 6. February 19, 2026, at 9:02 AM for a pain scale of 7. An interview with the Director of Nursing on February 20, 2026, at 11:10AM reviewed the above findings which demonstrated staff administered the narcotic pain medication outside of the physician ordered pain scale parameter for Resident 64. 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, observation, and staff interview, it was determined the facility failed to implement procedures to maintain records of controlled drugs and ensure accurate drug administration for one out of the 29 residents sampled (Resident 64). Findings include: A review of the facility policy titled Administering Medications, last reviewed by the facility on February 2, 2026, revealed that medications are to be administered by licensed nurses or other staff authorized to do so by the state, as ordered by the physician, and in accordance with professional standards of practice to prevent contamination, infection, and medication errors. The policy further requires that the licensed nurse administering a medication immediately document the resident's name, date and time of administration, dose, route of administration, and the signature of the nurse on the medication administration record. The policy requires the individual administering the medication to initial the residents Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next medication. A review of the facility policy Controlled Substances last reviewed by the facility on February 2, 2026, revealed that controlled substance inventory is monitored and reconciled to identify loss, or potential diversion in a manner that minimizes the time between loss/diversion and detection/ follow up. The policy requires nursing staff to count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The policy outlines that the coming on duty nurse and the going off duty nurse make the count together and document and report any discrepancies to the director of nursing. The policy documented the system of reconciling the receipt, dispensing, and disposition of controlled substances includes records of personnel access and usage, medication administration records, declining inventory records, and destruction, waste and return to pharmacy records. A review of the clinical record revealed Resident 64 was admitted to the facility on [DATE], with hydrocephalus (an abnormal accumulation of fluid within the brain's ventricles, causing them to widen and exert harmful pressure on brain tissue) and cerebral infarction (a life-threatening, often disabling medical emergency caused by blocked blood flow to the brain, leading to tissue death). A review of the clinical record revealed a physician's order dated January 9, 2026, for Oxycodone 5mg tablets, administer 5mg by mouth every 4 hours as needed for severe pain 8-10. Oxycodone is a Schedule II controlled substance, a medication with accepted medical use but regulated due to its potential for misuse or dependence. Review of facility records revealed the facility utilized a Controlled Drug Receipt/Record/Disposition Form (a narcotic log used to track the receipt, use, and disposition of controlled substances) and a Medication Administration Record (MAR, the clinical record used to document each dose of medication administered, including date, time, medication, dose, and the administering staff member). A comparison of Resident 64's Controlled Drug Receipt/Record/Disposition Form with the MAR for January 2026 and February 2026 revealed repeated discrepancies between medications signed out on the controlled substance record and medications documented as administered on the MAR. Specifically, staff either signed out Oxycodone 5 mg from the narcotic log without documenting administration on the MAR, or documented administration on the MAR without a corresponding entry on the narcotic log. The discrepancies included the following: Documented on MAR but not recorded on the narcotic log: January 13, 2026, at 12:41 PM; January 19, 2026, at 7:51 AM; January 22, 2026, at 7:43 PM; January 28, 2026, at 7:00 PM. Signed out on the narcotic log but not documented as administered on the MAR: January 15, 2026, at 7:05 PM; January 22, 2026, at 5:45 PM; January 24, 2026, at 10:17 AM; January 25, 2026, at 5:00 AM; February 1, 2026, at 1:37 PM; February 4, 2026, at 9:00 PM; February 5, 2026, at 9:00 PM; February 7, 2026, at 9:00 PM; February 8, 2026, at 9:00 PM; February 12, 2026, at 10:25 AM; February 13, 2026, at 1:45 PM; February 13, 2026, at 7:00 PM; February 14, 2026, at 7:00 PM; February 15, 2026, at 7:00 PM (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PMFebruary 16, 2026, at 8:40 AM These inconsistencies demonstrated the facility failed to ensure accurate documentation and reconciliation of controlled substances. When staff do not reconcile the narcotic log with the MAR, the facility cannot account for the medication's administration, raising concerns regarding medication diversion, medication errors, and resident safety. A review of the facility Narcotic Count Sheets (shift-to-shift verification forms requiring both the oncoming and off-going nurse to physically count and verify controlled substances at each shift change) revealed the following:On February 18, 2026, at 9:00 AM, review of the January 2026 Narcotic Count Sheet for the C Hall cart revealed the following missing signatures:January 5, 2026, Second shift oncoming nurseJanuary 9, 2026, Third shift oncoming and off-going nursesJanuary 13, 2026, Third shift off-going nurseJanuary 27, 2026, Third shift off-going nurse On February 18, 2026, review of the January 2026 Narcotic Count Sheet for the A Hall cart revealed the following missing signatures:January 2, 2026, First shift oncoming nurseJanuary 7, 2026, First shift off-going nurseJanuary 15, 2026, Third shift off-going nurseJanuary 16, 2026, Third shift off-going nurse On February 19, 2026, review of the January 2026 Narcotic Count Sheet for the B Hall cart revealed the following missing signatures:January 13, 2026, First shift oncoming nurseJanuary 13, 2026, Second shift oncoming and off-going nursesJanuary 27, 2026, Second shift oncoming and off-going nursesJanuary 27, 2026, Third shift off-going nurseJanuary 30, 2026, First shift oncoming nurseJanuary 30, 2026, Third shift off-going nurseFebruary 17, 2026, Third shift off-going nurseFebruary 19, 2026, First shift oncoming nurse Interview with Employee 5, Registered Nurse on February 19, 2026, at 8:46 AM revealed she had not signed the narcotic log because she had not yet verified the count, despite facility policy requiring the oncoming and off-going nurses to complete the count together at the time of shift change. During an interview on February 19, 2026, at 12:00 PM, the Director of Nursing reviewed the above findings regarding the facility's failure to ensure accurate reconciliation of Resident 64's controlled substances and failure to consistently complete required shift-to-shift narcotic counts. 28 Pa Code 211.5(f)(xi) Medical records. 28 Pa Code 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12 (d)(1)(3)(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 observation, review of select facility policy and clinical records, and staff interviews, it was determined the facility failed to adhere to acceptable storage and labeling practices for multi-dose medications in one of two medication carts observed (Cart A). Findings include: Review of the facility policy titled Medication Labeling and Storage last reviewed by the facility February 2, 2026, indicated that if a multi-use medication vial/injectable (container of liquid medication intended for injection of more than one dose) had been opened and accessed (needle was inserted through the rubber stopper and medication was withdrawn) the vial should be dated and discarded within 28 days unless the manufacturer specified a different date for that opened vial. An observation of the medication cart located on Unit 1 Hall Cart A on February 19, 2026, at 8:22 AM, in the presence of Employee 5 (Registered Nurse-RN), of the medication stored in the medication cart, revealed one (1) multi-dose insulin pen of Insulin Aspart (a short acting insulin medication used to lower blood sugar) and two (2) multi-dose pens of Insulin Lispro (a rapid acting insulin medication used to lower blood sugar) that had been opened and available for resident use, but not dated with an opened date or expiration date, despite the sticker on the pen having an area to document the date opened and expiration date. Further observation revealed one (1) multi-dose insulin pen of Insulin Aspart (a short-acting insulin used to lower blood sugar) with a date on the sticker of the pen documenting the pen was opened and currently in use, with an opened date of January 2, 2026, with no expiration date documented. Review of manufacturer safety information revealed the multi-dose pen of Insulin Aspart is to be discarded 28 days after opening indicating the dated pen should have been discarded on January 30, 2026. Interview with Employee 5, Registered Nurse, on February 20, 2026, at 8:24 AM, confirmed that two multi-dose insulin pens of Insulin Lispro and one insulin pen of Insulin Aspart had been opened, were available for use, were actively being used for medication administration, and were not labeled with expiration dates. Employee 5 further confirmed that the Insulin Aspart pen should have been discarded 28 days after opening; however, it remained in the medication cart and available for use beyond that timeframe. Interview with the Director of Nursing (DON) on February 20, 2026, at 11:00 AM, reviewed the above findings of the facility's failure to ensure the facility staff adhere to the policy of dating and storing multi-dose pens of insulin. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code 211.10 (c) Resident care policies.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Mountain Top Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. Based on observation, review of select facility policy, state laws, and professional licenses, as well as staff interview, it was determined the facility failed to ensure professional staff were licensed, certified, or registered in accordance with state laws upon hire for one of five personnel files reviewed (Employee 2). Findings include: Pennsylvania's Professional Nursing Law, Section 8 (a) indicated that each person who met the professional nursing licensure requirements would be issued a certificate setting forth that the person was licensed to practice professional nursing. Review of the facility Credentialing of Nursing Service Personnel Policy last reviewed February 2, 2026, indicated that nursing service personnel who require a license or certification to provide resident care or treatment without direction or supervision within the scope of the individual's license or certification must present verification of such license or certification prior to or upon employment. Nursing personnel requiring a license or certification are not permitted to perform direct resident care services until all licensing and background checks have been completed. Observation on February 18, 2026, at 10:30 AM revealed that Employee 2 Licensed Practical Nurse (LPN) was working on the D Hall on Unit 2. Interview with the director of nursing (DON) on February 18, 2026, at 1:00 PM revealed that Employee 2 (LPN) was newly hired and had been sent home. The DON noted that he was notified by human resources that upon review of her personnel file there was inadequate proof that Employee 2 (LPN) had a valid Pennsylvania LPN license. Review of Employee 2's (LPN) personnel file revealed that she was hired as an LPN on January 28, 2026. Employee 2 (LPN) received a Practical Nursing Program Diploma on November 14, 2025. An Exam Appointment History revealed that Employee 2 (LPN) took the Practical Nurses Exam on January 23, 2026, and passed. However, there was no evidence of a Pennsylvania Practical Nurse license in her personnel file. Interview with the DON on February 20, 2026, at 9:40 AM revealed that Employee 2's (LPN) Practical Nurse license was issued on February 18, 2026, with an effective date of February 18, 2026, and expiration date of June 30, 2026. The DON confirmed the delay in the license being issued was due to the need for verification being provided to the state licensing board for Employee 2's (LPN) required mandatory Child Abuse online training. Once the verification of the completed mandatory Child Abuse online training was received the employee's license was issued. Review of Employee 2 (LPN) time punches revealed that prior to February 18, 2026, the employee worked at the facility on the following dates before being issued a license from the Pennsylvania Bureau of Professional and Occupational Affairs: January 28, 2026, February 2, 3, 4, 5, 7, 9, 11, 12, 13, 15, 16, and February 17, 2026. Interview with the Nursing Home Administrator (NHA) on February 20, 2026, at 10:30 AM confirmed that human resources did not complete a license verification upon hire for Employee 2 (LPN) as per facility policy. The NHA confirmed that Employee 2 (LPN) should not have been able to work at the facility without a verified license. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.19 (1)(3) Personnel policies and procedures. 28 Pa. Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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NAME OF PROVIDER OR SUPPLIER Mountain Top Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, transfer notices, and staff interviews, it was determined the facility failed to notify the resident and the resident's representative(s) of the transfer in writing and in a language and manner they understand for 1 out of 29 residents reviewed (Resident 98). Findings include: A clinical record review revealed Resident 98 was admitted to the facility on [DATE]. Further clinical record review revealed Resident 98 was transferred to a community hospital on January 14, 2026, and was readmitted to the facility on [DATE]. The facility was unable to provide documented evidence that the resident or resident representative was notified of the reasons for the transfer in writing and in a language and manner they understand. During an interview on February 20, 2026, at approximately 11:30 AM, the nursing home administrator was unable to provide documented evidence that Resident 98 and their representatives, as applicable, were notified of the reasons for the transfers on the aforementioned date. 28 Pa. Code 201.14(a) Responsibility of licensee.		