

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395582	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Hazle Township Boulevard Hazleton, PA 18202	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456</p> <p>Based on review of clinical records, the facility's abuse prohibition policy, and select investigative reports, and interviews with staff, residents and resident representatives, it was determined that the facility failed to ensure that one resident was free from sexual abuse and resultant psychosocial harm (Resident 16) and that one resident (Resident 106) was free from physical abuse out of 11 residents sampled for abuse prohibition.</p> <p>Findings include:</p> <p>A review of a facility policy entitled Pennsylvania Resident Abuse: Abuse, Neglect, and Exploitation, dated August 30, 2023, revealed that it is the policy of the facility to not tolerate abuse, neglect, mistreatment, exploitation of residents, or misappropriation of resident property by anyone. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property an injuries, of unknown source. The definition of sexual abuse includes but is not limited to, non-consensual sexual contact of any type, sexual harassment, sexual coercion, or sexual assault.</p> <p>A review of Resident 16's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses, which included mild cognitive impairment of uncertain or unknown etiology.</p> <p>A review of the resident's Admission Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 24, 2024, revealed that the resident was severely cognitively impaired with a BIMS score of 7 (Brief Interview For Mental Status score of 7, a tool to assess the resident's attention, orientation and ability to register and recall new information, a score of 00-07 equates to severe cognitive impairment).</p> <p>A review of Resident 91's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of hemiplegia (paralysis of one side of the body) affecting the left non dominant side due to history of a cerebral infarct (when a cluster of brain cells die due to lack of blood flow), depression and congestive heart failure (CHF occurs when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 91's admission MDS assessment dated [DATE], revealed that the resident was cognitively intact with a BIMS score of 14 (scores of 13-15 equate to intact cognition).</p> <p>A review of a facility investigation report dated July 6, 2024, at 6:00 PM revealed that Employee 1, a nurse aide, walked into Resident 16's room and observed Resident 16 and Resident 91 naked in Resident 16's bed.</p> <p>A review of Employee 1's witness statement dated July 6, 2024 revealed that she entered Resident 16's room to give her a dinner tray and found both residents lying naked in the resident's bed. When Resident 16 saw Employee 1 she quickly sat up. The nurse aide immediately notified the nurse. The residents were quickly separated and were placed in their own rooms.</p> <p>Nursing documentation dated July 6, 2024, at 10:13 PM from Employee 2 the Registered Nurse indicated Resident 91 reported that Resident 16, called him over into her room and they engaged in a sexual act.</p> <p>A review of the facility investigation dated July 9, 2024, revealed statements from both residents. Employee 2, RN, obtained a statement from Resident 16, which indicated that this female resident did not remember a guy being in her room. She stated if a guy was in her room it would be her boyfriend. Resident 16 continued to state that all she did all was stay in her room and change her clothing twice. Employee 2 stated the resident had no recollection of the sexual encounter with Resident 91.</p> <p>A statement was obtained from Resident 91, whose primary language is not English, and may require a translator as requested, and was translated and written by Employee 3, Licensed Practical Nurse (LPN) on July 6, 2024. According to Resident 91's statement, he observed Resident 16 in her room across the hall. Resident 91 stated that Resident 16 was naked and gestured to him to come to her room. He walked over to Resident 16's room and he climbed on top of her and had sexual intercourse with Resident 16. He stated a girl walked in while he was still engaged in sexual intercourse with Resident 16. He then stopped the sexual act, pulled his pants up and left the room and went back to his room. Resident 91 also stated Resident 16 was provoking him the prior day by talking and conversing with him.</p> <p>A telephone interview conducted on July 9, 2024, at 1:26 AM with Employee 1. the nurse aide, revealed that she found both residents naked in bed in Resident 16's room on the evening of July 6, 2024, and immediately told a nurse. She stated she was very surprised because Resident 91 usually stays to himself in his room and he barely comes out. She stated he rings his call bell when he needs something. She stated she usually didn't see him conversing with Resident 16. Employee 1 stated that Resident 91 does speak to her because she is able to converse with him in his primary language. She stated on the evening of this sexual encounter Resident 91 was taken to the dayroom and staff watched him on a one-to-one basis until Resident 16 was moved to another room. Employee 1 stated Resident 16 is very social and was frequently observed walking up and down the hallway on a regular basis and often spoke to others about her boyfriend.</p> <p>An interview with Resident 91 was attempted on July 9, 2024 however the resident was not available as he was out at an appointment on the day of the survey.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Resident 16 was conducted on July 9, 2024, but she was unable to recall the event and shared pictures of her boyfriend with the surveyor, that were on her dresser next to her bed in her new room.</p> <p>An interview with Employee 2, RN, at 12:52 PM on July 9, 2024, revealed that the residents were both separated that evening and placed on every 15 minute security checks. Resident 16 was moved to another room in a different building of the facility (facility comprised of two separate buildings on the same campus).</p> <p>A telephone interview was conducted with Resident 16's interested representative, a close friend, on July 9, 2024, at 11:46 PM. The resident's friend stated that Resident 16 is a long time friend, and she was not surprised of her actions with the male resident. The resident's friend stated that Resident 16 may have thought the male resident was her boyfriend. She stated that the resident may not want to remember what happened because she is very forgetful and may not want to accept what happened because of the loyalty she has to her boyfriend. The resident's friend stated that the resident can be very outgoing and that she wished had the opportunity to speak with facility staff to apprise them of the resident's resident's behavior and relationship with her boyfriend. The resident's representative stated that she believed that information would be necessary for the facility to explain the resident's behaviors. Resident 16's interested representative also relayed that she could never allow the resident's boyfriend to be aware of this sexual encounter because of the negative effects it would have on their relationship and also did not wish to notify the resident's daughter of the event due to the humiliation and embarrassment.</p> <p>A review of the resident's admission paperwork revealed that her daughter signed the documents upon admission and remained listed as a second emergency contact. The resident's friend was listed as the primary contact.</p> <p>A review of Resident 16's care plan, at the time of the survey, did not identify the significance of the resident's relationship with her boyfriend.</p> <p>Neither Resident 16's or Resident 91's care plans, identified any history of sexual behaviors.</p> <p>Resident 16 is cognitively impaired and did not possess the ability to consent to sex with Resident 91. A repeat BIMS score was obtained shortly after the encounter and her score was assessed at a 3 indicating severe cognitive impairment. Applying the reasonable person concept, in the case of Resident 16, who is unable to cognitively speak for herself due to severe cognitive impairment, and the assessment of how most people would react to the situation of being sexually abused by Resident 91, Resident 16 would have been negatively affected by Resident 91's actions.</p> <p>A review of Resident 106's clinical record revealed admission to the facility on [DATE], with diagnoses which include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and anxiety.</p> <p>A review of the resident's Quarterly Minimum Data Set assessment dated [DATE], indicated the resident was severely cognitively impaired with a BIMS score of 3.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 12's clinical record revealed admission to the facility on [DATE], with diagnoses which included intermittent explosive disorder and epilepsy.</p> <p>A review of the resident's annual Minimum Data Set assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS score of 3.</p> <p>A facility incident report dated June 21, 2024, at 2:30 PM indicated that Resident 109, a cognitively intact resident, reported observing Resident 12 hit Resident 106 in the stomach as Resident 106 was walking in the hallway. The residents were redirected and separated and placed on increased supervision. Assessment completed and no injuries were noted.</p> <p>Applying the reasonable person concept, in the case of Resident 106, who is severely cognitively impaired, and the assessment of how most people would react to the situation of being physically abused by Resident 12, Resident 106 would have suffered psychosocial harm and humiliation.</p> <p>An interview with the nursing home administrator on July 9, 2024, at approximately 1:00 PM confirmed that the facility failed to ensure that Residents 16 was free from sexual abuse perpetrated by Resident 91 and Resident 106 was free from physical abuse perpetrated by Resident 12.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29 (a)(c) Resident Rights</p> <p>28 Pa. Code 211.12(c)(d)(5) Nursing Services</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456</p> <p>Based on review of clinical records, the facility's abuse prohibition policy, and select investigative reports, and interviews with staff, residents, and resident representatives, it was determined that the facility failed to implement their established procedures for responding to an incident of sexual abuse of one resident (Resident 16) perpetrated by another resident (Resident 91) out of 11 residents reviewed for abuse prohibition.</p> <p>Findings include:</p> <p>Review of the facility policy entitled Pennsylvania Resident Abuse: Abuse, Neglect, and Exploitation, dated August 30, 2023, revealed that it is the policy of the facility to not tolerate abuse, neglect, mistreatment, exploitation of residents, or misappropriation of resident property by anyone. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property an injuries, of unknown source. The definition of sexual abuse incudes but is not limited to, non-consensual sexual contact of any type, sexual harassment. sexual coercion, or sexual assault.</p> <p>Procedures include Screening, Training, prevention & Identification, Protection of the Resident and Reporting. The Facility will educate its staff upon orientation and periodically thereafter regarding the facility's policy concerning abuse, neglect, mistreatment, exploitation, involuntary seclusion and/or misappropriation of property and how to handle resident-to-resident Abuse and Injuries of Unknown Source. Protection of the resident includes if the resident is injured as a result of the alleged or suspected incident, the Facility should take immediate action to treat the resident.</p> <p>Staff should report all incidents immediately to their direct supervisors. Staff should not leave a resident unattended, unless it is necessary to summon assistance. Staff should not move the resident until he/she has been assessed by a nurse supervisor for possible injuries.</p> <p>A nurse should perform an initial assessment of the resident. The assessment should generally include the following: range of motion (ROM); full body assessment for signs of injury; and vital signs.</p> <p>The resident's attending physician should be notified if an incident has occurred requiring physician involvement. If appropriate, the facility should send the resident to the hospital for an examination.</p> <p>The facility will contact the police for any allegation of misappropriation of resident property. Administrator or designee will notify police when the facility receives a complaint of, or suspect sexual abuse, serious bodily injury or suspicious death in Allegations of Sexual Abuse every effort will be made to preserve evidence on both the resident and the perpetrator.</p> <p>For both the Resident and the perpetrator:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Will not be bathed or cleaned</p> <p>Will not receive incontinence care</p> <p>Incontinence brief will not be changed</p> <p>Clothing will not to be changed</p> <p>No oral care will be provided</p> <p>Both resident and perpetrator will be evaluated in the ER.</p> <p>Linens will be bagged and provided as evidence, if applicable</p> <p>Police to be notified</p> <p>A review of Resident 16's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included mild cognitive impairment of uncertain or unknown etiology.</p> <p>A review of the resident's Admission Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 24, 2024, revealed the resident was severely cognitively impaired with a BIMS score of 7 (Brief Interview For Mental Status score of 7, a tool to assess the resident's attention, orientation and ability to register and recall new information, a score of 00-07 equates to severe cognitive impairment).</p> <p>A review of Resident 91's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of hemiplegia (paralysis of one side of the body) affecting the left non dominant side due to history of a cerebral infarct (when a cluster of brain cells die due to lack of blood flow), depression and congestive heart failure (CHF occurs when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs).</p> <p>A review of Resident 91's admission MDS dated [DATE], revealed that he was cognitively intact with a BIMS score of 14 (13-15 equates to intact cognition).</p> <p>An investigative report date July 6, 2024, revealed that Employee 1, a nurse aide found, Resident 16 and Resident 91 naked in bed together. The residents were immediately separated.</p> <p>Employee 3, Licensed Practical Nurse (LPN), translated Resident 91's statement, as English is not Resident 91 primary language. The resident's translated statement, obtained on July 6, 2024, indicated that he observed Resident 16 in her room across the hall. Resident 91 stated that Resident 16 was naked and gestured to him to come to her room. He walked, across the hall, over to Resident 16's room. He climbed on top of her and had sexual intercourse with Resident 16. He stated a girl walked in while he was still engaged in sexual intercourse with Resident 16. He then stopped the sexual act, pulled his pants up and left the room and went back to his room. Resident 91 also stated Resident 16 was provoking him the prior day by talking and conversing with him.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nursing documentation written by Employee 2, a Registered Nurse (RN), dated July 6, 2024, at 10:13 PM AM revealed the Administrator, DON and family was notified. The physician was notified, the family declined any medical treatment at the hospital. Agency of Aging was notified at 8:11 PM. The police was notified at 8:21. The police came in and did an investigation and talked to both parties. Head to toe assessment was completed on both residents. There is no history of either of the resident conversing prior to this. The male resident continues to be on 1:1 until tomorrow. She is moving to white building in a different room.</p> <p>An interview with the nursing home administrator (NHA) and Director of Nursing (DON) on July 9, 2024 at 10:00 AM revealed that the facility notified the resident's representative, which was a close friend. The resident's daughter was listed as a contact but she was not notified since the friend is the resident's first emergency contact to be notified. The NHA and DON also confirmed that neither residents was sent to the hospital for an evaluation as per facility policy because Resident 16's representative declined to have her sent out and the physician did not want Resident 91 sent to the hospital for an evaluation.</p> <p>A telephone interview with Resident 16's representative on July 9, 2024 at 11:46 PM revealed that she did not want Resident 16 sent to the hospital for an evaluation after the sexual encounter because she did not want to upset the resident. She stated that she also did not call the resident's daughter because she didn't want to get her involved because she is very busy and lives out of state. The resident's representative stated that she was very concerned about the resident's boyfriend finding out because he would be upset and the resident would not want him to know. The resident's representative stated she was not aware the facility policy required the resident to be examined at the hospital. She stated if she was knew it was facility policy she would have agreed to the transfer for an exam. The resident's representative stated that the facility told her they would examine the resident in the facility. She was concerned about the potential for sexually transmitted communicable disease and suggested testing to rule out disease. The resident's representative stated that she did not want the resident moved to another building (the facility is comprised of two buildings within the same campus) but the facility insisted it was for her safety and so she agreed.</p> <p>A Focused Head to Toe Observation of Resident 16 dated July 6, 2024 at 7:46 PM completed by Employee 2, RN, in response to the sexual incident did not include documented evidence of an comprehensive examination of her entire body to identify any possible injuries to her mouth, anus, or genitalia. The resident was also not tested for potential STIs (sexually transmitted infections) until July 8, 2024. There was no evidence that the residents' clothing or bedding was preserved as evidence according to facility policy.</p> <p>Interview with the NHA and DON on July 9, 2024 at 11:00AM confirmed that the residents were not sent to the hospital for evaluation according to facility policy. The NHA confirmed that the facility did not inform Resident 16's representative that it was facility policy to send the resident to the hospital for an examination and testing following sexual abuse. The NHA and DON confirmed that the facility had not followed their policy for sending the residents to the hospital and preserving evidence. The DON stated that Resident 91's physician did not want to send the resident to the hospital to be evaluated despite facility policy.</p> <p>Resident 16 was transferred to another room in an another building of the facility even though the resident's representative was not in agreement with the room change and move to the other building on the facility's campus.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview with Employee 2, RN, on July 9, 2024, at 12:52 PM she stated that she completed the head to toe assessment on Resident 16 but verified that she did not document that she examined Resident 16's mouth, anus, or genitalia and no orders were obtained to acquire bloodwork to rule out STI. She confirmed that she had not completed a sexual assault examination and verified that she is not trained to complete that type of examination. When asked about the facility policy for preservation and collection of evidence she stated the bed linens should be washed, but stated she was unsure what was done with the resident's bedding and clothing.</p> <p>Employee 2, RN also verified that she did not conduct an assessment of Resident 91 following the incident according to facility policy.</p> <p>A telephone interview with Employee 1, the nurse aide, on July 9, 2024 at 11:26 AM revealed she was unaware that according to facility policy she was to preserve the bed linens. She stated Resident 16 was independent and able to shower herself.</p> <p>Interview via telephone with Employee 3 an LPN on July 9, 2024 at 11:34 AM confirmed that Resident 91 showered shortly after the incident. Interview with Employee 3 revealed that she was aware of the facility policy indicating that the residents should not shower, and the need for preservation of evidence but stated that since the resident was not transferred out for an examination, when he asked to shower she told the resident that it was OK.</p> <p>In response to this incident the facility completed training with Employee 1 and Employee 2 on the facility's abuse policy on July 7, 2024. However, when interviewed by telephone on July 9, 2024, these employees were unaware of the facility policy and procedures for collection and preservation of evidence following a sexual incident.</p> <p>Refer F600 and F726</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services</p> <p>28 Pa. Code 201.29 (a)(c) Resident Rights</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on observation, review of select facility incident reports and clinical records, and staff interview, it was determined that the facility failed to provide adequate supervision and maintain an environment free of accident hazards to prevent a minor injury (a cut to the thumb) sustained by one of 11 sampled residents (Resident 65).</p> <p>Findings include:</p> <p>A review of clinical record revealed that Resident 65 was admitted to the facility on [DATE], with diagnoses which included chronic alcoholism and hypertension.</p> <p>A review of the resident's Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 10, 2024, indicated the resident was moderately cognitively impaired with a BIMS (brief screener that aids in detecting cognitive impairment) score of 8 (a score of 8-12 indicates moderate cognitive impairment).</p> <p>A review of the resident's current care plan revealed that the resident did have a self-care deficit and required the assistance of one staff for bathing and was independent for ambulation and toileting.</p> <p>A facility incident report dated July 3, 2024, at 6:35 PM revealed that the resident sustained a cut to his right thumb. The resident was found standing at the medication cart holding multiple used razors. The resident stated that he had to dig them out in the shower room. The resident sustained a cut measuring 1.0 cm x 0.2 cm with a scant amount of dried blood. Resident washed hands with antibacterial soap. Right thumb flushed with normal saline and patted dry. Physician and Resident Representative notified. New physician order to cleanse right thumb with normal saline solution, apply triple antibiotic ointment, and band aid daily. STAT {immediate} CBC, BMP, and Hepatitis Panel were ordered. Tdap Vaccine ordered. Resident placed on increased supervision. All Sharps containers (container used for disposal of used needles and other sharps to reduce risk of harm to others) were checked and changed as necessary. Sharps containers were removed from the shower rooms.</p> <p>During an onsite survey on July 9, 2024, at 2:05 PM observations were conducted on the third floor which revealed the following potential accident hazards</p> <p>-the sharps container was removed from the wall, but the mounted encasement that previously held the sharps container remained on the shower wall, and a razor was observed in the hollow case allowing for access of the sharp object by just placing a hand inside</p> <p>-this same situation was observed in the third floor bathroom of the lounge area. The sharps container was removed from the wall, but the mounted encasement that previously held the sharps container remained on the wall, and a razor was observed in the hollow case allowing for access of the sharp object by just placing a hand inside</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- observation in room [ROOM NUMBER]'s bathroom revealed no sharps container, but the encasement, that previously held the container, contained two razors that were easily accessible by placing a hand inside in the case.</p> <p>Observation on the second floor nursing unit revealed two razors in the encasement receptacle, that previously held the sharps container, mounted on the wall of the shower room. The director of nursing stated the facility removed the sharps container from the boxes that held them to the walls but staff continued to place the razors in that box which allowed continued access to the sharp items they contained.</p> <p>Interview with the director of nursing on July 9, 2024, at approximately 2:30 PM failed to provide evidence the facility provided adequate supervision and maintained an environment free of accident hazards to prevent injury to Resident 65.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395582	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Mountain City Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Hazle Township Boulevard Hazleton, PA 18202	
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>13456</p> <p>Based on review of select facility policy and staff interview, it was determined the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets to conduct a thorough resident assessment of residents following an incident of sexual abuse involving two out of 11 residents reviewed (Resident 16 and Resident 91)</p> <p>Findings include:</p> <p>A review of the facility's policy entitled Pennsylvania Resident Abuse last reviewed by the facility August 2023, indicated that after an allegation of sexual abuse The resident's attending physician should be notified if an incident has occurred requiring physician involvement. If appropriate, the facility should send the resident to the hospital for an examination.</p> <p>The facility will contact the police for any allegation of misappropriation of resident property. Administrator or designee will notify police when the facility receives a complaint of, or suspect sexual abuse, serious bodily injury or suspicious death in Allegations of Sexual Abuse every effort will be made to preserve evidence on both the resident and the perpetrator.</p> <p>The facility policy included the following procedures to be implemented for both the resident victim and the perpetrator:</p> <p>Will not be bathed or cleaned</p> <p>Will not receive incontinence care</p> <p>Incontinence brief will not be changed</p> <p>Clothing will not to be changed</p> <p>No oral care will be provided</p> <p>Both resident and perpetrator will be evaluated in the ER.</p> <p>Linens will be bagged and provided as evidence, if applicable</p> <p>Police to be notified</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of nursing documentation in Resident 16's clinical record, dated July 6, 2024 at 10:13 PM, written by Employee 2 an RN, revealed that Aide came to LPN stating she walked in on resident (Resident 16) and another resident {91} having sex. This RN went to their rooms. At this point each resident was in their separate rooms. The male resident {Resident 91} said that the female resident was naked and motioning for him to come over {to her room}. Once the male resident came over they started to engage in sex. Once the aide came in with the meal tray they stopped and he went back to their separate rooms. The female resident {Resident 16} stated that she doesn't remember a guy being here and if there was a guy here it would be {Resident 16's boyfriend name} Administrator, DON and family was notified. The physician was notified, the family declined any medical treatment at the hospital. Agency of Aging was notified at 8:11 PM. The police were notified at 8:21 PM. The police came in and did an investigation and talked to both parties. Head to toe assessment was completed on both residents. There is no history of either of the resident conversing prior to this. The male resident {Resident 91} continues to be on 1:1 until tomorrow. She {Resident 16} is moving to white building in a different room.</p> <p>Employee 2 wrote an identical entry in Resident 91's medical record.</p> <p>Further review of Resident 16's clinical record revealed nursing documentation entitled Focused Head to Toe Observation regarding sexual occurrence dated July 6, 2024 at 7:46 PM. Employee 2 did not document the results of an examination an examination of the resident's mouth, anus, or genital areas.</p> <p>The residents were not sent to the hospital for evaluation according to facility policy.</p> <p>During a telephone interview with Employee 2, RN, on July 9, 2024, at 12:52 PM she stated that she completed the head to toe assessment on Resident 16. However, she verified that she did not document that she examined Resident 16's mouth, anus, or genitalia and did not obtain orders to complete bloodwork to rule out sexually transmitted diseases She confirmed that she had not performed a sexual assault examination on Resident 16 and confirmed that she is not trained to conduct that type of examination. When asked about preservation and collection of evidence, she stated the bed linens should be washed. Employee 2 stated that she was unsure what was done with the residents' bedding and clothing. Employee 2 also confirmed she did not complete or document any assessment of Resident 91.</p> <p>As per the International Association of Forensic Nurses, a healthcare provider trained to conduct sexual assault exams performs a sexual assault exam. A sexual assault forensic examiner (SAFE), a sexual assault nurse examiner (SANE), or one of these types of doctors.</p> <p>A review of Employee 2's records revealed that she was not trained to conduct a sexual assault forensic exam.</p> <p>The DON and NHA confirmed during interview on July 9, 2024, that the residents were not sent to the hospital according to facility policy and Employee 2, RN, did not possess the necessary competencies to perform a sexual assault exam and she was not specifically trained to perform that type of sexual examination on the residents to include mouth, anus and genitalia.</p> <p>28 Pa. Code 211.10 (a)(d) Resident care policies</p> <p>28 Pa. Code 211.5 (f)(ii) (iii) (iv)Medical records</p> <p>(continued on next page)</p>

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 201.18 (e)(1) Management. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services. 28 Pa. Code 201.19 (1)(3) Personnel records

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>21738</p> <p>Based on review of the facility's plan of correction from the survey of April 19, 2024, and the findings of the survey ending July 10, 2024, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to develop and implement corrective action plans to prevent a continued quality deficiency related to abuse prohibition to ensure that plans designed to improve the delivery of care and services were consistently implemented to effectively deter future quality deficiencies.</p> <p>Findings include:</p> <p>During a standard survey completed at the facility on April 19, 2024, deficient facility practice was identified under the requirement for residents to be free from abuse and neglect. In response to this quality deficiency the facility developed a plan of correction, to include a quality assurance monitoring component to ensure that solutions were sustained. This plan was to be completed by May 14, 2024.</p> <p>In response to the quality of care deficiency cited during the survey of April 19, 2024, related to the facility's failure to prevent resident abuse the facility's plan of correction was to:</p> <p>Educate facility staff (interdisciplinary) on identifying behaviors and placing interventions to reduce initiating and/or receiving physical aggression.</p> <p>To prevent abuse from reoccurring, the nursing home administrator (NHA)/designee educated staff on the Abuse Policy.</p> <p>To monitor and maintain ongoing compliance, the director of nursing (DON)/designee reviewed progress notes five times per week times four weeks then monthly times two to identify any residents exhibiting aggressive behaviors. To monitor and maintain ongoing compliance, the DON/designee reviewed progress notes five times per week for four weeks then monthly times two to identify residents having increased behaviors that put them at risk for receiving aggression. To monitor and maintain ongoing compliance the DON/designee interviewed five interviewable residents weekly times four then monthly times two to ensure they feel safe in the facility. To monitor and maintain ongoing compliance, the DON/designee will review resident to resident incidents weekly times four then monthly times two to establish patterns of day of the week and shift.</p> <p>However, during the revisit survey ending July 10, 2024, a review clinical records, facility incident reports, and staff interviews revealed that the facility failed to ensure that one resident (Resident 106) was free from physical abuse and one resident (Resident 16) was free from sexual abuse and resultant psychosocial harm out of 11 sampled residents.</p> <p>The facility's quality assurance monitoring plans failed to identify the ongoing quality deficiency and sustain solutions to the identified quality deficiency to be free from abuse and neglect.</p> <p>Refer F600</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 211.12 (c) Nursing services</p> <p>28 Pa. Code 201.18(e)(3)(4) Management</p>		