STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395582	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Nursing & Rehabilitation Center	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)
F 0689 Level of Harm - 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 review of clinical records, facility policy, observations, facility-provided investigative documentation, security camera evidence, and resident and staff interviews, it was determined that the facility failed to ensure appropriate supervision and implementation of safety interventions to protect a resident from accident hazards (medications) and elopement from the facility. This failure resulted in actual physical harm for one out of 10 residents sampled (Resident 1). Findings include: A review of the facility policy titled Elopement/Unauthorized Absence, last reviewed by the facility on August 15, 2025, revealed that it is the policy of the facility to identify residents with potential or actual risk factors for elopement and protect the residents through development and implementation of safety interventions. Further review revealed that in the event of a resident elopement, the facility will implement its policies and procedures promptly to locate the resident in a timely manner. Elopement occurs when a resident leaves the premises or a safe area without authorization or necessary supervision to do so, and residents identified at risk will have interventions promptly implemented to reduce the risk of elopement. A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include insomnia (a sleep disorder causing difficulty falling asleep, staying asleep, or waking up too early) and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression). A review of an annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 16, 2025, revealed that Resident 1 was cognitively intact with a BIMS score of 13 (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 physician orders dated November 4, 2025, at 10:12 AM, revealed that Resident 1 was ordered to ambulate independently in the room and on the unit without a device and independently off the unit and on facility grounds with a rollator walker (a wheeled walking aid). A nurse's progress note dated November 29, 2025, at 7:20 PM documented that the resident fell in the blue building after losing balance and falling backward onto her buttocks. A clinical record review of a physician's order dated December 2, 2025, at 4:47 PM revealed the resident was independent with ambulation in the room and on the unit without an assistive device. The previous order allowing the resident to ambulate independently in the room and on the unit without a device and independently off the unit and on facility grounds with a rollator walker was discontinued. A review of the elopement risk assessment dated [DATE], revealed that Resident 1 was assessed as not being at risk for elopement. A clinical record review of a physician's order dated December 3, 2025, at 9:01 AM revealed the resident was independent with ambulation in the room and on the unit without an assistive device and independent off the unit within the building with a rollator walker. A review of a nurse's (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	progress note dated December 15, 2025, at 11:56 PM revealed that the resident activated her call bell and self-reported that she had fallen by the sink. The note further documented that the resident scooted herself to the bed in order to get up. A review of Resident 1's clinical record revealed a nursing progress note dated December 29, 2025, at 3:13 AM, which documented that the resident was observed walking back from the bathroom with an unsteady gait (difficulty maintaining balance while walking). The note revealed the resident's oxygen saturation (the percentage of oxygen carried in the blood, measured by a pulse oximeter clipped to the finger to assess how well the lungs are oxygenating the blood) was 84 percent, below the normal range of 95 to 100 percent. The progress note documented that Resident 1 told staff that she had taken pills. When asked what type of pills she had taken, the resident was unable to respond. The record indicated that the resident was transferred to the emergency department for further evaluation.A review of outside emergency department records dated December 29, 2025, revealed that the resident was evaluated for a possible medication overdose. The hospital documentation revealed that Resident 1 was administered two doses of Narcan (a life-saving medication that rapidly reverses opioid effects by blocking opioid receptors in the brain), after which the resident became more responsive. A review of a nurse's progress note dated December 29, 2025, at 4:32 PM revealed that the resident returned to the facility with new physician orders to discontinue trazodone (a medication commonly used to treat depression and insomnia). The note documented that both the physician and the resident were made aware of the medication change. An interview with Resident 1 conducted on January 12, 2026, at 11:20 AM revealed that during medication administration she sometimes drops pills onto the floor or onto her bed. The resident stated that she sometimes keeps dropped pills in her drawer and takes them later if she chooses to do so. She further stated that she was unsure which medications she had taken on December 29, 2025, and reported that the pills were found on the floor of her room. She stated she did not know what they were, but that there were around four of them.An interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) conducted on January 12, 2026, at 12:00 PM revealed the facility did not complete an internal investigation related to the potential medication overdose involving Resident 1. The Director of Nursing stated that because the emergency department did not confirm that an overdose had occurred, the facility did not investigate the incident further, despite documentation and resident statements indicating the resident consumed unknown pills. A review of a nurse's progress note dated December 30, 2025, at 4:42 AM revealed the resident activated her call bell. Upon entering the room, the nurse found the resident sitting on the floor next to the bed. The nurse's note documented that the resident stated she had fallen out of bed while reaching for her call bell. A clinical record review of a physician's order dated December 30, 2025, the resident was to transfer with assistance from one person and to ambulate using a rollator walker. The order allowing the resident to be independent off the unit within the building was discontinued. A review of a nurse's progress note dated December 30, 2025, at 3:30 PM revealed that nursing staff were called to the social services office located on the ground floor (resident resided on the first floor) after the resident was found on the floor. Upon assessment, the resident was observed sitting in a chair. The nurse's note documented that the resident stated she did not fall and reported that she had been lying on the floor to hide from social services in order to scare them. The note further documented that the resident's ambulation status had changed to requiring assistance from one person with a rollator walker and that independence off the unit within the building was discontinued pending evaluation by physical therapy. A review of a written witness statement dated December 30, 2025, from Employee 1 (Social Services) revealed that a walker was positioned in front of the office door and that upon entering the office, the employee (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	observed the resident lying on the floor with her eyes closed. The statement further documented that when the employee called out to the resident, the resident sat up. When asked whether she had laid down or fallen, the resident stated that she had laid down. The statement noted that the resident stated that she was not being given her medications. Clinical record review revealed that following the events on December 30, 2025, when the resident was found on the floor in the social services area and her ambulation status was changed to require assistance from one person with a rollator walker, and independence off the unit within the building was discontinued, the facility did not complete a new elopement risk assessment or revise supervision and safety interventions to reflect the resident's increased need for monitoring and the restriction of off-unit mobility. A review of a nurse's progress note dated December 31, 2025, at 4:35 AM revealed that the resident activated her call bell requesting trazodone (a medication commonly used to treat depression and insomnia). The nurse documented that trazodone had been discontinued following the resident's recent hospital return and that the resident was informed the physician would be contacted regarding the request. A review of written witness statements dated December 31, 2025, from Employee 4 (Nurse Aide) revealed that at 4:30 AM the resident rang her call bell and asked for her medication. The employee documented that she did not see the resident after this interaction. A review of written witness statements dated December 31, 2025, from Employee 3 (Nurse Aide) revealed that the resident was last observed at 4:30 AM lying in bed after ringing her call bell. The employee documented that the resident did not request to go outside. The statement further revealed that the employee was later notified that the resident had been found outside near the gazebo on the ground and observed emergency medical services at that location. A review of written witness statements dated December 31, 2025, from Employee 2 (Nurse Aide) revealed that the resident was last seen in bed at 4:30 AM and was later found outside near the gazebo. A review of a written witness statement dated December 31, 2025, from Employee 5 (Licensed Practical Nurse) revealed that at 5:07 AM the employee was notified that a resident had called 911 reporting a fall in the gazebo. Upon arrival, emergency medical services were present. The resident was observed sitting on the floor in the gazebo wearing winter clothing and was assisted to a stretcher by emergency medical services. A review of facility-provided investigative documentation from the Nursing Home Administrator dated December 31, 2025, revealed that security camera footage showed the resident exiting the white building through the front doors at 4:36 AM dressed in winter clothing. At 4:39 AM the resident was observed walking through the blue building parking lot (a review of facility layout information revealed that the facility consists of two separate buildings, commonly referred to as the white building and the blue building, which are located adjacent to one another and separated by a parking lot. Resident 1 resided in the white building. Access between the two buildings requires travel across the parking lot and outdoor grounds) and at 4:41 AM she was seen walking toward the gazebo area (660 feet from the front door of white building). The gazebo was not visible on camera. The documentation noted that the resident avoided the paved walkway due to snowy conditions. The outside temperature at that time was 25 degrees Fahrenheit, (per weather history documentation) indicating cold weather exposure while the resident was outside without staff supervision. Emergency medical services arrived at 5:06 AM as observed on camera. A review of a nurse's progress note dated December 31, 2025, at 7:46 AM revealed that a 911 dispatcher contacted the facility at 5:07 AM reporting that a resident had fallen outside near the gazebo and had called for an ambulance. Staff immediately checked the resident's room, which was empty, and then proceeded outside to assist the resident as EMS was arriving. The nurse documented that the resident reported leg pain, feeling cold, and stated that she went outside to go for a walk. The nurse further documented that the resident stated (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	she was upset that her doctor would not give her medication to help her sleep. Emergency medical services transferred the resident to the hospital before a full head-to-toe assessment could be completed. The resident was noted to be wearing a black coat, pants, and sneakers. Resident 1 was admitted to the hospital from [DATE], through January 6, 2026. A review of outside hospital diagnostic imaging dated December 31, 2025, revealed that the resident sustained a left femoral neck fracture (a break in the upper portion of the thigh bone near the hip joint), which required surgical intervention, and a left pelvic hematoma with active extravasation (a collection of blood caused by ongoing bleeding from damaged blood vessels). A review of the resident's care plan revealed that a problem area related to elopement and wandering was initiated on December 31, 2025, after the elopement event occurred. The care plan identified the resident as being at risk for injury related to elopement and wandering and documented noncompliance with transfer status, self-ambulation, and signing in and out of the unit. A goal was identified for the resident to wander safely within her environment and not elope from the facility. The care plan did not reflect the elopement event of December 31, 2025, or include updated, specific interventions addressing the incident during the survey period ending January 12, 2026. A review of an elopement risk assessment dated [DATE], revealed that Resident 1 was assessed as being at potential risk for elopement and required additional interventions to address identified risk factors. Increased supervision, including 15-minute checks, was initiated after the elopement event. An interview with Employee 6 (Maintenance Director) conducted on January 12, 2026, at 10:00 AM revealed that the doors in the white building always remain unlocked. The employee explained that residents exiting the white building must use the elevator to access the main lobby in order to leave the building. The employee further explained that elevator alarms activate and the elevator locks only when a resident wearing a wander guard bracelet attempts to exit. An interview with Resident 1 on January 12, 2026, at 11:20 AM revealed that in the early morning hours of December 31, 2025, she was upset because trazodone had been discontinued and she felt she was not aware of the change at the time. The resident stated she then felt like she wanted to blow off some steam and go for a walk. She reported that she put on her winter coat, gloves, and an extra sweatshirt and walked down to the elevators with her walker, went into the elevators down to the main floor, and left through the front doors of the white building. She stated she wanted to go to the gazebo because she felt like it would be less windy. The resident stated that she fell when she arrived near the gazebo, was unable to get up because she could not grab anything to lift herself up due to leg pain and called 911 using her personal cell phone. She stated she remained outside for 30 minutes. The resident further stated that on the evening of January 11, 2026, time unknown, she walked to the nurse's station and did not observe staff present. She stated that this led her to believe she could leave the facility without staff awareness. The resident further stated that she later informed staff that she could have left again and was told that she could not because she was wearing a wander guard bracelet, despite not having a wander guard bracelet applied at that time. The resident acknowledged that she should not have left the facility unattended on December 31, 2025, and stated she understood she should not do so again. Interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on January 12, 2026, at 1:30 PM revealed the facility had not utilized a wander guard system for Resident 1, because the facility felt it was a restraint despite the resident's ability to consent or deny the use of the system. Following the interview, facility staff discussed the use of a wander guard system with Resident 1 who agreed to allow one to be applied. The security camera footage from December 31, 2025, was reviewed by the surveyor on January 12, 2026, at 11:40 AM. Following surveyor inquiry, a review of a physician's order dated January 12, 2026, at 1:56 PM revealed an order for (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	application of a wander guard bracelet and monitoring for proper placement and function. During an interview with the Nursing Home Administrator and Director of Nursing conducted on January 12, 2026, at 2:00 PM the above findings for Resident 1 were confirmed. The facility failed to ensure appropriate supervision and timely implementation of safety interventions to protect a resident from accident hazards and elopement from the facility. Specifically, the facility failed to investigate and address a reported accident hazard after Resident 1 indicated she had consumed unknown pills on December 29, 2025, and failed to reassess supervision needs and elopement risk following significant changes in the resident's condition and functional status. As a result, the resident exited the facility unsupervised on December 31, 2025, and sustained serious physical injuries, including a left femoral neck fracture requiring surgical intervention and a pelvic hematoma, constituting actual harm. 28 Pa Code 201.14(a) Responsibility of Licensee. 28 Pa Code 201.18(b)(1) (e)(1) Management. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing Services.