

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395582	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
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)		
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 clinical records, physician orders, facility documentation, and interviews with staff and the resident's family, it was determined the facility failed to honor and implement the resident representative's end-of-life treatment decisions by failing to facilitate and implement requested hospice services after the resident representative authorized hospice care and requested a change in the resident's Pennsylvania Orders for Life-Sustaining Treatment (POLST) order, for one of three residents reviewed (Resident CR1). Findings include: A review of Resident CR1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors, muscle stiffness, slowness of movement, and poor balance and coordination) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the arms or legs). The resident expired at the facility on [DATE]. Social Services documentation dated [DATE], at 4:04 PM, revealed the facility received notification from a hospice agency that the resident's son contacted the agency requesting hospice services for Resident CR1. Hospice is a coordinated program of end-of-life care that focuses on comfort, symptom management, and emotional and spiritual support for individuals with a terminal illness. The Social Services employee contacted the resident's son to discuss comfort measures (care focused on relieving pain and other symptoms without attempting to cure the underlying illness) and hospice services. The son remained adamant that hospice services be initiated and stated he had already contacted a hospice provider. Social Services documented that the resident's POLST (Physician Orders for Life-Sustaining Treatment form is a medical order that allows seriously ill patients to specify the types of medical care they want or do not want in emergencies) would need to be updated and confirmed by the resident representative before hospice services could proceed. The facility forwarded the resident's clinical information to the hospice agency and contacted the resident representative regarding hospice services and the resident's code status. Social Services documentation dated [DATE], at 4:33 PM, revealed the resident representative initially declined hospice services, stating she was not yet ready to proceed and planned to discuss the matter with the physician. A review of the social services progress note dated [DATE], at 5:21 PM, revealed the resident's code status (the level of medical treatment a resident has chosen to receive during a medical emergency) was documented as Do Not Resuscitate (DNR), meaning that if the resident's heart stopped beating or the resident stopped breathing, cardiopulmonary resuscitation (CPR) (an emergency procedure that uses chest compressions and, when appropriate, assisted breathing to attempt to restore a heartbeat and breathing) would not be initiated. Documentation indicated the resident representative had spoken with the physician, who reportedly did not recommend hospice at that time but planned to evaluate (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident on [DATE]. Social Services documented that a physician's order would be required before hospice services could be initiated. Nursing documentation dated [DATE], at 6:49 PM, revealed the resident's POLST was updated from Full Code to Do Not Resuscitate (DNR) based on the resident representative's verbal consent, witnessed by two licensed nurses. Nursing documentation dated [DATE], revealed the resident representative came to the facility and signed the updated POLST. The documentation further indicated the resident representative asked whether the physician agreed with her decision and staff documented that the physician was OK with family wishes. A subsequent review of the clinical record failed to identify documentation that the physician evaluated the resident on [DATE], as planned. The record also failed to identify a physician order initiating hospice services, documentation that a hospice referral was completed following the resident representative's request, documentation that hospice services were initiated, or evidence that the facility informed the resident representative that hospice services had not been implemented. A review of the physician orders, care plan, and nursing documentation failed to identify evidence that the resident received hospice services before the resident expired on [DATE]. During an interview on [DATE], at 1:15 PM, the Nursing Home Administrator and Employee 2, Social Services, confirmed Resident CR1 was not receiving hospice services at the time of death despite the resident representative's request for hospice care. During an interview on [DATE], at 1:48 PM, conducted by three-way telephone call with the resident representative and the resident's son, the resident representative stated the resident had been declining since the middle of [DATE]. She explained that she initially delayed hospice because she wanted the resident to attend a scheduled medical appointment and was informed that the appointment would not occur if hospice services were initiated. She stated that after the appointment she contacted the facility and requested hospice services. She further stated she spoke with the physician, who planned to evaluate the resident the following day, and later came to the facility to sign the updated POLST. The resident representative stated that when she asked whether the physician agreed with her decision, she was informed that he did. She stated, My wish was for my dad to be put on hospice. That is what I was waiting for. She further stated, When they told me the physician agreed with our decision, I believed my dad was being placed on hospice. A review of the resident's physician orders, care plan, and nursing notes failed to identify evidence that hospice services were initiated or provided following the resident representative's request. The clinical record contained no evidence that the physician evaluated the resident regarding hospice despite the documented plan to do so. The clinical record also contained no evidence that the facility informed the resident representative that hospice services had not been initiated or took additional steps to implement the resident representative's expressed end-of-life goals and preferences. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, dental consultation records, documentation from the dental provider, and staff and resident representative interviews, it was determined the facility failed to assist a resident in obtaining timely medically necessary dental services after a fractured tooth requiring extraction was identified, for one of 13 residents reviewed (Resident CR1) for dental services. Findings included: A review of the facility policy titled Dental Services, last reviewed [DATE], revealed the facility would assist residents in obtaining routine and emergency dental care and services to meet each resident's needs. The policy indicated nursing staff were responsible for notifying Social Services of a resident's need for dental services. Social Services personnel would assist the resident and resident representative in making dental appointments and transportation arrangements to and from the dental service location. A review of Resident CR1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors, muscle stiffness, slowness of movement, and poor balance and coordination) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the arms or legs). The resident expired at the facility on [DATE]. Clinical record review revealed nursing documentation dated [DATE], at 1:49 PM indicating the resident representative requested the resident be evaluated by the facility's in-house dentist. Nursing documentation dated [DATE], at 11:07 AM revealed a mobile dental provider evaluated the resident and documented a fractured tooth requiring evaluation by the dentist. A Dental Consult Sheet dated [DATE], revealed the in-house dentist evaluated the resident. The resident reported pain involving tooth number 4. A dental x-ray (an imaging study used to evaluate the teeth and surrounding bone) was obtained. The dentist recommended extraction (removal of the tooth), prescribed an antibiotic (a medication used to treat bacterial infection), and prescribed pain medication for 20 days. Continued review of the clinical record failed to identify evidence the recommended extraction was completed. A Dental Consult Sheet dated [DATE], revealed the resident continued to report discomfort involving tooth number 4, and the dentist again recommended extraction. Nursing documentation dated February 4, 2026, at 7:10 PM revealed the mobile dental provider evaluated the resident and documented it was awaiting physician approval and resident representative consent. The February 4, 2026, Dental Consult Sheet revealed the fractured tooth remained present and recommended extraction by an oral surgeon (a dentist specially trained to perform surgical procedures involving the mouth, jaw, and facial structures). The dentist again prescribed an antibiotic for 20 days. Nursing documentation dated February 6, 2026, at 4:48 AM revealed the physician approved the recommended extraction. Nursing documentation dated February 7, 2026, documented the resident representative consented to the procedure and the mobile dental provider was notified. Despite physician approval and resident representative consent, the facility failed to ensure the recommended extraction was obtained. Social Services documentation dated February 17, 2026, at 9:12 AM revealed the resident's son requested that his father receive the tooth extraction as soon as possible. Documentation indicated several local oral surgeons had been contacted but did not accept the resident's Medicaid insurance coverage. Social Services documented the family was advised either to change Medicaid plans or pay privately for the procedure and declined both options. Documentation indicated Social Services would continue to monitor. Nursing documentation dated February 24, 2026, at 7:35 AM revealed that nursing staff spoke with the physician and the resident's antibiotic was discontinued because the procedure had been cancelled. (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record failed to identify documentation the facility developed or implemented an alternative plan to obtain the recommended extraction after cancellation of the procedure. Social Services documentation dated [DATE], at 3:36 PM revealed nursing notified Social Services the resident continued to complain of tooth pain. Social Services documented that the in-house dentist was unable to perform the extraction and that multiple local oral surgeons had been contacted but would not accept the resident's Medical Assistance coverage. Documentation indicated the resident representative was advised the extraction could be completed if the family paid privately and that the family preferred to have the procedure covered by insurance. The clinical record failed to identify documentation the facility coordinated treatment with the mobile dental office located approximately 92 miles away in a different city, arranged transportation, communicated available transportation services to the family, or documented additional efforts to overcome identified barriers after physician approval and family consent had been obtained. During an interview on [DATE], at 1:15 PM, Employee 2 (Social Services) stated the in-house dentist could not perform the extraction and that mobile dental company maintained an office near Philadelphia where the extraction could be completed. Employee 2 stated the resident's son did not want the resident to travel to Philadelphia because of the distance. Employee 2 further stated several local oral surgeons had been contacted but none accepted Medicaid and the family was advised they could pay privately for the extraction. During an interview, the Nursing Home Administrator stated the facility would have transported the resident to the mobile dental office near Philadelphia at no cost to the resident. However, during a three-way telephone interview conducted on [DATE], at 1:48 PM, the resident representative and the resident's son expressed frustration that the resident had experienced pain from a fractured tooth since [DATE]. They stated they were never informed the facility would provide transportation to the appointment. They reported they believed transportation was their responsibility and, because the resident was non-ambulatory (unable to walk independently), they did not believe they had an appropriate vehicle or could safely transport him to an appointment located approximately 92 miles from the facility. The resident representative stated, Transportation was never offered. We were led to believe it was our responsibility to get him there. Had we known they would drive him there, it wouldn't have been an issue. Documentation provided by the mobile dental provider, dated [DATE], indicated the provider maintains an office located approximately 92 miles from the facility in another city where dental extractions that cannot be performed in the mobile setting are completed. The documentation further stated, According to the facility, the family of (Resident CR1) declined to transport the resident to our office for treatment. Per our notes, the extraction was initially recommended on [DATE], and the treatment plan was signed on [DATE]. However, the extraction consent form was not received. During the same telephone interview, the resident representative stated she completed and returned all consent forms mailed to her and was never informed additional documentation was required. She further stated neither the dental provider nor the facility notified her that any required paperwork remained outstanding or advised that the facility would provide transportation for the appointment. During an interview on [DATE], at 3:30 PM, the Nursing Home Administrator was unable to provide documentation demonstrating the facility informed the resident representative that transportation would be provided, notified the family that additional consent documentation was needed, or documented ongoing efforts to coordinate and facilitate the recommended extraction after it had been ordered. The facility failed to implement its Dental Services policy by failing to coordinate, facilitate, and document the actions necessary to obtain timely recommended dental treatment after the need for extraction had been identified, approved by the physician, and consented to by the resident representative. The facility failed to address identified (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	barriers related to provider availability, transportation, insurance coverage, and required documentation to obtain the medically necessary dental service. As a result, Resident CR1 remained without receiving the recommended extraction for 8 months before his death. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services. 28 Pa Code 211.12 (c) Resident care policies.		