

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 02/07/2025
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>48277</p> <p>Based on review of select facility policy, facility grievance forms, and resident, family and staff interviews, it was determined the facility failed to make ongoing efforts to resolve grievances and the provision of timely follow-up with residents and/or their representative regarding the status update on the resolution progress of a grievance for three of seven residents reviewed (Residents 107, 15 and 4).</p> <p>Findings include:</p> <p>A review of the facility's policy titled Resident Grievances and Concerns Policy last reviewed by the facility on November 12, 2024, indicated that upon receipt of an oral, written, or anonymous grievance submitted by a resident, the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, if indicated. The grievance review will be completed in a reasonable time frame consistent with the type of grievance, but in no event will the review exceed thirty (30) days. If the Grievance Committee/Grievance Official determines that a resident rights violation has occurred, then violation must be corrected within ten (10) days. Upon completion of the review, the Grievance Official will complete a written grievance decision. The Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved. A copy of the written grievance decision will be provided to the resident, upon request. The facility will keep evidence of the resolution of all grievances for a period of three (3) years from the date the grievance decision is issued.</p> <p>During a group interview conducted on February 5, 2025, at 10:00 AM with six alert and oriented residents, two of the six residents in attendance reported they filed grievances but never received a response from the facility. Resident 107 stated she had filed three grievances within the last 2 months and never received a response from the facility. She reported that an aide filled out the concern forms for me because I can't write so good. I saw her put it in the box(grievance box)</p> <p>Resident 15 stated that she filed a written grievance about six months ago and never received a response.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview conducted on February 6, 2025, at 8:13 AM with Resident 4's family member revealed that, We have 30-40 concern forms filed since admission to the facility in April (2024). Maybe 2-3 have been addressed, otherwise we have received no response, nothing has been resolved and no appropriate steps have been taken. The family member continued to report that Assistant Director of Nursing, RN Supervisor, nurses, Social Services and/or kitchen manager are the staff members who have taken he and his mother's verbal concerns and complaints. He indicated that many of the grievances centered around dietary issues, lack of receiving fresh water daily, staff treatment of his mother, wandering residents, and other care and service concerns. He reported that They come in and fill out the paperwork and say they'll take care of it and then I don't hear from them again. No resolution, no response. The lack of follow-up is concerning.</p> <p>Review of the grievance log for Resident 4 revealed three (3) grievances on file since admission to the facility in April 2024. The results of the three grievances indicated that they were resolved.</p> <p>There was no documented evidence the resident's additional complaint/grievances were investigated. There was no documented evidence of a summary of findings or conclusion regarding the resident's concerns as a result of the grievances.</p> <p>During an interview on January 7, 2025, at 9:30 AM the Nursing Home Administrator (NHA) confirmed the facility only had three grievances on file for Resident 4. The NHA was unable to provide evidence of prompt efforts to resolve a grievance and to keep the resident/family appropriately apprised of progress toward resolution.</p> <p>28 Pa. Code 201.18(e)(1) Management</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 48277</p> <p>Based on review of the facility's abuse prohibition policy, clinical records, information submitted by the facility, and select investigative reports and staff interview, it was determined the facility failed to assure that two residents (Residents 366 and 52) out of 35 sampled were free from physical abuse perpetrated by another resident (Resident 180).</p> <p>Findings include:</p> <p>A review of facility policy titled Pennsylvania Resident Abuse: Abuse, Neglect, and Exploitation last reviewed by the facility on November 12, 2024, revealed 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.</p> <p>A review of Resident 366's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues) and diabetes mellitus (body has trouble controlling blood sugar and using it for energy).</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 December 6, 2024, indicated that the resident was cognitively intact with a BIMS (Brief Interview for Mental Status - a tool to assess cognition) score of 15 (13-15 represents intact cognitive responses).</p> <p>A review of Resident 180's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included vascular dementia, severe with behavioral disturbances (a decline in thinking skills caused by conditions that block or reduce blood flow to parts of the brain, depriving them of oxygen and nutrients) and metabolic encephalopathy (chemical imbalance in the blood that affects the brain which can cause loss of memory and difficulty coordinating motor tasks).</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 2.</p> <p>A review of nursing documentation from June 2024 through December 2024, revealed that Resident 180 displayed behaviors of pacing, wandering the halls, wandering into other residents' rooms, yelling, agitation, aggressive behavior, verbally abusive with staff and other residents, physically abusive to staff, cursing, walking the hallway with no pants on, and attempting to elope from the facility. It was further noted that the resident would kick and hit staff while walking past him in the hall. It was documented that constant redirection was given, but the resident does not consistently follow redirection.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of nursing documentation dated December 10, 2024, at 3:33 AM revealed that Resident 180 was found in Resident 366's room. Staff noted that Resident 180 was standing next to Resident 366's bed. When redirection was attempted, resident 180 became agitated and was directed back to his room. Resident 366 reported Resident 180 initiated physical aggression towards her. One-to-one support provided and assessed for injuries. No injuries were noted.</p> <p>A review of the Mandatory Abuse Report dated December 10, 2024, at 4:26 AM documented that Employee 8 (nurse aide) responded to Resident 366's call light and observed Resident 180 in her room. Resident 366 reported that Resident 180 poked her right thigh forcefully, causing pain. Employee 11 (registered nurse) assessed Resident 366, who stated that Resident 180 entered her room and punched her leg multiple times with full force. Resident 366 described feeling shocked and noted that Resident 180 was significantly larger than her. Facility interventions included redirecting Resident 180 to his room, administering PRN lorazepam, offering Resident 366 a room change, relocating her to another hall, providing one-to-one emotional support, offering Tylenol for pain, and reporting the incident to law enforcement.</p> <p>Facility documentation indicated a pattern of aggressive behaviors and intrusive wandering behaviors by Resident 180 prior to the reported incident involving Resident 366. The facility failed to demonstrate proactive measures to prevent the incident.</p> <p>A review of Resident 52's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures) and cerebral infarction (brain damage that results from a lack of blood).</p> <p>A review of the resident's Quarterly Minimum Data Set Assessment (dated December 17, 2024, indicated that the resident was severely cognitively impaired with a BIMS score of 4.</p> <p>On December 27, 2024, at 8:46 AM, Resident 180 approached Resident 52 in the hallway and slapped him on the right cheek.</p> <p>A review of the Mandatory Abuse Report dated December 27, 2024, at 8:47 AM indicated that Resident 52 was seated in the hallway, singing and talking to himself, when Resident 180 approached him, raised both fists, and struck Resident 52 on the right cheek with one hand. A physical assessment revealed no noted injuries, redness, or marks. Facility interventions included the immediate separation of the residents, initiation of safety checks for Resident 52 every 15 minutes, implementation of one-to-one supervision for Resident 180, completion of body assessments, and notification of the physician and responsible party.</p> <p>A review of a witness statement submitted by Employee 10 (Physical Therapist) on December 27, 2024, with an additional statement signed on December 31, 2024, indicated that Employee 10 observed Resident 180 walking up and down the [NAME] Hall several times. While documenting at the nurse's desk, Employee 10 heard Resident 52 singing and repeating a phrase from a kitchen aide's t-shirt. Employee 10 observed Resident 52 seated in a wheelchair at the start of East Hall across from the desk. Resident 180 was seen walking from [NAME] Hall past the desk, stopping in front of Resident 52, raising his fists, and striking Resident 52 on the right cheek. Employee 10 immediately intervened, escorting Resident 180 away and redirecting him to his room. A nurse aide approached Resident 52, and the LPN was notified. The LPN then informed the RN Supervisor.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to ensure that Residents 366 and 52 were free from physical abuse perpetrated by Resident 180.</p> <p>An interview with Nursing Home Administrator on February 7, 2025, at approximately 9:35 AM confirmed the facility failed to prevent the physical abuse of Residents 366 and 52 perpetrated by Resident 180, which resulted in a punch to the thigh and a slap to the face.</p> <p>The facility failed to implement sufficient supervision and monitoring measures to address Resident 180's known history of aggression, resulting in physical abuse of other residents.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51306</p> <p>Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessments accurately reflected the status of two residents out of 35 sampled (Resident 179 and Resident 159).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 179 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs) and dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders and personality changes).</p> <p>A review of Resident 179's quarterly MDS assessment dated [DATE], revealed that Section E-Behavior, item E0900, was coded as 0-Behavior not exhibited, indicating the resident did not exhibit wandering behaviors. However, a review of the clinical record revealed documentation of wandering behavior. A progress note dated November 6, 2024, at 9:49 PM indicated that the resident had multiple incidents of wandering into and out of other residents' rooms.</p> <p>An interview with the Nursing Home Administrator on February 7, 2025, at 11:27 AM confirmed that Resident 179's quarterly MDS dated [DATE], was coded inaccurately in Section E-Behavior, item E0900, as it did not reflect the resident's documented wandering behavior.</p> <p>A review of the clinical record revealed that Resident 159 was admitted to the facility on [DATE], with diagnoses that included psychosis (mental disorder characterized by a disconnection from reality).</p> <p>A review of Resident 159's quarterly MDS dated [DATE], indicated the following in Section N:</p> <p>N0415 High-Risk Drug Classes was coded to indicate the resident was receiving a hypnotic medication (a psychoactive medication prescribed to treat sleeplessness); however, a review of the clinical record revealed no documented evidence that the resident was receiving a hypnotic medication.</p> <p>N0450 Antipsychotic Medication Review was coded in:</p> <p>N0450A to indicate the resident was receiving antipsychotic medication on a routine basis.</p> <p>N0450B to indicate that a Gradual Dose Reduction (GDR, a stepwise tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose) had not been attempted.</p> <p>N0450E did not indicate a date that the physician determined a GDR was clinically contraindicated.</p> <p>Further review of the clinical record revealed a physician order dated November 17, 2024, to discontinue Secuado (an antipsychotic) 0.8 mg/24 hours one patch applied transdermally (administer a drug through the skin) one time daily for psychosis and removed per schedule.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nurse's note dated December 13, 2024, at 12:48 PM, documented that the resident was scratching their face during the shift and required redirection with one-on-one intervention. The note also indicated the resident had recently undergone a GDR of the Secuado patch and that the resident's representative and physician were aware, with orders pending.</p> <p>A subsequent nurse's note dated December 13, 2024, at 6:28 PM documented that the resident was exhibiting behaviors including restlessness, agitation, and repetitive movements. A new physician's order was received to restart Secuado 0.8 mg/24 hours, one patch applied transdermally once daily for psychosis and removed per schedule.</p> <p>A physician's order dated December 13, 2024, documented the reinstatement of Secuado 0.8 mg/24 hours, one patch applied transdermally once daily for psychosis and removed per schedule.</p> <p>A social services note dated December 16, 2024, indicated that an interdisciplinary review had determined that the GDR had failed.</p> <p>An interview with the Director of Nursing on February 6, 2025, at approximately 2:00 PM confirmed that Resident 159's quarterly MDS assessment dated [DATE], was inaccurate.</p> <p>The facility failed to ensure that MDS assessments accurately reflected the clinical status of Residents 179 and 159, resulting in incomplete or inaccurate assessments used for care planning.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 211.12(c)(d)(1)(5) Nursing services</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 48277</p> <p>Based on a review of clinical records, select facility investigative reports, and resident and staff interviews, it was determined the facility failed to implement effective safety measures to prevent an injury during transfer for one out of the 35 sampled residents (Resident 157).</p> <p>Findings include:</p> <p>A clinical record review revealed Resident 157 was admitted to the facility on [DATE], with diagnoses to include but not limited to arthritis (a disease that causes swelling and tenderness in one or more joints) 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).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 3, 2024, revealed that Resident 157 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).</p> <p>A review of Resident 157's plan of care dated August 28, 2024, indicated that the resident had a self-care deficit related to decreased mobility requiring extensive-to-total assistance with mobility and transfers. Interventions implemented included assisting the resident during all transfers with the assistance of two staff members via mechanical lift with a black sling (a lift that uses hydraulic power to transfer a person while cradled in a sling).</p> <p>A care plan indicating Resident 157 has a self-care deficiency requiring extensive-to-total assistance with mobility and transfers related to decreased mobility initiated on August 28, 2024. Interventions implemented include assisting the resident during all transfers with the assistance of two staff members via mechanical lift with a black sling.</p> <p>A facility investigation report dated August 30, 2024, at 9:03 PM, revealed Resident 157 sustained a forehead laceration during a transfer from her bed to a bariatric bed with a new air mattress using a mechanical lift. The investigation report indicated the forehead laceration injury was new and bleeding. A wound report dated August 30, 2024, at 10:31 PM, revealed a forehead laceration measuring 5 cm x 0.5 cm.</p> <p>A witness statement dated August 30, 2024, no time indicated, provided by Employee 1 (nurse aide), revealed she was using the mechanical lift to transfer Resident 157 from her bed to a bariatric bed with new air mattress. Employee 1 indicated she was driving the lift and put her in the hallway to transfer the resident into the new bed. When lowering the bed, the leg of the lift got caught between the wheels of the bed, and Employee 2 (nurse aide), pushed Resident 157 and pulled himself toward her, and then he flipped over and hit Resident 157 in the head where the top part of the sling was, causing a small wound. An injury was identified, and Employee 1 immediately reported to the supervisor.</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 - Few</p>	<p>A witness statement dated August 30, 2024, no time indicated, provided by Employee 2 revealed Resident 157 was transferred into a bariatric bed in the hallway next to her room in the mechanical lift and was positioned over the bariatric bed, and during lowering the resident, her weight became displaced, and the base of the lift tipped over.</p> <p>A progress note dated August 30, 2024, at 9:03 PM provided by Employee 3, Registered Nurse, revealed that Resident 157 was being transferred to a different bed in the hallway to allow the contractor to put a new air mattress on the resident's bed. Upon transfer, via mechanical lift, Resident 157 suddenly hit the bed and was heard screaming OW, OW, OW. Employee 3 was at the nurses' desk, looked up, and saw that Resident 157 was in the bed and the lift was tipped on top of her. Upon arrival, Employee 3 pulled the lift from the resident's forehead and assessed the laceration that was actively bleeding, and pressure was placed on the wound, and 911 was called.</p> <p>A progress note by Employee 3, RN, dated August 30, 2024, 9:03PM, revealed the cause of the injury was improper placement and use of the mechanical lift.</p> <p>A statement from Resident 157 dated September 3, 2024, no time indicated, revealed that her air mattress had popped, and Employee 1 and Employee 2 transferred her to a bariatric bed with a new mattress via mechanical lift in the hallway. Resident 157 stated that during the transfer, the lift was pulled and hit her in the head. Resident 157 stated, I am not in any pain, but they said I have a cut.</p> <p>A community emergency department report dated August 30, 2024, at 11:10 PM documented that Resident 157 was evaluated for a laceration after being struck in the head with the mechanical lift during transfer. A head CT scan (a noninvasive medical procedure that uses x-rays to create detailed images of the body), was performed and was negative. The resident was prescribed Tylenol for pain.</p> <p>A progress note dated August 30, 2024, at 2:55 AM, revealed the resident returned from the emergency department.</p> <p>During an interview on February 4, 2024, at 1:00 PM, Resident 157 confirmed that she was hit in the head during a transfer into a new bariatric bed and had to be transferred to an emergency department for evaluation of her bleeding wound.</p> <p>A review of the facility's investigation confirmed the injury occurred due to improper placement and use of the lift during the transfer. Competency evaluations revealed that both Employee 1 and Employee 2 had satisfactory transfer skills and knowledge.</p> <p>During an interview on February 7, 2025, at 9:15 AM, the Nursing Home Administrator (NHA) confirmed that it was the facility's responsibility to ensure effective safety measures were implemented to prevent accidents and injuries to residents. The NHA acknowledged that Resident 157 sustained a laceration during the transfer on August 30, 2024.</p> <p>This deficiency is cited as past non-compliance.</p> <p>The facility's corrective action plan was to identify other residents with the potential to be affected; the Director of Nursing (DON)/designee completed a house-wide audit of proper lift technique and that air mattresses had proper inflation.</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 - Few</p>	<p>To prevent this from recurring the unit manager provided education to nursing staff regarding proper transfer technique and lift competencies were completed, and mechanical lifts were inspected for safety.</p> <p>To monitor and maintain ongoing compliance, the DON/designee audits and assesses 5 residents weekly x 4 to ensure proper lift technique is used during transfers and air mattresses are inflated without issues. Any negative findings will be immediately corrected. Results of audits will be forwarded to facility QAPI for review and recommendation as indicated.</p> <p>The facility's immediate corrective action plan was completed on September 2, 2024.</p> <p>28 Pa. Code 211.18 (e)(1) Management.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on review of clinical records, select facility investigative reports, and staff interview, it was determined the facility failed to maintain accurate and complete clinical records, in accordance with professional standards of practice for one (1) of 35 sampled residents (Resident 266).</p> <p>Findings include:</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The registered nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all of following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.18. (a)(5) document and maintain accurate records.</p> <p>According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place.</p> <p>Review of the clinical record revealed that Resident 266 was admitted to the facility on [DATE], with diagnoses to include diabetes and dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders and personality changes).</p> <p>A physician order dated [DATE], noted an order for a LCS (low concentrated sweets) regular texture diet.</p> <p>Review of an Occupational Therapy Evaluation dated [DATE], indicated the resident was independent for self-feeding.</p> <p>(continued on next page)</p>		

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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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a nurses note dated [DATE], at 6:45 PM written by Employee 7 (RN) revealed the resident was found unresponsive, was determined to be a full code (medical order that instructs healthcare team to perform all possible life-saving measures if the patient's heart or lungs stop working), and life-saving measures were immediately initiated, 911 was called immediately, EMS (Emergency Medical Services) arrived at the facility, continued life-saving measures, and the resident was transferred to the hospital. Physician and Resident Representative were made aware.</p> <p>A nurses note dated [DATE], at 11:11 PM written by Employee 7 (RN) revealed that the hospital notified the facility that the resident expired at the hospital on [DATE], approximately 7:30 PM.</p> <p>Review of the resident's SBAR Communication Form (situation, background, assessment recommendation used in healthcare to share information about a patient's condition) dated [DATE], completed by Employee 7 (RN) revealed that Resident 266 was found unresponsive at 6:45 PM, it was determined that resident was a full code and life saving measures were immediately initiated, 911 was called immediately with their arrival at 7:10 PM, EMT continued lifesaving measures and resident transported to the hospital emergency room . Resident representative and physician notified.</p> <p>Further review of the resident's SBAR Communication Form dated [DATE], revealed that Employee 7 (RN) electronically completed the form. However, Employee 7 (RN) indicated at the bottom of the SBAR Communication Form that Employee 5 (LPN) completed the form.</p> <p>Review of a facility investigative report dated [DATE], revealed that Resident 266 was noted to be choking on his dinner. The Heimlich Maneuver (first-aid technique that uses abdominal thrusts to help someone who is choking) was immediately performed without success. The resident then became unresponsive, and CPR (cardiopulmonary resuscitation-emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped) was initiated. The resident was sent to the emergency room for further evaluation of the situation.</p> <p>A review of a witness statement from Employee 4 (nurse aide) dated [DATE], revealed on [DATE], at 6:45 PM Employee 4 (nurse aide) heard the resident choking. Employee 4 (nurse aide) went into the resident's room to assist while he was coughing. Employee 4 (nurse aide) performed the Heimlich Maneuver until the resident went completely unresponsive. By then the nurse had arrived and CPR was started.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a witness statement from Employee 6 (LPN) which was signed but not dated revealed that on [DATE], Employee 6 (LPN) was alerted by staff that Resident 266 was choking. Upon entering the resident's room, the resident was sitting at the side of the bed and color was cyanotic (bluish, grayish). Employee 4 (nurse aide) was behind the resident performing the Heimlich Maneuver, the resident was unresponsive, laid on bed, mouth sweep done unable to feel or see anything. Dentures were in resident's mouth. Resident suctioned, small pieces of food, resident with no respirations, no pulse, Code Blue called, CPR initiated. 911 called. AED (automated external defibrillator which is a medical device that delivers an electric shock to the heart to help restore a normal rhythm) pads placed, no call for shock. CPR continued. Emergency Medical Technician (EMT) arrived. LUCAS (mechanical chest compression system that helps healthcare providers perform CPR on patients in cardiac arrest) device placed on resident. IV (intravenous- giving medications or fluids through a needle or tube inserted into a vein) line started. Two doses of medication were administered. While EMT was attempting to intubate (medical procedure which involves inserting a tube into a patient's airway to help them breathe) resident, a full-size meatball was pulled out of the resident's throat. CPR continued. Pulse obtained. Resident was transferred to the hospital emergency department.</p> <p>A review of a witness statement from Employee 5 (LPN) dated [DATE], revealed that on [DATE], noted that Resident 266 was observed prior to the incident moving around the unit and talking with everybody without any problems or concerns. Upon returning from break, heard the Code Blue and ran to the scene. Employee 5 (LPN) started helping. Resident 266 was sent to the hospital via ambulance. Resident unresponsive. Family made aware of the transfer.</p> <p>The investigative report documented a choking episode, but the resident's clinical record lacked any documentation of the choking incident, the Heimlich Maneuver, or the removal of a full-size meatball from the resident's airway by EMT personnel.</p> <p>Review of facility documentation revealed inconsistencies between the nursing notes, SBAR Communication Form, witness statements, and the facility's investigative report.</p> <p>An interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 5, 2025, at approximately 11:30 AM confirmed the facility's nursing staff failed to accurately and consistently document the incident in the resident's clinical record. The NHA and DON confirmed there was no documented evidence of the resident's choking incident. The DON verified that the staff member listed at the bottom of the SBAR Communication Form should have accurately reflected the individual completing the form. The facility failed to ensure that the residents clinical record was accurate and complete.</p> <p>28 Pa. Code 211.5 (f)(ii)(iii)(ix) Medical records.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>48277</p> <p>Based on a review of the facility's plan of correction from the survey ending February 7, 2025, the results of the current revisit survey on March 27, 2025, review of clinical records, information submitted by the facility, and staff interview it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies related to abuse prevention and 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>As a result of the deficiencies cited under the requirements related to abuse prevention during the survey of February 7, 2025, the facility developed a plan of correction to serve as their allegation of compliance, which included a quality assurance monitoring component to ensure solutions were sustained. The corrective plan was to be completed and functional by March 11, 2025.</p> <p>However, during the survey ending March 27, 2025, continuing deficient facility practice was identified with these same requirements.</p> <p>According to the facility's plan of correction for the deficiency cited on February 7, 2025, relating to implementation and adherence to procedures to ensure abuse prevention and to ensure deficient practice was corrected included (1) Resident 233 was discharged with no ill effects. Resident 180 plan of care was reviewed, and an updated activity assessment was completed to assess possible diversionary activity interest, (2) To identify other residents that have the potential to be affected, residents that exhibit aggressive behaviors will be reviewed by the IDT. Care plan will be updated, as necessary, (3) To prevent this from reoccurring, re-education of the abuse policy and behavior interventions will be completed with facility staff by the staff educator/designee, and (4) To monitor and maintain compliance, the DON/designee will review 10 residents that exhibit aggressive behaviors to ensure that behaviors are addressed, and care plan interventions are appropriate for behaviors exhibited. The audits will be completed weekly times 4 weeks and then monthly times 3. The results of the audits will be forwarded to QAPI committee for further review and recommendations.</p> <p>The results of the revisit survey conducted on March 27, 2025, cited under F600, revealed that the facility's QAPI committee failed to successfully implement their plan to prevent abuse and to ensure residents in the facility are protected from residents with aggressive behaviors.</p> <p>The facility's quality assurance monitoring plan, designed to ensure solutions were sustained, failed to identify the continuing deficient practice with this quality requirement and prevent recurrence of similar deficient practice as cited during the survey of February 7, 2025.</p> <p>Refer F600</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>(continued on next page)</p>		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51306</p> <p>Based on a review of select facility policy and clinical records and staff interviews, it was determined the facility failed to offer and/or provide the influenza immunization, unless the immunization was medically contraindicated or the resident had already been immunized, to one resident out of five residents reviewed for administration of the flu vaccine. (Resident 110).</p> <p>Findings include:</p> <p>A review of facility policy titled Resident Vaccination Policy, last reviewed November 12, 2024, revealed that each resident is to be offered an influenza immunization unless the immunization is medically contraindicated. Nursing staff will provide educational information to the resident/authorized representative prior to the administration of each vaccine. Once education has been completed, a signed consent form is to be obtained prior to the administration of the vaccine.</p> <p>A review of the clinical record revealed that Resident 110 was admitted to the facility on [DATE], with diagnoses to 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 major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest in activities, fatigue, and feelings of worthlessness).</p> <p>Review of Resident 110's Informed Consent for Influenza, Pneumococcal, and Covid Vaccines signed by Resident 110's resident representative on August 26, 2024, confirmed authorization for the facility to administer the influenza vaccine., Covid vaccine, and pneumococcal vaccines.</p> <p>However, there was no documented evidence that the influenza vaccine was administered as per the signed consent.</p> <p>An interview with the Director of Nursing on February 7, 2025, at 12:24 PM confirmed the facility failed to provide the influenza immunization to Resident 110 despite having obtained the required valid signed consent.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa Code 211.5 (f)(i) Medical records.</p> <p>28 Pa. Code 211.10(a)(d) Resident care policies .</p> <p>28 Pa code 211.12 (c)(d)(1)(5) Nursing Services.</p>		