

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Mount Carmel Senior Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2616 Locust Gap Highway MT Carmel, PA 17851	
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Based on observation, clinical record review, review of facility documents, and staff interview, it was determined that the facility failed to protect the rights of a resident to be free from neglect by not providing the services necessary to avoid physical harm related to a fracture of her left lower leg for one of five residents reviewed for abuse/neglect (Resident 1). This deficiency is cited as past noncompliance Findings include: Observation of Resident 1 on December 3, 2025, at 1:00 PM revealed she was in bed and she appeared to be sleeping. Clinical record review for Resident 1 revealed a progress note dated October 24, 2025, at 11:27 AM that indicated Resident 1 was being transported in her wheelchair to an outside activity. Resident 1 was holding her legs up, but she put them down. Her legs were not on leg rests, and she started to complain of pain in her left leg. Further clinical record review revealed that Resident 1 had her initial x-ray of her left lower leg on October 24, 2025. The results were received the same day at 3:17 PM and were negative for a fracture. On October 26, 2025, at 10:39 PM nursing documentation indicated that Resident 1 was resting in bed with her call bell in reach. Resident 1 continued to complain of left ankle discomfort. Her ankle remained edematous (swollen) and ice and Tylenol were administered per physician orders. Resident 1's feet were propped up on pillow. she yells out with any movement of her foot. Nursing will continue to observe. On October 28, 2025, at 11:31 AM the PA-C reviewed the left knee ankle x-rays and had no new orders. A physician's progress note dated October 30, 2025, at 11:38 AM revealed that Resident 1 was examined, and she was still complaining of pain in her left ankle. The physician ordered for her left lower leg to be x-rayed again. A progress note dated October 30, 2025, at 1:26 PM indicated that the x-ray results were received and showed an acute fracture of the distal left tibia (large bone in the lower leg between the knee and ankle) and fibula (thin bone in the lower leg that runs parallel to the tibia on the outer side of the leg). A progress note dated October 30, 2025, at 1:26 PM revealed that Resident 1's physician was made aware of her left lower leg x-ray results and ordered an orthopedic consult, pain medications, a splint to the left lower leg, and for her to be non- weight bearing on her left leg. A progress note dated October 30, 2025, at 2:32 PM indicated that the Certified Physician Assistant ordered the facility to send Resident 1 to the emergency room because orthopedics was unable to see her. Resident 1 was transferred to the emergency room at 2:49 PM. She returned to the facility on October 31, 2025, at 8:15 AM. A CT scan completed in the emergency room confirmed Resident 1 had a fracture of her left tibia and fibula. A progress note dated November 6, 2025, at 2:55 PM revealed that resident returned from an orthopedic appointment with a cast on her left lower extremity. Review of the facility's investigation into Resident 1's incident that caused the fracture, dated October 24, 2025, at 10:00 AM revealed a witness statement by Employee 1, Licensed Practical Nurse (LPN) that indicated she was pushing Resident 1 back in the door from an outside activity when Resident 1 yelled that her leg got stuck. Employee 1 indicated that she did not see Resident 1's legs because they were covered with a blanket. Her statement indicated that she took Resident 1 back to her room and put her in bed. She then notified the supervisor and the physician. She received orders to apply ice to the left lower leg and to obtain and x-ray. Interview of the Director of Nursing and Nursing Home Administrator at 11:30 AM revealed that their investigation determined that Resident 1 was being pushed back into the facility in her wheelchair by Employee 1 and she did not have leg rests on her wheelchair during the transport. They indicated that when they interviewed Employee 1, who is an agency LPN, she indicated that she was unaware of the facility's current policy related to transporting residents via wheelchair that indicated if a resident is unable to self-propel then leg rests need to be utilized. They indicated that this prompted them to review all new hire and agency hire orientation packets to make sure the policy related to transporting residents via wheelchair was included. Review of the facility's corrective action revealed that Employee 1 was suspended during the investigation. She was educated on transporting residents in wheelchairs on October 24, 2025. All staff were educated on the current policy of transporting residents in wheelchairs and neglect. This was completed on November 1, 2025. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on December 3, 2025, at 2:30 PM. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights</p>		