| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395589 | A. Building<br>B. Wing | 07/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mount Carmel Senior Living Community | 2616 Locust Gap Highway<br>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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>Based on observation and staff interview, it was determined that the facility failed to maintain confidentiality of residents' personal health information for four of four previous surveys reviewed that were located in one of one survey results binder (main lobby of facility). Findings include: Observation of a seating area located in the main lobby of the facility on July 15, 2025, at 10:55 AM revealed a binder that contained the results of the most recent surveys of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. Review of the contents of the binders revealed that the facility placed the full health survey letters and complaint deficiency letters (letters sent to administration after a survey) along with the Statement of Deficiencies (Form CMS-2567) into the binder. The deficiency letters also noted the specific resident identifiers and associated resident names used for any cited deficiencies in the Statement of Deficiencies. The binder contained the following deficiency letters with the resident identifiers and the associated Statement of Deficiencies: A deficiency letter dated April 21, 2025, with the attached survey that ended April 18, 2025, and included two residents listed. A deficiency letter dated March 25, 2025, with the attached survey that ended March 18, 2025, and included four residents listed. A deficiency letter dated November 27, 2024, with the attached survey that ended November 25, 2024, and included ten residents listed. A deficiency letter dated August 28, 2024, with the attached survey that ended August 23, 2024, and included 23 residents listed. The information was reviewed with the Nursing Home Administrator on July 15, 2025, at 11:16 AM. 28 Pa. Code 201.14(a) Responsibility of licensee |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff and resident interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medication for one of five residents reviewed for medication review (Resident 2). Findings include: Clinical record review for Resident 2 revealed her medication regime included the use of the antipsychotic medication, Loxapine Succinate, 10 milligrams daily, since her admission on [DATE], for a diagnosis of unspecified schizophrenia (serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior. Review of progress notes from the facility's consulting psychiatric provider dated January 10, 2025, January 20, 2025, February 10, 2025, and April 28, 2025, revealed that Resident 2 had a history of depression for which she took the antidepressant medication, Fluoxetine, and that, pt (patient) with chronic psych illness, stable on current regimen. No psychiatric evaluations available in Resident 2's medical record included the diagnosis of schizophrenia or the use of the antipsychotic medication Loxapine Succinate. Review of the plans of care developed by the facility for Resident 2's care needs revealed a care plan to address her use of psychotropic medications related to schizophrenia (initiated January 8, 2025). The plan of care included no target behaviors exhibited by Resident 2 or monitored by the facility to support an adequate indication for the antipsychotic use. Review of behavior monitoring recorded on Resident 2's treatment administration records dated May, June, and July 2025, revealed the only target behavior tracked by the facility was if Resident 2 was, withdrawn. Interview with Resident 2 on July 18, 2025, at 11:30 AM revealed that she had no recollection of a practitioner diagnosing her with schizophrenia. Resident 2 stated that she developed deep depression after the death of her mother more than 30 years ago (when she was in her thirties) for which she received counseling and started taking an antidepressant. Resident 2 denied ever experiencing delusions, hallucinations, or disorganized thinking. Interview with Employee 1 (regional director of clinical) on July 17, 2025, at 3:35 PM confirmed that Resident 2's medical record did not contain supporting documentation regarding the history of Resident 2's schizophrenia diagnosis and that all documentation from the facility's consulting psychiatric provider only addressed Resident 2's diagnosis of depression. The interview with Employee 1 on July 18, 2025, at 9:41 AM confirmed that the facility did not monitor individual target behaviors related to Resident 2's diagnosis of schizophrenia or her use of the antipsychotic medication. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident and/or their representative received written notice of transfer for one of five residents reviewed for hospitalizations (Resident 41); and written notice of the facility bed-hold policy at the time of transfer for three of five residents reviewed for hospitalization (Residents 9, 11, 41).Findings include:<br><br>Clinical record review for Resident 41 revealed nursing documentation dated June 6, 2025, at 2:22 PM that Resident 41 wanted to go to the hospital due to rectal pain.<br><br>Nursing documentation dated June 6, 2025, at 2:35 PM revealed that staff called emergency medical services (911).<br><br>Hospital documentation dated June 6, 2025, confirmed that Resident 41 presented to the emergency department for evaluation of rectal pain.<br><br>There was no documented evidence that the facility provided Resident 41 or her responsible party with written information regarding the facility’s bed-hold policy. There was no documented evidence that the facility provided a written transfer notice to Resident 41's responsible party.<br><br>The surveyor requested evidence that the facility provided Resident 41 and her responsible party written notice of transfer and written notice regarding the facility's bed-hold policy during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (regional director of clinical) on July 16, 2025, at 1:45 PM.<br><br>Interview with Employee 11 (social services director) on July 17, 2025, at 10:46 AM revealed that although she created a transfer notice for Resident 41, she did not provide Resident 41's responsible party the written notification of transfer. Employee 11 also denied providing written notice of the facility's bed-hold policies to either Resident 41 or her responsible party.<br><br>Interview with the Director of Nursing on July 17, 2025, at 11:38 AM confirmed that the facility did not have evidence that bed-hold and transfer notices were provided to Resident 41 and her responsible party.<br><br>Nursing documentation for Resident 11 dated June 16, 2025, at 11:00 AM revealed that the resident had abdominal pain, and the medical provider wanted the resident sent to the Emergency Department for evaluation.<br><br>Nursing documentation for Resident 11 dated June 16, 2025, at 2:59 PM revealed the resident was admitted to the hospital.<br><br>Nursing documentation for Resident 11 dated June 24, 2025, at 1:29 PM revealed the resident returned to the nursing facility.<br><br>Further clinical record review revealed no documentation to indicate that Resident 11 and/or their representative received a written notice of the facility bed-hold policy at the time of transfer.<br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview on July 17, 2025, at 1:31 PM with the Director of Nursing and Employee 1, Regional Director of Clinical Services, confirmed that there was no evidence that a written notice of the facility bed-hold policy was provided to the Resident 11 and/or their representative at the time of transfer.<br><br>Review of Resident 9’s clinical record revealed that the facility transferred him to the hospital on March 26, 2025, for hypotension (low blood pressure). There was no documented evidence that the facility provided Resident 9 with written information regarding the facility’s bed hold notice.<br><br>Review of Resident 9’s clinical record revealed that the facility transferred him to the hospital on June 25, 2025, for hypotension. There was no documented evidence that that the facility attempted to provide Resident 9 with a transfer notice that included all the required contents: State long term care appeal agency or contact and address information for the Office of the State Long-Term Care Ombudsman including email address or provided Resident 9 with written information regarding the facility’s bed hold notice.<br><br>Interview with the Director of Nursing on July 17, 2025, at 1:30 PM confirmed the above findings for Resident 9.<br><br>28 Pa. Code 201.14(a) Responsibility of license<br><br>28 Pa. Code 201.29(a) Resident rights |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's status for one of three closed records reviewed (Resident 113). Findings include: Clinical record review for Resident 113 revealed a Discharge Return Not Anticipated Medicare MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated June 30, 2025, in which facility staff assessed the resident as being discharged to a short-term general hospital. Further closed clinical record review for Resident 113 revealed the resident had signed out of the facility against medical advice and was not discharged to a hospital on June 30, 2025. Interview with Employee 10, Registered Nurse Assessment Coordinator (RNAC), on July 17, 2025, at 10:37 AM confirmed the MDS did not accurately reflect Resident 113's discharge status. The above information was reviewed with the Director of Nursing on July 17, 2025, at 2:00 PM. 483.20(g) Accuracy of AssessmentsPreviously cited 8/23/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to revise a resident's comprehensive care plan for one of 21 residents reviewed (Resident 11).Findings include: Clinical record review for Resident 11 revealed a significant change MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated June 26, 2025. The MDS indicated the resident was assessed as receiving oxygen therapy. A current physician's order for Resident 11 noted supplemental oxygen at two liters per minute (LPM) via nasal cannula (a type of medical tubing to deliver supplemental oxygen to the nose) every shift for shortness of breath; check oxygen saturation (a non-invasive measurement of the amount of oxygen in the blood usually measured through a medical device placed on a finger) every shift to keep saturation above 90 percent. Resident 11's current care plan revealed the resident is on oxygen therapy related to ineffective gas exchange. An intervention dated June 25, 2025, included oxygen settings that noted the resident has oxygen via nasal prongs/mask at two liters continuously. Another intervention included to Give medications as ordered by physician. Monitor/document side effects and effectiveness. Observation on July 15, 2025, at 2:25 PM revealed that Resident 11 was in bed. The resident did not have any supplemental oxygen being administered. Observation of Resident 11 on July 18, 2025, at 11:15 AM revealed the resident was in bed and did not have any supplemental oxygen being administered. A concurrent interview with Resident 11 revealed that the resident does not utilize the supplemental oxygen. An interview with the Director of Nursing and Employee 1, Regional Director of Clinical Services, on July 18, 2025, at 11:30 AM revealed that Resident 11's oxygen order is based on oxygen saturation and the resident has been greater than 95 percent. The facility failed to revise Resident 11's comprehensive care plan based on changing goals, preferences, and needs of the resident and in response to current interventions. The above information for Resident 11 was reviewed with the Director of Nursing on July 18, 2025, at 12:02 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide transfer and eating assistance to a dependent resident for one of three residents reviewed for activities of daily living concerns (Resident 41).Findings include: Observation of Resident 41 on July 15, 2025, at 12:33 PM revealed she was in bed. Interview with Resident 41 on the date and time of the observation revealed that she stayed in bed due to physical limitations following her right leg surgery. Resident 41 stated that she was not out of bed yet on this date. During the observation and interview with Resident 41 on July 15, 2025, at 12:50 PM a nurse aide delivered her lunch. The nurse aide obtained assistance from a second staff person to reposition Resident 41 in bed; however, did not ask Resident 41 if she wanted to get out of bed. The nurse aide stayed to feed Resident 41 due to her reported loss of vision. Resident 41, in the presence of the nurse aide, stated that not all staff stay to assist her with her meal. Resident 41 stated that she has lost 40 pounds since her admission to the facility. Clinical record review for Resident 41 revealed an active physician's order dated May 6, 2025, for staff to get Resident 41 out of bed for all meals. Review of a plan of care developed by the facility to address Resident 41's deficits performing activities of daily living revealed interventions that included: Out of bed for all meals, initiated May 6, 2025The resident requires the assistance of two staff to reposition and turn in bed, initiated May 5, 2025 D (dependent) feed for eating, initiated May 6, 2025The resident requires total mechanical lift and the assistance of two staff for transfers Dietary documentation dated May 14, 2025, at 3:54 PM indicated that Resident 41 had lost 15.2 pounds and that Resident 41 was, .assisted with meals to ensure adequacy. Review of Resident 41's weight assessments revealed that she weighed 179.2 pounds on May 6, 2025, and 164 pounds on May 14, 2025 (a loss of 15.2 pounds). Observation of Resident 41 on July 16, 2025, at 12:42 PM revealed she was in bed. Interview with Resident 41 on the date and time of the observation revealed that she was not out of bed for her breakfast meal. Resident 41 stated that she has eaten all her meals while in bed and not once have staff gotten her out of bed for a meal. The surveyor reviewed the above observations and interviews with Resident 41 related to her assistance getting out of bed and eating her meals during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (regional director for clinical), on July 16, 2025, at 1:45 PM. A typewritten note provided by the facility the morning of July 17, 2025, revealed that the staff who obtained the physician's order to have Resident 41 out of bed for meals did not include it correctly within the tasks available for nurse aides to document, but that they updated the nurse aide task list. Observation of Resident 41 on July 18, 2025, at 11:28 AM revealed she was in bed. Resident 41 denied that staff asked her to get out of bed on this date. Interview with Employee 7 (nurse aide) on July 18, 2025, at 11:35 AM revealed that no staff documented morning care for Resident 41. Employee 7 confirmed that she was assigned to work the hall on which Resident 41 resided. Employee 7 confirmed that the instructions available to care for Resident 41 included that she needed the assistance of two staff for bed mobility, dressing, and transfers, and the assistance of one staff for feeding. Interview with Employee 8 (nurse aide) on July 18, 2025, at 11:38 AM revealed that she did not provide care to Resident 41. Employee 8 also confirmed that no staff documented care for Resident 41 for the morning on this date. Employee 8 confirmed that she did not ask Resident 41 if she wanted to get out of bed. Employee 8 stated that she believed staff from the overnight shift provided morning care to Resident 41; however, did not document that the care was provided. The interview indicated that overnight staff left the building, but that Employee 9 (nurse aide) documented Resident 41's breakfast meal intake for this date. Interview with Employee 9 on July 18, 2025, at 11:51 AM revealed that she worked on the hallway where Resident 41 resided until 10:00 AM and moved to another hallway assignment. Employee 9 confirmed that she charted Resident 41's breakfast meal percentage; but that she only gave Resident 41 ice water. Employee 9 questioned, is she a feed? Employee 9 reviewed task instructions for Resident 41 with the surveyor and confirmed that Resident 41 was assessed as dependent for feeding and that she should have had staff present during her breakfast meal. Employee 9 stated that she was not aware that Resident 41 needed to be out of bed for meals but then verified in the task directions that she was to be out of bed for all meals. The facility failed to provide Resident 41 necessary services for eating and transfer assistance. 483.24(a)(2) ADL Care Provided for Dependent ResidentsPreviously cited deficiency 11/25/24 28 Pa. Code 211.12(d)(1)(5) Nursing services |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered treatments and medications for two of 21 residents (Residents 11 and 48).Findings Include:<br><br>Clinical record review for Resident 11 revealed a diagnosis list that included atrial fibrillation (an irregular and sometimes rapid heart rhythm that can lead to complications such as stroke and heart failure).<br><br>Review of Resident 11’s current care plan revealed the resident has hypertension (high blood pressure) and an altered cardiovascular status related to atrial fibrillation.<br><br>A review of the current physician orders for Resident 11 revealed an order dated June 25, 2025, for Metoprolol Succinate ER Extended Release (a medication that is used to treat high blood pressure and/or heartrate) 100 milligrams (mg) give one tablet by mouth one time a day related to unspecified atrial fibrillation. Hold for a systolic blood pressure (SBP, the top number of a blood pressure reading where the heart contracts) less than 100 or apical pulse less than 60 beats per minute.<br><br>A review of the Medication Administration Record (MAR) for June and July 2025, for Resident 11 revealed that the Metoprolol was marked as administered outside of the physician specified parameters for the following dates:<br><br>June 30, the resident’s pulse was documented as 59.<br><br>July 1, the resident’s pulse was documented as 58.July 5, the resident’s pulse was documented as 55.<br><br>There was no documentation for Resident 11 to indicate why the medication was administered outside of the specific stated parameters.<br><br>The above information for Resident 11 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on July 16, 2025, at 2:00 PM.<br><br>A follow-up interview with the Director of Nursing on July 17, 2025, at 1:31 PM indicated there was no reason why Resident 11’s medication was administered outside of the specific stated parameters on the above dates.<br><br>An observation of Resident 48 on July 15, 2025, at 11:47 AM revealed the resident was in bed with multiple small bruises on both of her arms, and a bandage on her upper right arm. The resident stated she bruises very easily and has her whole life. Resident 48 stated anytime she is touched by staff to move her or slightly bumps her arms she bruises, and the bandage on her upper right arm was covering a skin tear she recently got during care.<br><br>Clinical record review or Resident 48 revealed an active physician’s order dated July 7, 2025, for the resident to have Geri-sleeves applied to her bilateral upper extremities for skin protection every shift.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 48 did not have Geri-sleeves on during the observation on July 15, 2025, noted above.<br><br>A follow up observation of Resident 48 on July 16, 2025, at 9:32 AM revealed the resident was in bed with no Geri-sleeves applied to her arms. Resident 48 stated, “I got another bruise on my arm last night. ” Resident 48 indicated she has not had any “sleeves” applied to her arm nor has she refused them for days.<br><br>The above information regarding Resident 48 not having Geri-sleeves in place as ordered was reviewed with the Nursing Home Administrator and Director of Nursing on July 16, 2025, at 2:00 PM.<br><br>Observation of Resident 48 on July 17, 2025, at 12:30 PM revealed the resident in bed with white tubi-grips (elastic tubular bandage) observed on both of her arms collected (slid down) around her wrists. Resident 48 stated, “This is not going to work, these are way too big and just slipped right down to my wrist. ” Concurrent interview with the Director of Nursing indicated facility staff would find something that fit the resident better.<br><br>483.25 Quality of carePreviously cited 8/23/24, 11/25/25, and 3/18/25<br><br>28 Pa. Code 211.10(c) Resident care policies<br><br>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure that a resident received proper treatment and assistive devices to maintain hearing abilities for one of one resident reviewed for hearing concerns (Resident 36). Findings include: Interview with Resident 36 on July 15, 2025, at 1:19 PM revealed that he had difficulty hearing. Observation of Resident 36 revealed that he utilized a headphone amplifier device that he removed to answer his mobile phone, which decreased his ability to hear the person on the phone. Resident 36 stated, was just up to the VA (Veterans Administration), they take care of my hearing. Resident 36 denied knowing the status of his hearing aids. Clinical record review of nursing documentation dated March 21, 2025, at 10:38 AM revealed that staff notified Resident 36's daughter that his hearing aid was not working. Staff noted that a filter in the hearing aid was occluded, and that the battery was corroded. Nursing documentation dated March 24, 2025, at 1:25 PM noted that Resident 36's daughter was aware that Resident 36's hearing aid needed a filter and service due to battery corrosion. Resident 36's daughter questioned if the facility handled the service and was told that the facility was unable to, but she was encouraged to call, where the hearing aid came from. Nursing documentation dated May 15, 2025, at 10:03 AM revealed that Resident 36 had a hearing aid in his right ear that needed batteries. Nursing documentation dated May 20, 2025, at 7:16 PM revealed that Resident 36 stated that he was missing his hearing aid, and Resident 36, stated that someone took them to fix them but I'm not sure what is true. Resident is a poor historian. Nursing documentation dated May 20, 2025, at 8:24 PM revealed that Resident 36 stated that he was at an appointment that day, staff asked him for his hearing aid, and he left them with office staff. Review of a plan of care initiated by the facility on March 12, 2025, revealed that Resident 36 had an alteration in his neurological status related to Alzheimer's dementia (brain disease that results in a decline in mental abilities severe enough to interfere with daily life). Review of a consultation form dated May 20, 2025, for Resident 36's VA appointment revealed that Resident 36's left ear was impacted with cerumen (wax), that staff were to implement treatment for four days with an over-the-counter ear wax treatment solution (Debrox), flush the ear with warm water, continue medications and therapy, and to follow-up in 12 months with laboratory testing before his next appointment. The document did not include any information related to Resident 36's hearing aid(s), and there was no information on the provider's progress note regarding a repair plan for a hearing aid or that they had possession of the hearing aid(s). Resident 36's clinical record contained no evidence that facility staff contacted Resident 36's audiology services provider regarding services necessary for Resident 36's hearing deficit or to confirm that the provider took possession of Resident 36's hearing aid(s). Resident 36's clinical record contained no further communication regarding the status of his hearing aid(s). The surveyor requested information regarding facility staff communication with the VA since Resident 36's May 2025 appointment during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (regional director of clinical) on July 16, 2025, at 1:45 PM. Review of an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated March 13, 2025, revealed that Resident 36 had minimal difficulty hearing, and that no hearing aid was used when completing the assessment. Staff indicated that the facility would proceed to a care plan to address Resident 36's hearing problem due to his minimal difficulty hearing. Review of a plan of care initiated by the facility on March 17, 2025, to address Resident 36's potential communication problem related to a hearing deficit, revealed no intervention that indicated Resident 36 utilized a hearing aid. Instructions per the Resident Assessment Instrument (RAI) Manual noted that when completing the section (B0200, Hearing) staff were to ensure that the resident is using their normal hearing appliance if they have one. Hearing devices may not be as conventional as a hearing aid. Some residents by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure the hearing appliance is operational. Review of a quarterly MDS assessment dated [DATE], revealed that Resident 36 had moderate difficulty hearing, but that no hearing aid was used when completing the assessment. The facility failed to accurately complete assessments, develop an individualized plan of care, and coordinate professional audiology services to assist Resident 36 to maintain his ability to hear. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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|---|---|---|---|
| | 395589 | A. Building<br>B. Wing | 07/18/2025 |

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|---|---|
| Mount Carmel Senior Living Community | 2616 Locust Gap Highway<br>MT Carmel, PA 17851 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to ensure a resident's environment remained free from accident hazards for one of five residents reviewed for accident hazards (Resident 83). Findings include: Observation of Resident 83's room on July 16, 2025, at 9:37 AM revealed a countertop wooden block with large scissors and seven knives visible near his television. Interview with Resident 83 on the date and time of the observation confirmed that he leaves his room often during the day to go outside or on leaves of absence, and his room door does not lock. The surveyor reviewed the above concern regarding Resident 83's open storage of knives in his room during an interview with the Nursing Home Administrator and the Director of Nursing on July 16, 2025, at 1:45 PM. Clinical record review for Resident 83 revealed documentation by the business office manager dated July 16, 2025, at 4:55 PM (following the surveyor's questioning) that she and social services staff went to see Resident 83 regarding the block of knives in his room. Resident 83 was notified that he could not have the knives, and they were removed from his possession and placed in the Nursing Home Administrator's office. 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Previously cited deficiency 8/23/24 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care or services that was trauma informed and/or culturally competent.<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for two of two residents reviewed for mood and behaviors (Residents 9 and 63).Findings include: Clinical record review for Resident 9 revealed a diagnosis of Post Traumatic Stress Disorder (PTSD, a mental and behavioral disorder that develops related to a terrifying event) since his admission to the facility on November 27, 2023. Review of Resident 9's care plan revealed that there were no identified triggers (everyday situations that cause a person to re-experience the traumatic event as if it was reoccurring) or interventions to alleviate individualized triggers. There was no documented evidence that the facility completed a trauma assessment on Resident 9 regarding his PTSD diagnosis. Review of Resident 63's clinical record revealed that the facility initiated a diagnosis of PTSD on November 7, 2023. A review of a physician's progress note dated November 7, 2023, indicated that Resident 63's only two daughters were murdered. Review of Resident 63's plan of care revealed that the facility did not identify Resident 63's trauma, complete a trauma assessment, or develop a care plan related to her PTSD to identify triggers or interventions to alleviate them. The facility failed to identify and care plan triggers that may retraumatize Resident 9 and Resident 63 related to their diagnosis of PTSD. The above findings were reviewed during an interview with the Director of Nursing (DON) on July 18, 2025, at 12:30 PM for Resident 9 and 63 and confirmed that the DON was aware of Resident 63's daughters being murdered. 28 Pa Code 211.12 (d)(3)(5) Nursing services |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by one of 21 residents reviewed (Resident 7). Findings include: Clinical record review for Resident 7 revealed the resident was admitted on [DATE], with a diagnosis of unspecified dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 7's admission minimum data set (MDS, a form completed at specific intervals to determine care needs) assessment dated [DATE], indicated that facility staff assessed Resident 7 as having a diagnosis of dementia, and a BIMS (brief interview of mental status) score of three indicating severe cognitive impairment. A review of Resident 7's plan of care developed by facility staff revealed alteration in cognition, with general basic interventions such as cueing and reorienting, therapy staff as needed, and lab work as needed. There was no evidence of any individualized person-centered interventions to address Resident 7's dementia and cognitive loss, to aid in caring for the resident. The findings were reviewed with the Director of Nursing on July 17, 2025, at 1:55 PM 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation and staff interview, it was determined that the facility failed to ensure adequate storage of medications and biologicals on one of four hallways (Maple).Findings include: Observation on July 17, 2025, at 12:00 PM of the Maple Hallway revealed an unlocked treatment cart against a wall, outside a resident's room. Opening drawers in the cart revealed multiple tubes of creams. Continued observation of the cart for five minutes revealed no employee attending the cart, and two residents were moving independently in the hallway. In an interview with the Director of Nursing (DON) on July 17, 2025, at 12:35 PM the unlocked cart was shown to the DON, who confirmed the cart should be locked. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that the facility failed to store food and maintain food service equipment in accordance with professional standards for food service safety in the facility's main kitchen, and two of two nursing unit pantries (Oak/[NAME] and Marble/Maple). Findings include: An observation in the facility's main kitchen on July 15, 2025, at 9:22 AM revealed the following: Open wire rack shelving was observed in the walk-in cooler near the beverage station. Multiple wire shelves were observed rusty with the exterior finish worn off. The lower shelves located six to eight inches from the floor with food products stored on them contained no barrier from the potential for mop water splash or sweeping debris from the floor. A black plastic tub was observed on the lower shelf in the same walk-in cooler with multiple clear plastic bags of unidentified meat. The tub was full of a clear liquid. Employee 6, dietary manager, indicated the bags contained chicken thighs, which were in a tub of water thawing for the dinner meal. There was label to indicate what the product was, when it was placed there, or when it needed used by. A plate warmer located by the meal serving line contained a build of dust, and dried food debris on the lower corner protective bumpers of the unit. Bulk flour and sugar bins located under a prep table were soiled on the exteriors with dried brown spills and black smudges. The flooring under the bulk flour and sugar bins extending under the ovens, cooking equipment, and plastic storage units contained dirt and debris buildup under the equipment and along wall edges. An observation of the Oak/[NAME] pantry storage area on July 15, 2025, at 9:43 AM revealed an assorted bin of snacks in the corner cabinet containing individual packaged cookies. There was no date on the bin/cookies to indicate when they were placed there or when they needed used by. Review of the temperature monitoring log on the refrigerator/freezer in the Oak/[NAME] pantry revealed no temperatures were recorded for the refrigerator or freezer since July 11, 2025. An observation of the Marble/Maple pantry area on July 15, 2025, at 9:46 AM revealed two soiled plastic meal trays stored in the cabinet under the sink, with a package of graham crackers, soiled plate base, and used plastic lids. The interior base of the cabinet was observed with a large dried brown liquid spill. The rims of the doors to the cabinet were soiled with black and brown dried spills. Review of the temperature monitoring log on the refrigerator/freezer in the Marble/Maple pantry revealed no temperatures were recorded for the refrigerator or freezer since July 11, 2025. The interior of the refrigerator was observed with ice/frost buildup covering the back of the interior. The interior of the freezer above the refrigerator was covered in thick ice/frost buildup. The above information was reviewed during an interview with the Nursing Home Administrator and Director of Nursing on July 16, 2025, at 2:10 PM. 28 Pa. Code 201.14 (a) Responsibility of Licensee |

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| F 0914<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide bedrooms that don't allow residents to see each other when privacy is needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and resident and staff interview, it was determined that the facility failed to assure full visual privacy for one of 32 residents reviewed (Resident 11).Findings include: Observation of Resident 11 in his room on July 17, 2025, at 9:15 AM revealed that the privacy curtain did not extend around the bottom of the bed, preventing full visual privacy. Upon entering the room with Employe 5, Licensed Practical Nurse, to observe a medication pass for Resident 11's roommate, Resident 11 was receiving a brief change. Employee 5 waited until Resident 11 was no longer exposed before walking past, but he was observed in bed, uncovered, wearing only a brief and in a state of undress. Further observation revealed that the curtain was not large enough to extend around the bottom portion of Resident 11's bed. Interview with Resident 11 on July 17, 2025, at 11:15 AM revealed that the curtain has not extended around the bed since their admission on [DATE]. The surveyor discussed the above findings with the Director of Nursing on July 17, 2025, at 1 :45 PM. |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>Based on review of employee education records and staff interview, it was determined that the facility failed to ensure that nurse aides received 12 hours of in-service training annually for three of three nurse aides reviewed (Employees 2, 3, and 4). Findings include: Review of the active nurse aide hire list revealed that Employee 2, nurse aide, was hired on May 3, 2018. There was no documented evidence that Employee 2 completed 12 hours of in-service training annually. Employee 2 only had six hours of in-service training since January 2025. Employee 3, nurse aide, was hired by the facility on May 3, 2018. There was no documented evidence that Employee 3 completed 12 hours of in-service training annually. Employee 3 only had six hours of in-service training since January 2025. Employee 4, nurse aide, was hired by the facility on June 21, 2021. There was no documented evidence that Employee 4 completed 12 hours of in-service training annually. Employee 4 only had six hours of in-service training since January 2025. Interview with the Director of Nursing on July 17, 2025, at 11:40 AM confirmed that the facility has recently only started in-service trainings for nurse aides since January 2025. 28 Pa. Code 201.18 (b)(3) Management 28 Pa. Code 201.19 Personnel policies 28 Pa. Code 201.20 (a)(c)(d) Staff development 28 Pa. Code 211.12(c) Nursing services |