STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Care and Rehabilitation Center	2309 Stafford Avenue Scranton, PA 18505

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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Keep all essential equipment working safely. 13456 Based on information submitted by the facility, observations and staff interviews it was determined the facility failed to maintain essential electrical and mechanical equipment in safe operating condition, to include the exhaust hood above the stove and the walk-in freezer in the kitchen, and magnetic door locking and wanderguard systems, to maintain a safe environment for residents placing the 85 residents residing in the facility in immediate jeopardy to their safety. Findings include: A review of information dated May 28, 2024, submitted by the facility, on May 27, 2024, at approximately 7:00 AM the facility lost electrical power for approximately 15 minutes. This loss of electrical power resulted in the lack of power and functionality of the facility's magnetic locking and wanderguard system for the doors, hot water heater, and exhaust hood of above the stove in the kitchen. The local fire company was onsite and drained the dry system deeming it inoperable. The dry system was the system used by the facility since the sprinkler system was also inoperable. As a result of the electrical power outage the facility was running select systems on emergency generator power. A fire company from across the state was called to repair the dry system along with the security company and an electrician as per the information submitted by the facility on May 28, 2024. Information submitted by the facility revealed that on May 30, 2024, at 11:22 PM the fire alarms sounded and the fire company arrived and assessed the entire facility and cleared the building. There was no burning smells or smoke. When the fire company entered the sprinkler room next to facility's chapel there was water coming out of the sprinkler system, all valves were turned off and the water stopped on its own. The facility was unable to reset the fire alarm. According to the facility, the fire company instructed the facility to disconnect the backup batteries to stop the fire alarms from going off. The facility was instructed to continue a fire watch. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024

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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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation upon arrival at the facility at 7:50 AM on May 31, 2024, revealed that the main entrance door was unlocked. Interview with NHA at that time, revealed that since the prior evening at 11:22 PM, there has been no dry system for fire suppression since it was drained. The facility had no means of fire suppression since both the sprinkler system and dry system were both inoperable. Further observation revealed that the generator was currently running at that time, and had been running since May 27, 2024. According to the NHA the walk-in freezer and hot water heaters were supported by the generator. The NHA was unable to state specifically what systems and equipment were supported by emergency generator. It was later determined, by surveyor observation and interview with the facility's maintenance man on May 31, 2024, at 8:30 AM, that facility's the central air conditioning was also supported by the generator. Observation on May 31, 2024, at 9 AM confirmed that the exhaust hood above the stove in the kitchen was not functioning and unable to vent potentially hazardous cooking exhaust. The facility had continued to use the stove from May 27, 2024, through the time of the survey on May 31, 2024, despite the lack of the functioning exhaust. At 10:05 AM on May 31, 2024, the fire alarm sporadically sounded, and the fire department arrived. It was determined at that time that no fire alarm panels were working, there was no power to the smoke detectors and heat detectors this in conjunction with no sprinkler or dry system to extinguish a fire. Observations and interviews with the facility's maintenance staff on May 31, 2024, at 10:30 AM confirmed that if the facility's gas powered generator was not running, or had to be turned off for any equipment repairs, the facility would not have hot water or air conditioning in the resident common areas. The individual PTAC units in the residents' room and wall oxygen were still supported by direct electrical power. Problem diagnostics determined that there was a malfunction in the transfer switch on the generator and if this switch was not replaced the door locking and wanderguard system would not work. At the time of the survey on May 31, 2024, 5 residents wore Wanderguard devices as an intervention to prevent elopements. Due to the failure of multiple essential operating systems and equipment failures, and limitations of running select systems on emergency generator power for extended periods of time, immediate jeopardy to the health and safety of residents was identified. The facility was unable to maintain a safe environment for residents due to the lack of fully functioning equipment and electrical systems to support essential equipment. On May 31, 2024, at 12:15 PM. the Nursing Home Administrator was informed that residents were in Immediate Jeopardy and the IJ template was provided. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1)(e)(1)(2.1) Management.