STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395276	A. BLDG: 00 B. WING:	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUMMIT AT BLUE MOUNTAIN NURSING AND REHABILITATION CENTER, T STATE LICENSE NUMBER: **070502**	**211 NORTH 12TH STREET LEHIGHTON, PA 18235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey completed on December 12, 2024, it was determined The Summit at Blue Mountain Nursing and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0637 SS=D		F 0637		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395276	A. BLDG: __00_____ B. WING: _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUMMIT AT BLUE MOUNTAIN NURSING AND REHABILITATION CENTER, T	**211 NORTH 12TH STREET LEHIGHTON, PA 18235**
STATE LICENSE NUMBER: **070502**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0637 SS=D	Continued from page 1 483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 0637	1. Significant Change Assessment Schedule for Resident 12 with ARD date of 12/24/2024. 2. Education provided to RNAC and inter-disciplinary team for guidance and definition of Significant Change Assessment. 3. Audit performed on facility census for residents with potential need of Significant Change Assessment. 4. Will audit for compliance of timely identification and completion of Significant Change Assessments weekly x 4, monthly x 2 by RNAC/designee. Finding will be reported to QAPI.	Completion Date: **01/06/2025** Status: **APPROVED** Date: **12/24/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395276	A. BLDG: 00 B. WING:	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUMMIT AT BLUE MOUNTAIN NURSING AND REHABILITATION CENTER, T STATE LICENSE NUMBER: **070502**	**211 NORTH 12TH STREET LEHIGHTON, PA 18235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0637 SS=D	Continued from page 2 Based on a review of clinical records and the Resident Assessment Instrument and staff interviews, it was determined the facility failed to conduct a significant change Minimum Data Set Assessments (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) for one of 12 residents reviewed (Resident 12). Findings include: According to the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) assessments dated October 2023, the facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines or should have determined that there has been a significant change in the resident's physical or mental condition. The RAI Manual indicates a "significant	F 0637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395276	A. BLDG: __00_____ B. WING: _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUMMIT AT BLUE MOUNTAIN NURSING AND REHABILITATION CENTER, T	**211 NORTH 12TH STREET LEHIGHTON, PA 18235**
STATE LICENSE NUMBER: **070502**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0637 SS=D	Continued from page 3 change" is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan." A review of the clinical record revealed that Resident 12 was admitted to the facility on June 27, 2024, with diagnoses to include diabetes and depression. Review of Resident 12's quarterly MDS dated October 24, 2024, indicated the resident was independent with eating, required partial-moderate assistance for dressing, transfer, and toileting, and was able to ambulate 10 feet once standing with partial to moderate assistance. A nurses note dated October 27, 2024, noted that Resident 12 was transferred and admitted to the	F 0637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395276	A. BLDG: __00_____ B. WING: _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUMMIT AT BLUE MOUNTAIN NURSING AND REHABILITATION CENTER, T	**211 NORTH 12TH STREET LEHIGHTON, PA 18235**
STATE LICENSE NUMBER: **070502**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0637 SS=D	Continued from page 4 hospital for evaluation of stroke-like symptoms. A nurses note dated October 31, 2024, noted Resident 12 was readmitted to the facility with a new diagnosis of acute CVA (cerebrovascular accident- stroke) with right-side weakness. A current physician order dated October 31, 2024, revealed an order for a full-body mechanical lift (medical device designed to lift and move pateints safely) with the assistance of two staff for transfers. Observation of Resident 12 during the lunch meal in the main dining room on December 11, 2024, at approximately 12:15 PM revealed that Resident 12 was positioned at a dining room table in a Geri-chair (a large, padded reclining chair designed for individuals with limited mobility). Resident 12 was not able to eat independently and was fed by staff. Further review of Resident 12's clinical record revealed no documented evidence that a significant change MDS was completed as required based on	F 0637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395276	A. BLDG: __00_____ B. WING: _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUMMIT AT BLUE MOUNTAIN NURSING AND REHABILITATION CENTER, T	**211 NORTH 12TH STREET LEHIGHTON, PA 18235**
STATE LICENSE NUMBER: **070502**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0637 SS=D	Continued from page 5 the resident's decline in more than one area of health status. Interview with the Nursing Home Administrator on December 12, 2024, at approximately 9:30 AM confirmed that a comprehensive significant change MDS assessment was not completed as required. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services	F 0637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395276	A. BLDG: 00 B. WING:	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUMMIT AT BLUE MOUNTAIN NURSING AND REHABILITATION CENTER, T STATE LICENSE NUMBER: **070502**	**211 NORTH 12TH STREET LEHIGHTON, PA 18235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 4880	Medical records. (f) In addition to the items required under 42 CFR 483.70(i)(5) (relating to administration), a resident ' s medical record shall include at a minimum: (i) Physicians' orders. (ii) Observation and progress notes. (iii) Nurses' notes. (iv) Medical and nursing history and physical examination reports. (v) Admission data. (vi) Hospital diagnoses authentication. (vii) Report from attending physician or transfer form. (vii) Diagnostic and therapeutic orders. (viii) Reports of treatments. (ix) Clinical findings. (x) Medication records. (xi) Discharge summary, including final diagnosis and prognosis or cause of death. This REGULATION is not met as evidenced by:	P 4880	1. Physician discharge summary note placed note for Resident 35. 2. Re-education to all physicians and physician extenders on importance of placing discharge summary note within 30 days of resident discharge from the facility. 3. A 6-month (June 2024- December 2024) lookback of discharged residents was completed to ensure timely discharge note was placed. 4. DON/Designee will complete audit of discharged residents and physician note entry monthly x 3 and reported to QAPI.	Completion Date: **01/06/2025** Status: **APPROVED** Date: **12/24/2024**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395276	A. BLDG: 00 B. WING:	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUMMIT AT BLUE MOUNTAIN NURSING AND REHABILITATION CENTER, T STATE LICENSE NUMBER: **070502**	**211 NORTH 12TH STREET LEHIGHTON, PA 18235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 4880	Continued from page 1 Based on a review of clinical records and interview with facility staff it was determined the facility failed to ensure that a discharge summary, with the physician's final diagnosis and cause of death, was completed for one out of two discharged residents reviewed (Resident 35) Findings include: A review of Resident 35's closed clinical record revealed the resident was admitted to the facility on January 26, 2018. The resident expired on November 9, 2024. A review of the resident's closed clinical record on December 12, 2024, revealed the resident's record did not contain a physician's discharge summary with the resident's final diagnosis and cause of death. An interview with the administrator on December 12, 2024, at approximately 1:00 PM confirmed the facility could not provide documentation a physician discharge summary was completed for Resident 35.	P 4880		

Certified End Page

SUMMIT AT BLUE MOUNTAIN NURSING AND REHABILITATION CENTER, T

STATE LICENSE NUMBER: 070502

SURVEY EXIT DATE: 12/12/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY