

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395331</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: <b>MOUNTAIN LAUREL HEALTHCARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>700 LEONARD STREET CLEARFIELD, PA 16830</b>
STATE LICENSE NUMBER: <b>032702</b>	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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  Findings of an abbreviated complaint survey and incident survey completed on January 9, 2025, at Mountain Laurel Healthcare and Rehabilitation Center identified no deficient practice under the requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities as it relates to the Health portion of the survey process; however, deficient practice was identified under 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

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)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395331</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: <b>MOUNTAIN LAUREL HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>032702</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>700 LEONARD STREET CLEARFIELD, PA 16830</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 1080	<p>Responsibility of licensee.</p> <p>(g) A facility owner shall pay in a timely manner bills incurred in the operation of a facility that are not in dispute and that are for services without which the resident ' s health and safety are jeopardized.</p> <p>This REGULATION is not met as evidenced by:</p>	P 1080	<p>National Healthcare Staffing has agreed to a payment schedule. The facility Scheduler will receive, review and process each National Healthcare Staffing invoice and forward to the Nursing Home Administrator for approval. Then the Business Office Manager/designee will forward electronically to the Accounts Payable for payment. Facility administrator will review the Accounts Payable relative to National Healthcare Staffing to ensure timely payments as follows: weekly x2, monthly x2 for timely processing of National Healthcare Staffing with results to the facility Quality Assessment and Assurance Committee.</p>	<p>Completion Date: <b>02/18/2025</b> Status: <b>APPROVED</b> Date: <b>01/24/2025</b></p>

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395331</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MOUNTAIN LAUREL HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>700 LEONARD STREET CLEARFIELD, PA 16830</b>		
STATE LICENSE NUMBER: <b>032702</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 1080	Continued from page 1  Based on a review of unpaid invoices, and interviews with administrative staff, it was determined that the facility failed to pay, in a timely manner, bills incurred in the operation of the facility for services without which the residents' health and safety are jeopardized.  Findings included:  A review of unpaid invoices provided by National Healthcare Staffing agency revealed outstanding accounts payable balances for: September 20, 2024 - \$46,143.11 October 4, 2024 - \$34,671.00 October 18, 2024 - \$34,671.09 November 1, 2024 - \$10,817.18 November 15, 2024 - \$36,002.50 November 29, 2024 - \$33,543.56 December 13, 2024 - \$31,628.28 December 27, 2024 - \$32,126.55 January 7, 2024 - \$35,369.58	P 1080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395331</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MOUNTAIN LAUREL HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>700 LEONARD STREET CLEARFIELD, PA 16830</b>		
STATE LICENSE NUMBER: <b>032702</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 1080	Continued from page 2  Interview with the owner of National Healthcare Staffing agency on January 8, 2025, at 1:33 p.m. revealed that the facility owes a current balance of \$324,648.00. He was told by the Nursing Home Administrator that a check was sent on January 7, 2025, for \$46,143.11, but it was sent by regular mail, so he is unsure when he will receive it. The check was to be for the invoice, dated September 20, 2024. National Healthcare Staffing refused to send more staff to the facility until they get a more significant amount of money.  Interview with the Nursing Home Administrator on January 8, 2025, at 11:01 a.m. confirmed that the facility has an outstanding balance due to National Healthcare Staffing agency and that the agency pulled their staff from the facility due to lack of payment. A payment was sent to the agency to pay the invoice for September 20, 2024, but not for any of the other invoices. The Nursing Home Administrator confirmed that the facility is unable to provide the required amount of nursing staff without the use of staffing agencies.	P 1080		



# Certified End Page

**MOUNTAIN LAUREL HEALTHCARE AND REHABILITATION CENTER**

**STATE LICENSE NUMBER: 032702**

**SURVEY EXIT DATE: 01/09/2025**

**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, 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