STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395542	A. BLDG: 00 B. WING:	04/18/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MOUNTAIN TOP REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **040802**	**185 S MOUNTAIN BOULEVARD MOUNTAIN TOP, PA 18707**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey completed on April 18, 2025, it was determined that Mountain Top Rehabilitation and Healthcare 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 0640 SS=F		F 0640		

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.

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F 0640 SS=F	Continued from page 1 483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.	F 0640	F0640 – Encoding /Transmitting Resident Assessment A. Corrective action taken for residents identified: Residents #70, #77, #58, #100, #78 #47 – outstanding MDS completed and submitted B. Registered Nurse Assessment Coordinator or designee will conduct an initial audit of open MDS assessments to review for timely completion. Findings will be addressed and corrected. C. Nursing Home Administrator or designee will re-educate on the required assessment completion and transmission timeframes per CMS regulations. D. Nursing Home Administrator or designee will complete an MDS tracking form weekly x6 weeks of completed assessments, to for timeliness. Any variances of completion or submission within regulatory timeframes will be addressed, and results will be shared with QA committee for review.	Completion Date: **05/28/2025** Status: **APPROVED** Date: **05/02/2025**

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F 0640 SS=F	Continued from page 2 (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by:	F 0640		

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F 0640 SS=F	Continued from page 3 Based on clinical record review and staff interview and review of the Resident Assessment Instrument Manual, it was determined the facility failed to transmit Minimum Data Set (MDS) assessments to the required electronic system, the Centers for Medicare and Medicaid Services (CMS) Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, within 14 days of completion for six of 22 residents reviewed (Residents 70, 77, 58, 100, 78, and 47). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (federally-mandated assessments of a resident's abilities and care needs), dated October 2024, revealed that all MDS assessments must be submitted within 14 calendar days of the MDS Completion Date (Z0500B + 14 days).	F 0640		

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F 0640 SS=F	Continued from page 4 A review of Resident 70's quarterly MDS with an Assessment Reference Date (ARD) of February 20, 2025, revealed that Section Z0500B was not completed or submitted on or before March 8, 2025 (within 14 days of the ARD date) and remained incomplete and not submitted to the QIES ASAP system through survey ending April 18, 2025. A review of Resident 77's quarterly MDS with an ARD of February 17, 2025, revleaed that Section Z0500B was not completed or submitted on or before March 5 (within 14 days of the ARD date) and remained incomplete and not submitted to the QIES ASAP system through survey ending April 18, 2025. Further review of Resident 77's clinical record revealed a quarterly MDS assessment with an ARD of September 25, 2024. Section Z0500B was not completed or submitted on or before October 11, 2024 (within 14 days of the ARD date) and	F 0640		

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F 0640 SS=F	Continued from page 5 remained incomplete and not submitted to the QIES ASAP system through survey ending April 18, 2025. A review of Resident 58's quarterly MDS with an ARD of February 25, 2025, revealed that Section Z0500B was not completed or submitted on or before March 10, 2025 (within 14 days of the ARD date) and remained incomplete and not submitted to the QIES ASAP system through survey ending April 18, 2025. A review of Resident 100's clinical record revealed a quarterly MDS assessment with an Assessment Reference Date (ARD) of February 24, 2025, revealed that Section Z0500B was not completed or submitted on or before March 14, 2025 (within 14 days of the ARD date) and remained incomplete and not submitted to the QIES ASAP system through survey ending April 18, 2025. A review of Resident 78's End of Part A Stay MDS with an ARD of February 26, 2025, revealed that	F 0640		

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F 0640 SS=F	Continued from page 6 Section Z0500B was not completed or submitted on or before March 12, 2025 (within 14 days of the ARD date) and remained incomplete and not submitted to the QIES ASAP system through survey ending April 18, 2025. A review of Resident 47's quarterly MDS with an ARD (assessment reference date) of March 18, 2024, revealed that Section Z0500B was not completed or submitted on or before April 1, 2025 (within 14 days of the ARD date) and remained incomplete and not submitted to the QIES ASAP system through survey ending April 18, 2025. During an interview conducted on April 17, 2025, at 11:33 AM, the facility's Registered Nurse Assessment Coordinator (RNAC) confirmed that the above MDS assessments were not completed and submitted to the QIES ASAP system within the required 14-day timeframe. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0640		

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F 0640 SS=F	Continued from page 7 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0640		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 8 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	F0641 – Accuracy of Assessments A. Resident #49: MDS assessment modified and resubmitted to reflect the accurate assessment B. Registered Nurse Assessment Coordinator will conduct an initial audit to identify other residents/MDS assessments with coding discrepancies for item O0110K1 (hospice). All findings will be addressed. C. Nursing Home Administrator or designee will re-educate the Registered Nurse Assessment Coordinator on RAI Manual guidelines related to O0110K1 coding. D. Nursing Home Administrator or designee will audit O0110K1 of completed MDS assessments, weekly x6 weeks, to ensure accuracy. Inaccurate coding will be addressed upon identification and results will be shared with QA committee for review.	Completion Date: **05/28/2025** Status: **APPROVED** Date: **05/02/2025**

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F 0641 SS=D	Continued from page 9 Based on a review of clinical records and the Resident Assessment Instrument and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 22 sampled (Resident 49). Findings include: A review of the clinical record revealed that Resident 49 was admitted to the facility on October 31, 2023, with diagnosis to include Alzheimer's disease (a progressive brain disease that destroys memory and other important mental functions), and protein-calorie malnutrition (a condition caused by not getting enough calories or the right amount of protein and nutrients needed for health). Further review of Resident 49's clinical record revealed the resident was currently receiving hospice services (specialized medical service that focuses on	F 0641		

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F 0641 SS=D	Continued from page 10 comfort and quality of life for people with a terminal illness). A review of Resident 49's quarterly MDS assessment dated December 20, 2024, revealed in Section O, Special Treatments K. Hospice Care, that the resident was not receiving Hospice Care. An interview with the Director of Nursing on April 17, 2025, at 10:40 AM confirmed the resident was receiving Hospice Care during the period reviewed for the Quarterly MDS assessment dated December 20, 2024, and the resident's MDS Assessment was inaccurate with respect to Hospice Care. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0641		

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F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	F Tag 0657: 1. Resident 91's plan of care was updated to reflect weight changes with implementation of appropriate interventions. 2. Director of Nursing or Designee will conduct an initial of residents with significant weight changes to verify that their individualized plans of care were completed addressing current weight significant changes and implementation of interventions as warranted. 3. Director of Nursing or Designee will be provided re-education to the Interdisciplinary Care Team on Comprehensive Plans of Care updating/reviewing reflecting weights. 4. Director of Nursing or designee will conduct audits on residents identified as having a significant weight changes to verify care plans and implementation of interventions as warranted. The audits will be conducted weekly x 4 weeks and monthly x 3 months. Results of these audits will be brought to the QAPI Committee for review and recommendations	Completion Date: **05/28/2025** Status: **APPROVED** Date: **05/02/2025**

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F 0657 SS=D	Continued from page 12 Based on review of clinical records and staff interviews, it was determined the facility failed to review and revise the resident's care plan to reflect a significant change in condition related to weight loss for one of 22 residents sampled (Resident 91). Findings include: Review of the clinical record revealed Resident 91 was admitted to the facility on December 12, 2023, with diagnoses that included dementia (a group of symptoms affecting memory, thinking, and social abilities that interfere with daily functioning). A review of the resident's weight history showed that on March 18, 2025, Resident 91 weighed 138.6 pounds. This represented an 8.5% loss of body weight over the prior 90 days. A nutrition progress note dated March 18, 2025, documented the registered dietitian had continued to implement nutritional interventions to address the resident's weight loss. However, review of the	F 0657		

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F 0657 SS=D	Continued from page 13 resident's care plan revealed the most recent revision was dated December 13, 2023, and stated the resident was at nutritional risk related to kidney disease, hypertension, and a history of weight fluctuations. Upon review during the survey conducted April 15-18, 2025, there was no documented evidence that the resident's care plan had been reviewed or revised to reflect the significant weight loss identified on March 18, 2025. There were no updates to existing interventions or additions of new interventions addressing the change in nutritional status or ongoing monitoring of weight. During an interview conducted on April 17, 2025, at 2:30 PM, the Nursing Home Administrator confirmed the facility failed to update Resident 91's care plan to reflect the resident's current weight status and associated needs. The Administrator acknowledged that the resident's plan of care should have been reviewed and revised in response to the noted weight loss.	F 0657		

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F 0657 SS=D	Continued from page 14 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0657		

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P 5280	Pharmacy services. (j.1) The facility shall have written policies and procedures for the disposition of medications that address all of the following: (1) Timely and safe identification and removal of medications for disposition. (2) Identification of storage methods for medications awaiting final disposition. (3) Control and accountability of medications awaiting final disposition consistent with standards of practice. (4) Documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition. (5) A method of disposition to prevent diversion or accidental exposure consistent with applicable Federal and State requirements, local ordinances and standards of practice. This REGULATION is not met as evidenced by:	P 5280	P 5280 – Disposition of Medications 1. The facility cannot retroactively correct said deficiency. 2. Residents discharged within the last 14 days will be reviewed by the Director of Nursing or Designee to verify proper documentation for disposition of medications occurred. 3. Director of Nursing or Designee will re-educate licensed nurses on documentation of disposition of medications. 4. Director of Nursing or Designee will conduct audits of discharged residents daily x 2 weeks, weekly x 4 weeks and monthly x 2 months to ensure proper documentation of disposition of medications occurred. Results of these audits will be reviewed by the facility's QAPI Committee for review and recommendations	Completion Date: **05/28/2025** Status: **APPROVED** Date: **05/02/2025**

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:
	395542	A. BLDG: __00_____ B. WING: _____	04/18/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MOUNTAIN TOP REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **040802**	**185 S MOUNTAIN BOULEVARD MOUNTAIN TOP, PA 18707**

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P 5280	Continued from page 1 Based on closed clinical record review and staff interview, it was determined the facility failed to document the accounting and disposition of medications in the clinical record upon the discharge of one of four discharged residents reviewed (Resident 109). Findings include: A review of the closed clinical record for Resident 109 revealed the resident was admitted to the facility on November 6, 2024, and discharged on January 29, 2025. At the time of the survey, which concluded on April 18, 2025, there was no documented evidence in the resident's clinical record indicating the accounting of remaining medications or the disposition of those medications at the time of discharge. An interview conducted with the Nursing Home Administrator on April 18, 2025, at 10:30 AM confirmed the facility did not document the	P 5280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395542	A. BLDG: __00_____ B. WING: _____	04/18/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MOUNTAIN TOP REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **040802**	**185 S MOUNTAIN BOULEVARD MOUNTAIN TOP, PA 18707**

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P 5280	Continued from page 2 accounting or disposition of Resident 109's medications upon discharge.	P 5280		

Certified End Page

MOUNTAIN TOP REHABILITATION & HEALTHCARE CENTER

STATE LICENSE NUMBER: 040802

SURVEY EXIT DATE: 04/18/2025

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
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