STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395582	A. BLDG: 00 B. WING:	02/07/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MOUNTAIN CITY NURSING & REHAB CTR STATE LICENSE NUMBER: **085602**	**403 HAZLE TOWNSHIP BOULEVARD** **HAZLE TOWNSHIP, PA 18202**

(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, Abbreviated Complaint, and Civil Rights Compliance Survey completed on February 7, 2025, it was determined that Mountain City Nursing & Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0585 SS=E		F 0585		

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 0585 SS=E	Continued from page 1 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	Step 1 R4, R107, & R15 will be interviewed to determine if they have any unresolved grievances. Follow up will occur based on the findings of the interviews. Step 2 To identify other residents that have the potential to be affected, the DON / designee will interview residents with a BIMs of 12 or greater to determine if they have any unresolved grievances. The residents with a BIMs less than 12 will have their representative contacted to determine if they have any unresolved grievances. Follow up will occur based on the findings. Step 3 To prevent this from reoccurring, the staffing educator / designee will educate community staff on the grievance process. Step 4 To monitor and maintain compliance, the IDT team will interview 10 residents and 10 resident representatives to ensure that any grievances that they have voiced	Completion Date: **03/11/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0585 SS=E	Continued from page 2 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585	have been followed up on. The audits will be completed weekly times 4 weeks and then monthly times 3. The results of the audits will be forwarded to QAPI committee for further review and recommendations.	

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F 0585 SS=E	Continued from page 3 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=E	Continued from page 4 Based on review of select facility policy, facility grievance forms, and resident, family and staff interviews, it was determined the facility failed to make ongoing efforts to resolve grievances and the provision of timely follow-up with residents and/or their representative regarding the status update on the resolution progress of a grievance for three of seven residents reviewed (Residents 107, 15 and 4). Findings include: A review of the facility's policy titled "Resident Grievances and Concerns Policy" last reviewed by the facility on November 12, 2024, indicated that upon receipt of an oral, written, or anonymous grievance submitted by a resident, the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, if indicated. The grievance review will be completed in a reasonable time frame consistent with the type of grievance, but in no event will the review exceed	F 0585		

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F 0585 SS=E	Continued from page 5 thirty (30) days. If the Grievance Committee/Grievance Official determines that a resident rights violation has occurred, then violation must be corrected within ten (10) days. Upon completion of the review, the Grievance Official will complete a written grievance decision. The Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved. A copy of the written grievance decision will be provided to the resident, upon request. The facility will keep evidence of the resolution of all grievances for a period of three (3) years from the date the grievance decision is issued. During a group interview conducted on February 5, 2025, at 10:00 AM with six alert and oriented residents, two of the six residents in attendance reported they filed grievances but never received a response from the facility. Resident 107 stated she had filed three grievances within the last 2 months and never received a response from the facility. She reported that an "aide filled out the concern forms	F 0585		

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F 0585 SS=E	Continued from page 6 for me because I can't write so good. I saw her put it in the box"(grievance box)" Resident 15 stated that she filed a written grievance about six months ago and never received a response. An interview conducted on February 6, 2025, at 8:13 AM with Resident 4's family member revealed that, "We have 30-40 concern forms filed since admission to the facility in April (2024). Maybe 2-3 have been addressed, otherwise we have received no response, nothing has been resolved and no appropriate steps have been taken". The family member continued to report that Assistant Director of Nursing, RN Supervisor, nurses, Social Services and/or kitchen manager are the staff members who have taken he and his mother's verbal concerns and complaints. He indicated that many of the grievances centered around dietary issues, lack of receiving fresh water daily, staff treatment of his mother, wandering residents, and other care and service concerns. He reported that "They come in and fill	F 0585		

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F 0585 SS=E	Continued from page 7 out the paperwork and say they'll take care of it and then I don't hear from them again. No resolution, no response. The lack of follow-up is concerning". Review of the grievance log for Resident 4 revealed three (3) grievances on file since admission to the facility in April 2024. The results of the three grievances indicated that they were resolved. There was no documented evidence the resident's additional complaint/grievances were investigated. There was no documented evidence of a summary of findings or conclusion regarding the resident's concerns as a result of the grievances. During an interview on January 7, 2025, at 9:30 AM the Nursing Home Administrator (NHA) confirmed the facility only had three grievances on file for Resident 4. The NHA was unable to provide evidence of prompt efforts to resolve a grievance and to keep the resident/family appropriately apprised of progress toward resolution.	F 0585		

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F 0585 SS=E	Continued from page 8 28 Pa. Code 201.18(e)(1) Management	F 0585		
F 0600 SS=E		F 0600		

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F 0600 SS=E	Continued from page 9 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	Step 1- No ill side effects noted with R52. R366 was discharged with no ill effects. R180's POC was reviewed and an updated activity assessment was completed to assess possible diversional activity interests. Step 2- To identify other residents that have the potential to be affected, residents that exhibit aggressive behaviors will be reviewed by the IDT. Care plans will be updated, as necessary. Step 3 To prevent this from reoccurring, re-education of the abuse policy and behavior interventions will be completed with facility staff by the by the staff educator/designee. Step 4 To monitor and maintain compliance, the DON/designee will review 10 residents that exhibit aggressive behaviors to ensure that behaviors are addressed and care plan interventions are appropriate for behaviors exhibited. The audits will be completed weekly times 4 weeks and then monthly times 3. The results of the audits will be	Completion Date: **03/11/2025** Status: **APPROVED** Date: **02/25/2025**

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F 0600 SS=E	Continued from page 10	F 0600	forwarded to QAPI committee for further review and recommendations	

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F 0600 SS=E	Continued from page 11 Based on review of the facility's abuse prohibition policy, clinical records, information submitted by the facility, and select investigative reports and staff interview, it was determined the facility failed to assure that two residents (Residents 366 and 52) out of 35 sampled were free from physical abuse perpetrated by another resident (Resident 180). Findings include: A review of facility policy titled "Pennsylvania Resident Abuse: Abuse, Neglect, and Exploitation" last reviewed by the facility on November 12, 2024, revealed it is the policy of the facility to not tolerate abuse, neglect, mistreatment, exploitation of residents, or misappropriation of resident property by anyone. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.	F 0600		

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F 0600 SS=E	Continued from page 12 A review of Resident 366's clinical record revealed the resident was admitted to the facility on December 3, 2024, with diagnoses which included congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues) and diabetes mellitus (body has trouble controlling blood sugar and using it for energy). A review of the resident's Admission Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 6, 2024, indicated that the resident was cognitively intact with a BIMS (Brief Interview for Mental Status - a tool to assess cognition) score of 15 (13-15 represents intact cognitive responses). A review of Resident 180's clinical record revealed that the resident was admitted to the facility on February 8, 2024, with diagnoses which included vascular dementia, severe with behavioral	F 0600		

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F 0600 SS=E	Continued from page 13 disturbances (a decline in thinking skills caused by conditions that block or reduce blood flow to parts of the brain, depriving them of oxygen and nutrients) and metabolic encephalopathy (chemical imbalance in the blood that affects the brain which can cause loss of memory and difficulty coordinating motor tasks). A review of the resident's Quarterly Minimum Data Set Assessment dated November 9, 2024, indicated the resident was severely cognitively impaired with a BIMS score of 2. A review of nursing documentation from June 2024 through December 2024, revealed that Resident 180 displayed behaviors of pacing, wandering the halls, wandering into other residents' rooms, yelling, agitation, aggressive behavior, verbally abusive with staff and other residents, physically abusive to staff, cursing, walking the hallway with no pants on, and attempting to elope from the facility. It was further noted that the resident would kick and hit staff while walking past him in the hall. It was documented that	F 0600		

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F 0600 SS=E	Continued from page 14 constant redirection was given, but the resident does not consistently follow redirection. A review of nursing documentation dated December 10, 2024, at 3:33 AM revealed that Resident 180 was found in Resident 366's room. Staff noted that Resident 180 was standing next to Resident 366's bed. When redirection was attempted, resident 180 became agitated and was directed back to his room. Resident 366 reported Resident 180 initiated physical aggression towards her. One-to-one support provided and assessed for injuries. No injuries were noted. A review of the Mandatory Abuse Report dated December 10, 2024, at 4:26 AM documented that Employee 8 (nurse aide) responded to Resident 366's call light and observed Resident 180 in her room. Resident 366 reported that Resident 180 poked her right thigh forcefully, causing pain. Employee 11 (registered nurse) assessed Resident 366, who stated that Resident 180 entered her room and punched her leg multiple times with full	F 0600		

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F 0600 SS=E	Continued from page 15 force. Resident 366 described feeling shocked and noted that Resident 180 was significantly larger than her. Facility interventions included redirecting Resident 180 to his room, administering PRN lorazepam, offering Resident 366 a room change, relocating her to another hall, providing one-to-one emotional support, offering Tylenol for pain, and reporting the incident to law enforcement. Facility documentation indicated a pattern of aggressive behaviors and intrusive wandering behaviors by Resident 180 prior to the reported incident involving Resident 366. The facility failed to demonstrate proactive measures to prevent the incident. A review of Resident 52's clinical record revealed the resident was admitted to the facility on August 7, 2015, with diagnoses which included epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures) and cerebral infarction (brain damage that results from a lack of blood).	F 0600		

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F 0600 SS=E	Continued from page 16 A review of the resident's Quarterly Minimum Data Set Assessment (dated December 17, 2024, indicated that the resident was severely cognitively impaired with a BIMS score of 4. On December 27, 2024, at 8:46 AM, Resident 180 approached Resident 52 in the hallway and slapped him on the right cheek. A review of the Mandatory Abuse Report dated December 27, 2024, at 8:47 AM indicated that Resident 52 was seated in the hallway, singing and talking to himself, when Resident 180 approached him, raised both fists, and struck Resident 52 on the right cheek with one hand. A physical assessment revealed no noted injuries, redness, or marks. Facility interventions included the immediate separation of the residents, initiation of safety checks for Resident 52 every 15 minutes, implementation of one-to-one supervision for Resident 180, completion of body assessments, and notification of the physician and responsible party.	F 0600		

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F 0600 SS=E	Continued from page 17 A review of a witness statement submitted by Employee 10 (Physical Therapist) on December 27, 2024, with an additional statement signed on December 31, 2024, indicated that Employee 10 observed Resident 180 walking up and down the West Hall several times. While documenting at the nurse's desk, Employee 10 heard Resident 52 singing and repeating a phrase from a kitchen aide's t-shirt. Employee 10 observed Resident 52 seated in a wheelchair at the start of East Hall across from the desk. Resident 180 was seen walking from West Hall past the desk, stopping in front of Resident 52, raising his fists, and striking Resident 52 on the right cheek. Employee 10 immediately intervened, escorting Resident 180 away and redirecting him to his room. A nurse aide approached Resident 52, and the LPN was notified. The LPN then informed the RN Supervisor. The facility failed to ensure that Residents 366 and 52 were free from physical abuse perpetrated by Resident 180.	F 0600		

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F 0600 SS=E	Continued from page 18 An interview with Nursing Home Administrator on February 7, 2025, at approximately 9:35 AM confirmed the facility failed to prevent the physical abuse of Residents 366 and 52 perpetrated by Resident 180, which resulted in a punch to the thigh and a slap to the face. The facility failed to implement sufficient supervision and monitoring measures to address Resident 180's known history of aggression, resulting in physical abuse of other residents. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident Rights 28 Pa. Code 211.12(c)(d)(5) Nursing Services	F 0600		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 19 483.20(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	Step 1- R 159 and R179's MDS's were corrected and submitted. Step 2- To identify other residents that have the potential to be affected, the regional MDS staff will audit MDS assessments completed in the last 7 days will be reviewed for accuracy- areas of concern will be corrected and resubmitted. Step 3 To prevent this from reoccurring, education will be completed with the members of the IDT by the regional MDS re: ensuring all MDS assessments are completed accurately. Step 4 To monitor and maintain compliance, 10 residents Quarterly, Admission, or Significant Change MDS assessments will be completed by the MDS nurse/designee for accuracy. The audits will be completed weekly times 4 weeks and then monthly times 4. The results of the audits will be forwarded to QAPI committee for further review and recommendations.	Completion Date: **03/11/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0641 SS=D	Continued from page 20 Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessments accurately reflected the status of two residents out of 35 sampled (Resident 179 and Resident 159). Findings include: A review of the clinical record revealed that Resident 179 was admitted to the facility on November 11, 2023, with diagnoses that included chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs) and dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders and personality changes). A review of Resident 179's quarterly MDS assessment dated November 11, 2024, revealed that Section E-Behavior, item E0900, was coded as "0-Behavior not exhibited," indicating the resident	F 0641		

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F 0641 SS=D	Continued from page 21 did not exhibit wandering behaviors. However, a review of the clinical record revealed documentation of wandering behavior. A progress note dated November 6, 2024, at 9:49 PM indicated that the resident had multiple incidents of wandering into and out of other residents' rooms. An interview with the Nursing Home Administrator on February 7, 2025, at 11:27 AM confirmed that Resident 179's quarterly MDS dated November 11, 2024, was coded inaccurately in Section E-Behavior, item E0900, as it did not reflect the resident's documented wandering behavior. A review of the clinical record revealed that Resident 159 was admitted to the facility on August 4, 2023, with diagnoses that included psychosis (mental disorder characterized by a disconnection from reality). A review of Resident 159's quarterly MDS dated December 24, 2024, indicated the following in Section N:	F 0641		

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F 0641 SS=D	Continued from page 22 N0415 High-Risk Drug Classes was coded to indicate the resident was receiving a hypnotic medication (a psychoactive medication prescribed to treat sleeplessness); however, a review of the clinical record revealed no documented evidence that the resident was receiving a hypnotic medication. N0450 Antipsychotic Medication Review was coded in: N0450A to indicate the resident was receiving antipsychotic medication on a routine basis. N0450B to indicate that a Gradual Dose Reduction (GDR, a stepwise tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose) had not been attempted. N0450E did not indicate a date that the physician determined a GDR was clinically contraindicated. Further review of the clinical record revealed a physician order dated November 17, 2024, to discontinue Secuado (an antipsychotic) 0.8 mg/24 hours one patch applied transdermally (administer a drug through the skin) one time daily for psychosis	F 0641		

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F 0641 SS=D	Continued from page 23 and removed per schedule. A nurse's note dated December 13, 2024, at 12:48 PM, documented that the resident was scratching their face during the shift and required redirection with one-on-one intervention. The note also indicated the resident had recently undergone a GDR of the Secuado patch and that the resident's representative and physician were aware, with orders pending. A subsequent nurse's note dated December 13, 2024, at 6:28 PM documented that the resident was exhibiting behaviors including restlessness, agitation, and repetitive movements. A new physician's order was received to restart Secuado 0.8 mg/24 hours, one patch applied transdermally once daily for psychosis and removed per schedule. A physician's order dated December 13, 2024, documented the reinstatement of Secuado 0.8 mg/24 hours, one patch applied transdermally once daily for psychosis and removed per schedule.	F 0641		

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F 0641 SS=D	Continued from page 24 A social services note dated December 16, 2024, indicated that an interdisciplinary review had determined that the GDR had failed. An interview with the Director of Nursing on February 6, 2025, at approximately 2:00 PM confirmed that Resident 159's quarterly MDS assessment dated December 24, 2024, was inaccurate. The facility failed to ensure that MDS assessments accurately reflected the clinical status of Residents 179 and 159, resulting in incomplete or inaccurate assessments used for care planning. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services	F 0641		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 25 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Past noncompliance: no plan of correction required.	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0689 SS=D	Continued from page 26 Based on a review of clinical records, select facility investigative reports, and resident and staff interviews, it was determined the facility failed to implement effective safety measures to prevent an injury during transfer for one out of the 35 sampled residents (Resident 157). Findings include: A clinical record review revealed Resident 157 was admitted to the facility on July 10, 2023, with diagnoses to include but not limited to arthritis (a disease that causes swelling and tenderness in one or more joints) and morbid obesity (a chronic disease that's characterized by a body mass index of 40 or higher, or a body mass index of 35 or higher with obesity-related health issues). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 3, 2024, revealed that Resident 157 was cognitively	F 0689		

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F 0689 SS=D	Continued from page 27 intact with a BIMS score of 15 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A review of Resident 157's plan of care dated August 28, 2024, indicated that the resident had a self-care deficit related to decreased mobility requiring extensive-to-total assistance with mobility and transfers. Interventions implemented included assisting the resident during all transfers with the assistance of two staff members via mechanical lift with a black sling (a lift that uses hydraulic power to transfer a person while cradled in a sling). A care plan indicating Resident 157 has a self-care deficiency requiring extensive-to-total assistance with mobility and transfers related to decreased mobility initiated on August 28, 2024. Interventions implemented include assisting the resident during all transfers with the assistance of two staff members	F 0689		

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F 0689 SS=D	Continued from page 28 via mechanical lift with a black sling. A facility investigation report dated August 30, 2024, at 9:03 PM, revealed Resident 157 sustained a forehead laceration during a transfer from her bed to a bariatric bed with a new air mattress using a mechanical lift. The investigation report indicated the forehead laceration injury was new and bleeding. A wound report dated August 30, 2024, at 10:31 PM, revealed a forehead laceration measuring 5 cm x 0.5 cm. A witness statement dated August 30, 2024, no time indicated, provided by Employee 1 (nurse aide), revealed she was using the mechanical lift to transfer Resident 157 from her bed to a bariatric bed with new air mattress. Employee 1 indicated she was driving the lift and put her in the hallway to transfer the resident into the new bed. When lowering the bed, the leg of the lift got caught between the wheels of the bed, and Employee 2 (nurse aide), pushed Resident 157 and pulled himself toward her, and then he flipped over and hit	F 0689		

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F 0689 SS=D	Continued from page 29 Resident 157 in the head where the top part of the sling was, causing a small wound. An injury was identified, and Employee 1 immediately reported to the supervisor. A witness statement dated August 30, 2024, no time indicated, provided by Employee 2 revealed Resident 157 was transferred into a bariatric bed in the hallway next to her room in the mechanical lift and was positioned over the bariatric bed, and during lowering the resident, her weight became displaced, and the base of the lift tipped over. A progress note dated August 30, 2024, at 9:03 PM provided by Employee 3, Registered Nurse, revealed that Resident 157 was being transferred to a different bed in the hallway to allow the contractor to put a new air mattress on the resident's bed. Upon transfer, via mechanical lift, Resident 157 suddenly hit the bed and was heard screaming "OW, OW, OW.". Employee 3 was at the nurses' desk, looked up, and saw that Resident 157 was in the bed and the lift was tipped on top of her. Upon	F 0689		

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F 0689 SS=D	Continued from page 30 arrival, Employee 3 pulled the lift from the resident's forehead and assessed the laceration that was actively bleeding, and pressure was placed on the wound, and 911 was called. A progress note by Employee 3, RN, dated August 30, 2024, 9:03PM, revealed the cause of the injury was improper placement and use of the mechanical lift. A statement from Resident 157 dated September 3, 2024, no time indicated, revealed that her air mattress had popped, and Employee 1 and Employee 2 transferred her to a bariatric bed with a new mattress via mechanical lift in the hallway. Resident 157 stated that during the transfer, the lift was pulled and hit her in the head. Resident 157 stated, "I am not in any pain, but they said I have a cut.". A community emergency department report dated August 30, 2024, at 11:10 PM documented that Resident 157 was evaluated for a laceration after	F 0689		

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F 0689 SS=D	Continued from page 31 being struck in the head with the mechanical lift during transfer. A head CT scan (a noninvasive medical procedure that uses x-rays to create detailed images of the body), was performed and was negative. The resident was prescribed Tylenol for pain. A progress note dated August 30, 2024, at 2:55 AM, revealed the resident returned from the emergency department. During an interview on February 4, 2024, at 1:00 PM, Resident 157 confirmed that she was hit in the head during a transfer into a new bariatric bed and had to be transferred to an emergency department for evaluation of her bleeding wound. A review of the facility's investigation confirmed the injury occurred due to improper placement and use of the lift during the transfer. Competency evaluations revealed that both Employee 1 and Employee 2 had satisfactory transfer skills and knowledge.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395582	A. BLDG: __00_____ B. WING: _____	02/07/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MOUNTAIN CITY NURSING & REHAB CTR	**403 HAZLE TOWNSHIP BOULEVARD HAZLE TOWNSHIP, PA 18202**
STATE LICENSE NUMBER: **085602**	

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F 0689 SS=D	Continued from page 32 During an interview on February 7, 2025, at 9:15 AM, the Nursing Home Administrator (NHA) confirmed that it was the facility's responsibility to ensure effective safety measures were implemented to prevent accidents and injuries to residents. The NHA acknowledged that Resident 157 sustained a laceration during the transfer on August 30, 2024. This deficiency is cited as past non-compliance. The facility's corrective action plan was to identify other residents with the potential to be affected; the Director of Nursing (DON)/designee completed a house-wide audit of proper lift technique and that air mattresses had proper inflation. To prevent this from recurring the unit manager provided education to nursing staff regarding proper transfer technique and lift competencies were completed, and mechanical lifts were inspected for safety.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=D	Continued from page 33 To monitor and maintain ongoing compliance, the DON/designee audits and assesses 5 residents weekly x 4 to ensure proper lift technique is used during transfers and air mattresses are inflated without issues. Any negative findings will be immediately corrected. Results of audits will be forwarded to facility QAPI for review and recommendation as indicated. The facility's immediate corrective action plan was completed on September 2, 2024. 28 Pa. Code 211.18 (e)(1) Management. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services	F 0689		
F 0842 SS=D		F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0842 SS=D	Continued from page 34 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Step 1- Resident 266 d/c from the facility. Step 2 To identify other residents that have the potential to be affected, the DON/Designee will review the last 14 days of incident and accident events to ensure the resident's record accurately reflects the resident's status. Step 3 To prevent this from reoccurring, re-education will be provided by the staff educator/designee to the nursing staff re: ensuring that the documentation in the resident record accurately reflects the resident's status Step 4 To monitor and maintain compliance, the DON/designee will complete weekly audits of the resident incident and accident events to ensure that the resident record accurately reflects the resident record. The audits will be completed weekly times 4 weeks and then monthly times 3. The results of the audits will be forwarded to QAPI	Completion Date: **03/11/2025** Status: **APPROVED** Date: **02/20/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395582	A. BLDG: 00 B. WING:	02/07/2025

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F 0842 SS=D	Continued from page 35 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842	committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0842 SS=D	Continued from page 36 This REQUIREMENT is not met as evidenced by:	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0842 SS=D	Continued from page 37 Based on review of clinical records, select facility investigative reports, and staff interview, it was determined the facility failed to maintain accurate and complete clinical records, in accordance with professional standards of practice for one (1) of 35 sampled residents (Resident 266). Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0842 SS=D	Continued from page 38 parties. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The registered nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all of following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.18. (a)(5) document and maintain accurate records. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care	F 0842		

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F 0842 SS=D	Continued from page 39 team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. Review of the clinical record revealed that Resident 266 was admitted to the facility on October 3, 2024, with diagnoses to include diabetes and dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders and personality changes). A physician order dated December 24, 2024, noted an order for a LCS (low concentrated sweets) regular texture diet. Review of an Occupational Therapy Evaluation dated November 2, 2024, indicated the resident was independent for self-feeding.	F 0842		

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F 0842 SS=D	Continued from page 40 Review of a nurses note dated January 19, 2025, at 6:45 PM written by Employee 7 (RN) revealed the resident was found unresponsive, was determined to be a full code (medical order that instructs healthcare team to perform all possible life-saving measures if the patient's heart or lungs stop working), and life-saving measures were immediately initiated, 911 was called immediately, EMS (Emergency Medical Services) arrived at the facility, continued life-saving measures, and the resident was transferred to the hospital. Physician and Resident Representative were made aware. A nurses note dated January 19, 2025, at 11:11 PM written by Employee 7 (RN) revealed that the hospital notified the facility that the resident expired at the hospital on January 19, 2025, approximately 7:30 PM. Review of the resident's SBAR Communication Form (situation, background, assessment recommendation used in healthcare to share information about a patient's condition) dated	F 0842		

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F 0842 SS=D	Continued from page 41 January 19, 2025, completed by Employee 7 (RN) revealed that Resident 266 was found unresponsive at 6:45 PM, it was determined that resident was a full code and life saving measures were immediately initiated, 911 was called immediately with their arrival at 7:10 PM, EMT continued lifesaving measures and resident transported to the hospital emergency room. Resident representative and physician notified. Further review of the resident's SBAR Communication Form dated January 19, 2025, revealed that Employee 7 (RN) electronically completed the form. However, Employee 7 (RN) indicated at the bottom of the SBAR Communication Form that Employee 5 (LPN) completed the form. Review of a facility investigative report dated January 19, 2025, revealed that Resident 266 was noted to be choking on his dinner. The Heimlich Maneuver (first-aid technique that uses abdominal thrusts to help someone who is choking) was	F 0842		

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F 0842 SS=D	Continued from page 42 immediately performed without success. The resident then became unresponsive, and CPR (cardiopulmonary resuscitation-emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped) was initiated. The resident was sent to the emergency room for further evaluation of the situation. A review of a witness statement from Employee 4 (nurse aide) dated January 21, 2025, revealed on January 19, 2025, at 6:45 PM Employee 4 (nurse aide) heard the resident choking. Employee 4 (nurse aide) went into the resident's room to assist while he was coughing. Employee 4 (nurse aide) performed the Heimlich Maneuver until the resident went completely unresponsive. By then the nurse had arrived and CPR was started. A review of a witness statement from Employee 6 (LPN) which was signed but not dated revealed that on January 19, 2025, Employee 6 (LPN) was alerted by staff that Resident 266 was choking. Upon entering the resident's room, the resident was	F 0842		

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F 0842 SS=D	Continued from page 43 sitting at the side of the bed and color was cyanotic (bluish, grayish). Employee 4 (nurse aide) was behind the resident performing the Heimlich Maneuver, the resident was unresponsive, laid on bed, mouth sweep done unable to feel or see anything. Dentures were in resident's mouth. Resident suctioned, small pieces of food, resident with no respirations, no pulse, Code Blue called, CPR initiated. 911 called. AED (automated external defibrillator which is a medical device that delivers an electric shock to the heart to help restore a normal rhythm) pads placed, no call for shock. CPR continued. Emergency Medical Technician (EMT) arrived. LUCAS (mechanical chest compression system that helps healthcare providers perform CPR on patients in cardiac arrest) device placed on resident. IV (intravenous- giving medications or fluids through a needle or tube inserted into a vein) line started. Two doses of medication were administered. While EMT was attempting to intubate (medical procedure which involves inserting a tube into a patient's airway to help them breathe) resident, a full-size meatball was pulled out of the	F 0842		

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F 0842 SS=D	Continued from page 44 resident's throat. CPR continued. Pulse obtained. Resident was transferred to the hospital emergency department. A review of a witness statement from Employee 5 (LPN) dated January 19, 2025, revealed that on January 19, 2025, noted that Resident 266 was observed prior to the incident moving around the unit and talking with everybody without any problems or concerns. Upon returning from break, heard the Code Blue and ran to the scene. Employee 5 (LPN) started helping. Resident 266 was sent to the hospital via ambulance. Resident unresponsive. Family made aware of the transfer. The investigative report documented a choking episode, but the resident's clinical record lacked any documentation of the choking incident, the Heimlich Maneuver, or the removal of a full-size meatball from the resident's airway by EMT personnel. Review of facility documentation revealed inconsistencies between the nursing notes, SBAR	F 0842		

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F 0842 SS=D	Continued from page 45 Communication Form, witness statements, and the facility's investigative report. An interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 5, 2025, at approximately 11:30 AM confirmed the facility's nursing staff failed to accurately and consistently document the incident in the resident's clinical record. The NHA and DON confirmed there was no documented evidence of the resident's choking incident. The DON verified that the staff member listed at the bottom of the SBAR Communication Form should have accurately reflected the individual completing the form. The facility failed to ensure that the residents clinical record was accurate and complete. 28 Pa. Code 211.5 (f)(ii)(iii)(ix) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.	F 0842		

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F 0842 SS=D	Continued from page 46	F 0842		
F 0883 SS=D	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the	F 0883	Step 1- R110 was administered the flu vaccine. Step 2 To identify other residents that have the potential to be affected, the DON/designee reviewed residents to ensure that they were offered the flu and pneumonia vaccine were offered and administered if elected. Step 3 To prevent this from reoccurring, re-education will be provided by the staff educator/designee re: the facility flu/pneumonia vaccine policy Step 4 To monitor and maintain compliance, the DON/designee will audit new/re-admissions residents to ensure that that the flu/pneumo vaccines were offered and administered if needed. The audits will be completed weekly times 4 weeks and then monthly times 3. The results of the audits will be forwarded to QAPI committee for further review and recommendations.	Completion Date: **03/11/2025** Status: **APPROVED** Date: **02/20/2025**

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(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 0883 SS=D	Continued from page 47 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395582	A. BLDG: __00_____ B. WING: _____	02/07/2025

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F 0883 SS=D	Continued from page 48 Based on a review of select facility policy and clinical records and staff interviews, it was determined the facility failed to offer and/or provide the influenza immunization, unless the immunization was medically contraindicated or the resident had already been immunized, to one resident out of five residents reviewed for administration of the flu vaccine. (Resident 110). Findings include: A review of facility policy titled "Resident Vaccination Policy," last reviewed November 12, 2024, revealed that each resident is to be offered an influenza immunization unless the immunization is medically contraindicated. Nursing staff will provide educational information to the resident/authorized representative prior to the administration of each vaccine. Once education has been completed, a signed consent form is to be obtained prior to the administration of the vaccine. A review of the clinical record revealed that	F 0883		

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F 0883 SS=D	Continued from page 49 Resident 110 was admitted to the facility on September 6, 2017, with diagnoses to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest in activities, fatigue, and feelings of worthlessness). Review of Resident 110's Informed Consent for Influenza, Pneumococcal, and Covid Vaccines signed by Resident 110's resident representative on August 26, 2024, confirmed authorization for the facility to administer the influenza vaccine., Covid vaccine, and pneumococcal vaccines. However, there was no documented evidence that the influenza vaccine was administered as per the signed consent. An interview with the Director of Nursing on February 7, 2025, at 12:24 PM confirmed the	F 0883		

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F 0883 SS=D	Continued from page 50 facility failed to provide the influenza immunization to Resident 110 despite having obtained the required valid signed consent. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa Code 211.5 (f)(i) Medical records. 28 Pa. Code 211.10(a)(d) Resident care policies . 28 Pa code 211.12 (c)(d)(1)(5) Nursing Services.	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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H 0009	51.3 (g)(1-14) NOTIFICATION 51.3 Notification (g) For purposes of subsections (e) and (f), events which seriously compromise quality assurance and patient safety include, but not limited to the following: (1) Deaths due to injuries, suicide or unusual circumstances. (2) Deaths due to malnutrition, dehydration or sepsis. (3) Deaths or serious injuries due to a medication error. (4) Elopements. (5) Transfers to a hospital as a result of injuries or accidents. (6) Complaints of patient abuse, whether or not confirmed by the facility. (7) Rape. (8) Surgery performed on the wrong patient or on the wrong body part. (9) Hemolytic transfusion reaction. (10) Infant abduction or infant discharged to the wrong family. (11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence. (12) Notification of termination of any services vital to continued safe operation of the facility or the	H 0009	Step 1- R266 & R157's events were reported. Step 2- To identify other residents that have the potential to be affected, the NHA/Designee will review the last 14 days of incident and accident events to ensure any events that meet the criteria of a state reportable event are reported to the state agency as required. Step 3 To prevent this from reoccurring, re-education was provided by the regional nurse to the NHA/ANHA/DON re: state reportable events. Step 4 To monitor and maintain compliance the NHA/Designee will audit incident and accident reports to ensure any events that meet the criteria of a reportable event to the state is submitted as required. The audits will be completed weekly times 4 weeks and then monthly times 3. The results of the audits will be forwarded to QAPI committee for further review and recommendations.	Completion Date: **03/11/2025** Status: **APPROVED** Date: **02/20/2025**

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:
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H 0009	Continued from page 1 health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange of telephone service. (13) Unlicensed practice of a regulated profession. (14) Receipt of a strike notice. This REGULATION is not met as evidenced by:	H 0009		

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H 0009	Continued from page 2 Based on clinical record and facility investigative report reviews, and staff interview, it was determined the facility failed to notify the State Licensing Agency, Department of Health, Division of Nursing Care Facilities (via Event Reporting System) of a reportable event for one resident (Resident 157) who incurred an injury during a transfer with a mechanical lift requiring health care services and transfer to the hospital and one resident (Resident 266) who was found choking which required the Heimlich Maneuver (first-aid technique that uses abdominal thrusts to help someone who is choking), CPR (cardiopulmonary resuscitation-emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped), transfer to the hospital, and subsequently expired at the hospital out of 35 sampled residents. Findings include: A review of nursing documentation and a facility investigative report for Resident 157 dated August 30, 2024, revealed an incident on August 30, 2024,	H 0009		

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H 0009	Continued from page 3 in which Resident 157 sustained a head laceration during a mechanical lift transfer, requiring emergency medical evaluation and hospital transfer. A review of nurse's notes in Resident 266's clinical revealed on January 19, 2025, at 6:45 PM the resident was found unresponsive, and was determined to be a full code. A review of a facility investigative report and witness statements dated January 19, 2025, revealed an incident in which Resident 266 experienced a choking episode requiring the Heimlich Maneuver, CPR, hospital transfer, and subsequently expired at the hospital. Upon surveyor request to review the Event Reports submitted to the Department of Health and interview with the director of nursing on February 5, 2025, at 1:00 PM it was confirmed the facility failed to submit these reportable events. This failure to report the events to the State agency compromised the facility's compliance with mandated event reporting requirements and had the	H 0009		

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H 0009	Continued from page 4 potential to impact the health and safety monitoring of all residents.	H 0009		

Certified End Page

MOUNTAIN CITY NURSING & REHAB CTR

STATE LICENSE NUMBER: 085602

SURVEY EXIT DATE: 02/07/2025

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