

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

March 2, 2026

[REDACTED]
MOUNTAIN TOP REHABILITATION & HEALTHCARE CENTER, LLC

[REDACTED]
C/O CENTURY HEALTHCARE
[REDACTED]

RE: THE PRESERVE AT MOUNTAIN TOP
185 S.MOUNTAIN BLVD
MOUNTAIN TOP, PA, 18707
LICENSE/COC#: 23255

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/19/2025, 12/09/2025, 12/12/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE PRESERVE AT MOUNTAIN TOP* License #: *23255* License Expiration: *10/15/2026*
 Address: *185 S.MOUNTAIN BLVD, MOUNTAIN TOP, PA 18707*
 County: *LUZERNE* Region: *NORTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *MOUNTAIN TOP REHABILITATION & HEALTHCARE CENTER, LLC*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/17/1997* Issued By: *DLI*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *30* Waking Staff: *23*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Incident* Exit Conference Date: *12/12/2025*

Inspection Dates and Department Representative

11/19/2025 - On-Site: [REDACTED]
 12/09/2025 - On-Site: [REDACTED]
 12/12/2025 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *34* Residents Served: *30*
 Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:
 Hospice
 Current Residents: *0*
 Number of Residents Who:
 Receive Supplemental Security Income: *16* Are 60 Years of Age or Older: *27*
 Diagnosed with Mental Illness: *18* Diagnosed with Intellectual Disability: *1*
 Have Mobility Need: *0* Have Physical Disability: *2*

Inspections / Reviews

11/19/2025 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/15/2026*

Inspections / Reviews *(continued)*

01/20/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/02/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 01/27/2026

02/02/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/02/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 02/04/2026

03/02/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/02/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [REDACTED], Resident [REDACTED] reported Resident [REDACTED] was being [REDACTED], standing in front of Resident [REDACTED] yelling, and leaning into their face in a threatening manner. The incident was reported to Staff Person A and noted in progress notes. However, this allegation of abuse was not reported to the local area agency on aging.

On [REDACTED] Resident [REDACTED] was yelling at other residents, getting into peoples' faces, and tried to grab an ensure out of Resident [REDACTED] hand. This incident was witnessed by Staff Person B and noted in progress notes. However, the incident was not reported to the local area agency on aging.

On [REDACTED], Resident [REDACTED] was grabbing Resident [REDACTED] pulling on their arm, and trying to pull Resident [REDACTED] out of their seat. Later in the evening, Resident [REDACTED] went into Resident [REDACTED]s room, waking them up, pulling on their arm while trying to make them get up. This incident was witnessed by Staff Person A as noted in the progress notes. However, this was not reported to the local area agency on aging.

On [REDACTED], Resident [REDACTED] stood over Resident [REDACTED] at dinner. Resident [REDACTED] was clapping their hands over Resident [REDACTED] head and trying to take their Ensure shake. This was witnessed by Staff Person A as noted in the progress notes. However, this incident was not reported to the local area agency on aging.

On [REDACTED], Resident [REDACTED] was grabbing Resident [REDACTED] arm, and trying to pull them outside. This was witnessed by Staff Person C, as noted in the progress notes. However, this incident was not reported to the local area agency on aging.

On [REDACTED] Resident [REDACTED] 1 was pulling on multiple resident arms to get them to go with them, even after the residents expressed they did not want to. This was witnessed by Staff person B, as noted in the progress notes. However, this incident was not reported to the local area agency on aging.

On [REDACTED] Resident [REDACTED] was seen going down the hall after Resident [REDACTED], by Staff person D. Staff Person D witnessed Resident [REDACTED] in Resident [REDACTED] face. Staff Person D overheard Resident [REDACTED] say to Resident [REDACTED] "Don't hit me again!" On [REDACTED] Resident [REDACTED] went over to Resident [REDACTED] tried to take their coffee, and when redirected, grabbed the back of the resident's neck. These incidents were witnessed by Staff Person D, as noted in the progress notes. However, the incidents were not reported to the local area agency on aging.

On [REDACTED], Resident [REDACTED] was continuously grabbing and pulling on Resident [REDACTED] arm. This incident was witnessed by Staff Person E, as noted in the progress notes. However, this incident was not reported to the local area agency on aging.

On [REDACTED], Resident [REDACTED] was hitting and poking at other residents all day and evening. Resident [REDACTED] walked up to Resident [REDACTED] and used 2 fingers to poke Resident [REDACTED] in the face, hard enough that Resident [REDACTED] yelled out. Multiple

15a Resident Abuse Report (continued)

times, Resident [redacted] was grabbing Resident [redacted] by the neck, leaving small scratches. Resident [redacted] was also pushing and pulling on Resident [redacted]. These incidents were witnessed by Staff Person A, as noted in the progress notes. However, these incidents were not reported to the local area agency on aging.

On [redacted] Resident [redacted] took Resident [redacted] walker away from the resident, taking it through the dining room, to the exit door and leaving it there. This incident was witnessed by Staff Person D, as noted in the progress notes. However, this incident was not reported to the local area agency on aging.

Plan of Correction

Accept [redacted] - 02/02/2026)

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

The community Administrator facilitated the discharge from the facility of resident [redacted] on 1/02/2026.

The community Administrator has audited resident progress notes and incident reports from 11/27/25 to 1/20/2026 to ensure there were no further incidents of suspected resident abuse which had not been reported.

The Administrator performed staff re education to the communities Abuse Prevention Program on 12/29/2025. Re education includes mandatory reporting of abuse requirements.

The Administrator will ensure all newly hired staff members receive education to the facility Abuse Prevention Program, mandatory reporting of abuse requirements. This will be completed and monitored by the Administrator.

The Administrator will audit resident progress notes and incident reports weekly, to ensure Abuse reporting requirements are being followed. The Administrator will review with the community HR representative for further staff actions as needed based on the results of audits.

Licensee's Proposed Overall Completion Date: 01/21/2026

Implemented [redacted] 03/01/2026)

16c - Written Incident Report

2. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], Resident [redacted] reported Resident [redacted] was being aggressive, standing in front of Resident [redacted] yelling, and leaning into their face in a threatening manner. The incident was reported to Staff Person A and noted in progress notes. However, this allegation of abuse was not reported to the Department.

On [redacted] Resident [redacted] was yelling at other residents, getting into peoples' faces, and tried to grab an ensure out of Resident [redacted]s hand. This incident was witnessed by Staff Person B and noted in progress notes. However, the incident was not reported to the Department.

On [redacted], Resident [redacted] was grabbing Resident [redacted] pulling on their arm, and trying to pull Resident [redacted] out of their

16c - Written Incident Report (continued)

seat. Later in the evening, Resident [REDACTED] went into Resident [REDACTED] room, waking them up, pulling on their arm while trying to make them get up. This incident was witnessed by Staff Person A as noted in the progress notes. However, this was not reported to the Department.

On [REDACTED], Resident [REDACTED] stood over Resident [REDACTED] at dinner. Resident [REDACTED] was clapping their hands over Resident [REDACTED]'s head and trying to take their Ensure shake. This was witnessed by Staff Person A as noted in the progress notes. However, this incident was not reported to the Department.

On [REDACTED], Resident [REDACTED] was grabbing Resident [REDACTED]'s arm, and trying to pull them outside. This was witnessed by Staff Person C, as noted in the progress notes. However, this incident was not reported to the Department.

On [REDACTED] Resident [REDACTED] was pulling on multiple resident arms to get them to go with them, even after the residents expressed they did not want to. This was witnessed by Staff person B, as noted in the progress notes. However, this incident was not reported to the Department.

On [REDACTED] Resident [REDACTED] was seen going down the hall after Resident [REDACTED] by Staff person D. Staff Person D witnessed Resident [REDACTED] in Resident [REDACTED] face. Staff Person D overheard Resident [REDACTED] say to Resident [REDACTED] "Don't hit me again!" On [REDACTED], Resident [REDACTED] went over to Resident [REDACTED], tried to take their coffee, and when redirected, grabbed the back of the resident's neck. These incidents were witnessed by Staff Person D, as noted in the progress notes. However, the incidents were not reported to the Department.

On [REDACTED], Resident [REDACTED] was continuously grabbing and pulling on Resident [REDACTED] arm. This incident was witnessed by Staff Person E, as noted in the progress notes. However, this incident was not reported to the Department.

On [REDACTED], Resident [REDACTED] was hitting and poking at other residents all day and evening. Resident [REDACTED] walked up to Resident [REDACTED] and used 2 fingers to poke Resident [REDACTED] in the face, hard enough that Resident [REDACTED] yelled out. Multiple times, Resident [REDACTED] was grabbing Resident [REDACTED] by the neck, leaving small scratches. Resident [REDACTED] was also pushing and pulling on Resident [REDACTED]. These incidents were witnessed by Staff Person A, as noted in the progress notes. However, these incidents were not reported to the Department.

On [REDACTED] Resident [REDACTED] took Resident [REDACTED] walker away from the resident, taking it through the dining room, to the exit door and leaving it there. This incident was witnessed by Staff Person D, as noted in the progress notes. However, this incident was not reported to the Department.

Plan of Correction

Accept [REDACTED] - 02/02/2026)

The Administrator facilitated the discharge of Resident [REDACTED] from the community on 1/02/2026.

The Administrator reviewed resident progress notes from 11/27/25 to 1/20/2026 to ensure resident incidents requiring reporting to the Regional Office have been completed.

The Administrator completed community staff re-education to the facility Abuse Prevention Program; including mandatory reporting requirements on 12/29/2025. The Administrator completed community staff re-education on 12/29/2025 to mandatory incident reporting requirements.

The community Administrator will audit resident progress notes and incident reports, weekly, to ensure resident incidents have been reported by community staff per the requirements of 16.c. The Administrator will review with the community HR representative for further staff actions as needed based on the results of audits.

16c - Written Incident Report (continued)

Licensee's Proposed Overall Completion Date: 01/21/2026

Implemented - 03/01/2026)

42b - Abuse

3. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] Resident [redacted] was pulling on Resident [redacted] s arm, to the point Resident [redacted] almost fell, and called the police. This is not a new behavior for Resident [redacted] as indicated in progress notes. A review of Resident [redacted] s progress notes indicate the resident s behaviors became [redacted]; on [redacted], Resident [redacted] was taking other resident s food, on [redacted] Resident [redacted] was yelling in a threatening tone at Resident [redacted], and entering Resident [redacted] room, waking them up throughout the night. On [redacted] Resident [redacted] tried to rip the ensure out of Resident [redacted] s hand when they were taking a drink of it and then got [redacted] with staff when they attempted to redirect. On [redacted], Resident [redacted] was out on the porch yelling at residents and screaming in their faces, demanding milk and smokes. On [redacted] Resident [redacted] was grabbing and pulling on Resident [redacted] s arm, trying to pull the resident out of their seat, and then went into their room twice during the night, pulling on their arm to wake them up. On [redacted], after dinner, Resident [redacted] stood over Resident [redacted], clapping their hands over their head and trying to take their ensure. Later that evening, Resident [redacted] was waking other residents up during the night, entering Resident [redacted] s room, taking their chips. On [redacted], Resident [redacted] grabbed Resident [redacted] by the arm and pulled so hard the resident s arm turned white and almost fell, when Staff person A attempted to redirect, Resident [redacted] punched the staff in the face. On [redacted], Resident [redacted] was again grabbing Resident [redacted] arm, trying to pull the resident outside. On [redacted], Resident [redacted] was pulling on other residents to go with them, as the other residents are saying, "NO." On [redacted], Resident [redacted] was following Resident [redacted] down the hall, staff followed, finding Resident [redacted] in Resident [redacted] face, and Resident [redacted] was saying, "don t hit me again." Resident [redacted] then grabbed Resident [redacted] coffee cup and when redirected by staff, grabbed the back of Resident [redacted] s neck. On [redacted] Resident [redacted] was grabbing and pulling on Resident [redacted] all day, leaving scratch marks on their neck and pulling on Resident [redacted]. When Resident [redacted] finished their coffee, Resident [redacted] poked Resident [redacted] in the face hard enough they yelled out. On [redacted], Resident [redacted] took Resident [redacted] s walker from them and let it sit next to the exit door. Resident [redacted] then walked behind Resident [redacted] while in the wheelchair and began rocking them back and forth making the wheels come off the ground, scaring Resident [redacted] and the other residents in the area.

Resident interviews indicate they are fearful of Resident # [redacted] because of the erratic behaviors. Staff interviews indicate observed behavior changes of the residents when Resident [redacted] is in the home, by leaving the room if Resident [redacted] enters or becoming involved in more activities to avoid Resident [redacted]

Plan of Correction

Accept - 02/02/2026)

The community Administrator facilitated the discharge of Resident [redacted] on 1/02/2026. The Administrator interviewed Residents [redacted] on 12/29/2025 to ensure they do not have any negative effects related to the documented incidents. There were no further concerns identified by the Administrator.

The community Administrator completed re-education with community staff on 12/29/2025 on the facility Abuse Prevention Program. New hired community staff will be educated by the Administrator to the facility Abuse

42b Abuse (continued)

Prevention Program. Yearly re education to the Abuse Prevention Program will be completed with staff by the Administrator.

The community Administrator will audit resident progress notes and incidents, weekly, to ensure the Abuse Prevention Program is being maintained.

Licensee's Proposed Overall Completion Date: 01/21/2026

Implemented (█ - 03/01/2026)

42i - Health Services

4. Requirements

2600.

42.i. A resident shall receive assistance in accessing health services.

Description of Violation

On █ Northeast Counseling Services staff asked about psychiatric services for Resident █. The facility indicated they are unable to escort Resident █ to appointments. On █ Northeast counseling services recommended a mental health doctor be involved with Resident █ to evaluate medications. █, the facility received a call from a psychiatric intake medical doctor, the facility was unable to arrange transportation for Resident █ to get to the appointment. On █ crisis was in to see and evaluate Resident █ they indicated that Resident █ needed a different facility, no action was taken by the facility.

Plan of Correction

Accepted (█ - 02/02/2026)

The community Administrator facilitated the discharge of Resident █ on █. The resident was deemed through hospital evaluation to require a higher level of care and supervision.

On 12/10/2025 the Administrator completed an audit of current residents with recommendations for consult health services. There were no identified residents with consults pending, requiring transportation.

The Administrator will monitor resident appointments and recommendations for outside services, weekly. The Administrator will ensure that the facility facilitates transport through Shared Ride of Luzerne County if the resident has no form of personal transportation. Residents deemed to require alternative living placement will be reviewed immediately by the Administrator for further action steps as appropriate. The Administrator will document all measures related to the resident transfer process.

Licensee's Proposed Overall Completion Date: 01/21/2026

Implemented (█ - 03/01/2026)

144c1 - Smoking Area Guidelines

5. Requirements

2600.

144c1 - Smoking Area Guidelines (continued)

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

- 1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

Resident [redacted] was found smoking in their room on [redacted] at 6:08 p.m. and on [redacted] at 9:46 p.m.

Repeat Violation: [redacted]

Plan of Correction

Accept [redacted] - 02/02/2026)

The community Administrator facilitated the discharge of Resident [redacted] on [redacted]. Resident [redacted] had been transferred to the hospital on 11/27/2025 and did not return to the facility being then discharged to a higher level of care.

The facility currently has 6 residents, identified by the Administrator, as being smokers. The Administrator met with these residents on 11/20/2025 to review the community smoking policy. The residents verbally agree to follow the facility smoking policy and there have been no identified concerns regarding smoking.

The Administrator will review the community smoking policy with any admitting residents, verbalizing a desire to smoke while living in the facility. The Administrator will confirm the resident understanding of the policy and document the review and response in the resident record. The Administrator will follow up with any resident failing to follow the smoking policy for further actions as needed.

Licensee's Proposed Overall Completion Date: 01/21/2026

Implemented [redacted] 03/01/2026)

225c - Additional Assessment

6. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [redacted] began displaying new aggressive behaviors towards residents and staff on [redacted] when the resident began taking food from other residents. This behavior has become more aggressive toward staff and residents. The resident has also been witnessed eating non-edible items, such as cigarette butts, lit cigarettes, items from the garbage that also contained soiled briefs. Resident [redacted] assessment dated [redacted] notes the resident does not have problems with [redacted], and [redacted]. The assessment has not been updated regarding Resident [redacted] new behaviors or how the facility will address the behaviors and keep the resident safe.

Plan of Correction

Accept [redacted] - 02/02/2026)

An RASP assessment was completed on Resident # [redacted] on 11/19/2025, by the community Med Tech.

225c Additional Assessment (continued)

The Administrator and Med Tech completed an audit on 12/10/2025 of current community residents to identify any of those having a significant change of condition. There were no residents identified.

The Administrator and or Med Tech will review daily, any residents identified with significant changes in condition. The Administrator and or Med Tech will complete an additional RASP for any resident identified with a significant change in condition. The significant change in condition will be documented by the Administrator or Med Tech in the resident documentation; progress notes.

Licensee's Proposed Overall Completion Date: 01/21/2026

Implemented [REDACTED] - 03/01/2026)