STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395286	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broad Mountain Health and Rehabilitation Center	500 West Laurel Street Frackville, PA 17931

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 three residents (Residents 2,3, and 4) out of 3 sampled were free from physical abuse perpetrated by another resident (Resident 1). Findings include: A review of facility policy titled Pennsylvania Resident Abuse: Abuse, Neglect, and Exploitation last reviewed by the facility on May 2025, revealed it is the policy of the facility not to 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 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. A separate facility policy titled Resident Observation last reviewed May 2025, indicated the policy objective is to provide enhanced observation as a temporary safety mechanism during an acute episode where a resident is endangered. The procedure specifies that the Director of Nursing (DON) will assign a staff member to complete appropriate observation interventions, which may include 15- or 30-minute checks or one-to-one (1:1) monitoring. The policy requires that staff assigned to 1:1 monitoring remain with the resident at all times and document monitoring at designated intervals. Clinical record review revealed that Resident 1's was admitted to the facility on [DATE], with diagnoses which included Huntington's disease (a progressive neurological disease that causes nerve cells to decay over time. The disease affects a person's movements, thinking ability and mental health). A review of the resident's Quarterly Minimum Data Set Assessment (MDS-a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 4, 2025, indicated the resident was moderately cognitively impaired with a BIMS score of 3 (Brief Interview for Mental Status-a tool to assess cognition, a score of 0-7 indicates severe cognitive impairment), exhibited physical and verbal behaviors towards others, exhibited wandering behaviors and required the assistance of staff for ambulation.Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with diagnosis to include dementia and was severely, cognitively impaired with a BIMS score of 1. Review of Resident 1's plan of care dated February 28, 2025, for psychosocial well-being with interventions to include education to the resident on treatments and expectations on outcomes, behavioral health consults, document symptoms, encourage the resident to express feelings and administer medications as ordered. Nursing documentation dated from the time of admission to the facility the resident exhibited aggressive violent impulsive behaviors towards staff and other residents. She made verbal threats. She would attempt to stand and ambulate unassisted, often running from the east wing to the west wing nursing units. She would not sleep in her bed but would sleep in a chair in the dining room. A review of nursing documentation dated April 14, at 8:04 P.M. revealed, at 2:30 P.M. Resident 1 ran from the east unit to the west unit, proceeded to go into the dining room and sit in a chair and began screaming. Attempts were made to redirect the resident. At 5:05 P.M., Resident 1 got out of the chair, jumped on top of a resident (facility could not identify resident) lying in a recliner chair and laid on top of her. Attempts to redirect the resident were unsuccessful. The resident was physically lifted off the other resident. Resident 1 became combative, punching and kicking staff with full contact. Attempts were made to calm her, she continued to punch and kick staff. Attempts were made to medicate the resident with an antianxiety medication, Ativan. The resident refused. A telephone call made to the attending Physician with orders to send her to the emergency department for Psychiatry evaluation.The resident was sent to the hospital for an emergency commitment hospitalization (302 involuntary commitment to the hospital). The resident was evaluated, and the hospital refused the emergency commitment and ordered her to be returned to the facility. The resident was readmitted to the facility on [DATE], at 10:00 P.M. Nursing documentation continued to note her physical and verbal aggressive behaviors, often running from one nursing unit to the other located on the opposite side of the building. Despite repeated behaviors, supervision and interventions remained inconsistent. Nursing documentation dated July 27, 2025, at 11:29 A.M., revealed Resident 1 became agitated with another peer (facility could not identify resident) who had entered her personal space. Resident 1 was removed from the common area. Resident 1 proceeded to follow the resident stating she was going to spank her, raising her arm and making gestures of hitting toward the other resident. Staff intervened. A review of nursing documentation dated July 31, 2025, at 11:58 A.M. revealed that Resident 1 was observed