

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Broad Mountain Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation and resident and staff interviews, it was determined the facility failed to provide housekeeping and maintenance services to maintain a safe, clean and homelike environment in resident areas on two of two resident floors (first floor shower room and second floor dining room and residential units). Findings included: An observation on November 19, 2025, at 8:55 AM in the first-floor shower room revealed a large hole in the wall along the baseboard trim near the toilet and a missing ceiling tile in front of the privacy curtain. An observation on November 19, 2025, at 12:00 PM on the second floor East Wing revealed a 4-inch brown stain, resembling a water stain, with noted black stains within the brown on a ceiling tile near the nurses station. An observation on November 19, 2025, at 12:35 PM of the second floor East Wing dining room revealed three ceiling tiles that contained large brown stains, resembling water stains. An observation on November 19, 2025, at 12:40 PM of Resident 5's room revealed a used rubber glove, a used plastic cup, a towel, and multiple crumbs and debris under the resident's bed. An observation on November 19, 2025, at 12:45 PM of Resident 8's room revealed a Kennedy cup (lightweight, spill-proof drinking cup designed to be easy to hold and grip) with the lid removed on the floor containing brown liquid. The brown liquid was splattered on the floor between Resident 8 and Resident 6's bed and was also noted to be splattered on Resident 6's fitted bed sheet. Under Resident 8's nightstand were multiple used tissues, napkins, and a used face mask. Interview with Resident 7, Resident 6 and 8's roommate, during the time of the observation, reported that housekeeping does not come into their room to clean every day. The residents stated, somedays the floor is so bad, it's embarrassing. Continued observation of Resident 7's room revealed a tabletop oscillating fan positioned on top of a transfer board (a flat, smooth board used in therapy and rehabilitation to help a person move safely from one surface to another when they cannot stand or bear full weight) which was on top of the push handles of her roommate's wheelchair. The fan was plugged into the wall outlet. When questioned about the unsafe location and position of the fan, Resident 7 stated that the fan had previously been on an over-the-bed table, but staff removed the table to give it to another resident and propped the fan on the back of the wheelchair handles. Further observation revealed two positioning wedges (wedges utilized to support a resident to maintain a side lying position to offload pressure on their backside) in direct contact with floor in the corner of her room by the window. Interview with the Nursing Home Administrator and Director of Nursing on November 19, 2025, at 3:50 PM confirmed the facility's environment should be kept in good repair and maintained in a clean and homelike manner. 28 Pa Code 201.18(e)(2.1) Management</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395286
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of nursing staffing hours and staff to resident ratios, resident census, clinical records, select facility policy, and resident and staff interviews, it was determined that the facility failed to provide sufficient nursing staff to ensure that each resident received timely, person-centered care, services, and supervision necessary to maintain the physical, mental, and psychosocial well-being of the resident population for five of 18 sampled residents (Residents 1, 2, 3, 7, and 9). Findings include: A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses including cerebral vascular accident (stroke) with left-sided weakness and dementia (A condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment used to plan resident care) dated September 14, 2025, revealed the resident required staff assistance for activities of daily living and had a BIMS score of 14 (Brief Interview for Mental Status, a tool used to measure cognitive function; a score of 13-15 indicates cognition is intact). A review of a facility investigation dated October 26, 2025, at 3:30 PM revealed Employee 1, nurse aide, answered Resident 1's call bell and found the resident on the floor lying on her stomach, partially under the bed with blankets underneath her. The resident stated she had attempted to transfer from her bed into her chair and slipped, causing her to fall. Resident 1 resided on the east wing of the second floor. A review of the clinical record revealed Resident 2 was admitted on [DATE], with diagnoses including dementia. A quarterly MDS dated [DATE], revealed the resident required staff assistance for activities of daily living and had a BIMS score of 3 (a score of 0-7 indicates severe cognitive impairment). A review of a facility investigation report dated October 26, 2025, at 4:00 PM revealed Resident 2 was seated in a chair in the east wing resident dining room next to the wheelchair weight scale, which was stored and utilized in that area. Employee 2, nurse aide, was assisting the resident to the bathroom. Resident 2 stood up from the chair as Employee 2 turned to retrieve her walker. Resident 2 tripped over the wheelchair weight scale and fell, striking her head on the glass door. Documentation revealed she sustained a 2 centimeter by 0.4 cm (centimeter) laceration wound caused by tearing of the skin on the top left side of her head and a 1.8 cm by 0.2 cm laceration to her left cheek. She was sent to the hospital and received three staples and steri strips (soft adhesive wound closure strips). A review of the clinical record revealed Resident 3 was admitted on [DATE], with diagnoses including dementia. A quarterly MDS dated [DATE], revealed the resident required staff assistance for activities of daily living and had a BIMS score of 3, indicating severe cognitive impairment. A review of facility investigative documentation dated October 26, 2025, at 4:30 PM revealed Resident 3 was wandering between the east and west nursing units and was on a 15-minute observation schedule related to a previous elopement from the facility on October 11, 2025. Employee 3, nurse aide, observed Resident 3 enter the shower room located between the east and west wing units. The resident sat down on the bathtub and fell backward into the tub. A licensed nurse assessed the resident, and no injury was documented. A review of a written witness statement dated October 26, 2025, at 4:30 PM from Employee 3, nurse aide, revealed documentation indicating that the employee reported seeing Resident 3 walking in the hallway from the west unit toward the east unit and that the employee followed the resident with the intention of bringing her back to the west unit, where the resident resided. The statement documented that Resident 3 turned into the west shower room, located between the east and west nursing units, and that when the employee turned the corner into the shower room, the resident was sitting on the edge of the bathtub. The written statement further documented that, as I approached her, she fell backwards into the tub, striking her head then her back on the inside of the tub. The statement noted that the resident had last been observed by the employee 15 minutes prior as part of the resident's every-15-minute monitoring. A review of the facility document titled Resident Observation/Monitoring Tool (every 15-minute watch record) dated October 26, 2025, revealed documentation that Resident 3 was recorded as ambulating and wandering in the hallway continuously from 2:15 PM through 3:30 PM, at which time the record documented that Employee 3 rendered care. The documentation further revealed that Resident 3 was recorded as continuing to wander in the hallway from 3:30 PM through 5:45 PM. A review of the facility census for October 26, 2025, for the 3:00 PM to 11:00 PM shift revealed a total census of 105 residents, with 39 residents on the second-floor west unit and 44 residents on the east unit. A review of nursing documentation revealed that during this shift there were two residents on the west unit who were placed on</p>		