

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/06/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on review of select facility policy, the facility's infection control log, and staff interview, it was determined the facility failed to maintain and implement a comprehensive infection prevention and control program. Findings included: A review of the facility Infection Prevention and Control Program Policy last reviewed January 9, 2026, revealed it is the facility policy to maintain an organized, effective facility wide program designed to systematically prevent, identify, control, and reduce the risk of acquiring and transmitting infections among employees, volunteers, visitors, and contract healthcare workers, to conduct surveillance of communicable diseases and infectious outbreaks, and to monitor employee health. This program involves the intersection of many programs, policies, and services within the facility and is designed to meet the intent of regulatory guidance. Particular focus of the program will be on conducting assessment, surveillance, reducing healthcare associated infections, limiting transmission of disease, immunization, promoting antibiotic stewardship, and reporting as necessary. The infection preventionist's responsibilities for infection prevention and control include conducting surveillance of staff and residents for facility associated or community associated infections and, or communicable diseases. A review of facility monthly infection control logs for April 2025 through December 2025 revealed the facility failed to consistently document critical infection related details such as location of infections and symptoms experienced by residents. The facility's infection control tracking did not reflect evidence of a current functioning tracking system to monitor and investigate causes of infection and manner of spread. There was no documented evidence of a system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. During an interview with the Director of Nursing (DON) and Infection Preventionist on February 5, 2026, at 1:15 PM the DON failed to provide documented evidence of a system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. The DON acknowledged that the facility's infection control logs were incomplete and failed to support a comprehensive infection prevention and control program. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.		

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	If continuation sheet Page 1 of 11

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review, and interviews with residents and staff, it was determined the facility failed to ensure residents were afforded the right to participate in the planning of their care and treatment, including failure to conduct care plan conferences and failure to invite residents to participate in the interdisciplinary care planning process, for two of 25 residents reviewed (Residents 80 and 36). Findings include: Review of the facility policy titled Comprehensive Care Planning Policy last reviewed January 19, 2026, indicated the interdisciplinary team (IDT) is responsible for resident care plans. The IDT includes, but is not limited to, the resident's attending physician, a registered nurse with responsibility for the resident, a nursing assistant with responsibility for the resident, a member of the food and nutrition staff, to the extent practicable the resident and/or the resident's representative, and other staff as necessary to meet the needs of the resident, or as requested by the resident. The policy further states the care plan is reviewed on an ongoing basis and revised as indicated by the residents' needs, wishes, or a change in condition. At a minimum, this will occur with each comprehensive and quarterly assessment in accordance with the Resident Assessment Instrument (RAI) the mandated, standardized system used to assess nursing home residents and guide care planning) requirements. Review of the facility policy titled Care Plan Invitation Letter Policy last reviewed January 19, 2026, indicated the resident and the resident's responsible party or legal representative will be invited to attend the interdisciplinary care planning conference. The policy required a designated staff member to complete and deliver invitations to residents prior to the conference date and to mail or call family/responsible parties/representatives within seven days of the conference date. Copies of invitations are to be maintained as verification, and phone notifications are to be documented in the clinical record. The resident is to sign a copy of the invitation as verification of receipt. The policy also requires documentation in the electronic health record of all individuals attending the care planning conference, including the resident. Review of the clinical record revealed Resident 80 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), skin cancer, and Type 2 diabetes (chronic condition where the body resists the effects of insulin or does not produce enough, leading to high blood sugar levels). Review of Resident 80's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 22, 2025, revealed the resident was cognitively 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 intact cognition). During an interview on February 3, at 11:10 AM, Resident 80 stated that he had not been invited to participate in the care planning process and had not attended any care plan meetings with facility staff for a long time. He stated he would like to meet with staff to discuss his care. Review of the clinical record revealed no documented evidence that a care plan conference had been conducted for Resident 80 within the past year and no documentation that the resident was invited to participate in the development or review of his comprehensive care plan. Review of the clinical record revealed that Resident 36 was admitted to the facility on [DATE], with diagnoses including congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues), respiratory failure (not enough oxygen passes from the lungs to the blood, making it difficult to breath), and Type 2 diabetes. Review of Resident 36's quarterly MDS, dated [DATE], revealed the resident was cognitively intact with a BIMS score of 15. During an interview on February 3, at 11:25 AM, Resident 36 stated that he had not been invited to participate in the care planning process and had not attended a care plan conference with facility staff for at least one year. He stated he would (continued on next page)		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	like to meet with staff to discuss his care. Review of the clinical record revealed no documented evidence that a care plan conference had been conducted for Resident 36 within the past year and no documentation that the resident was invited to participate in the development or review of his comprehensive care plan. During an interview on February 5, 2026, at 1:05 PM, the Nursing Home Administrator reviewed the above findings. The Administrator confirmed there was no documentation to demonstrate that care plan conferences had been conducted for Residents 80 and 36 within the past year and no documentation to show the residents were invited to participate in the care planning process.28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12(d)(3) Nursing services.28 Pa. Code 211.10 (c)(d) Resident care policies.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and interviews with residents and staff, it was determined the facility failed to ensure effective pain management and failed to implement, monitor, and revise pain interventions to maintain each resident's highest practicable level of well-being for two of 25 residents reviewed (Residents 11 and 4). Findings include: A review of the facility's Pain Management Protocol, last reviewed January 19, 2026, revealed the facility would assess residents' pain to maintain their highest practicable level of physical, mental, and psychosocial well-being. Evaluation of pain treatment effectiveness would be monitored and adjusted according to resident needs. Both medication and non-medication techniques would be utilized to maintain resident comfort to the extent possible. When medication-related interventions are required, documentation will be included in the resident's clinical record on the effectiveness or need to adjust treatment. Clinical record review revealed that Resident 11 was admitted to the facility on [DATE], with a diagnosis of chronic pain and a Stage IV open pressure ulcer, (a severe open wound involving full-thickness tissue loss that may expose muscle, tendon, or ligament and is typically painful) located on the sacrum (lower back area near the tailbone). An admission Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care dated January 20, 2026, revealed that Resident 11 is cognitively intact with a BIMS score of 13 (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) and was identified to have a Stage IV pressure sore on admission. A review of the admission physician orders dated January 14, 2026, revealed treatment of the sacral wound every other day and as needed consisting of removal of the old dressing, cleansing of the wound, application of ointments, packing of the wound with dressing material, and placement of a protective covering to protect the wound from infection and promote healing. During an interview on February 6, 2026, at 9:15 AM, Resident 11 stated dressing changes to the sacral area were very painful, and that treatments performed on both day and evening shifts hurt. The resident explained that removal and replacement of the wound packing caused soreness and that staff were aware of this pain. Review of the care plan dated January 15, 2026, addressing pain related to skin integrity failed to indicate staff identified or considered the likelihood of pain during wound treatment procedures or implemented interventions to reduce procedural pain. A review of the January/February 2026 physician orders failed to indicate specific orders in which the resident would receive pain medication prior to the dressing changes to the sacral area to alleviate the pain and make the procedure more tolerable. A review of the treatment record for January and February 2026 revealed the resident received treatment for the Stage IV pressure ulcer five times since admission, in which there was no conclusive evidence that pain medication was offered prior to the treatment or that specific physician orders coordinated with the treatment to the sacral area were discussed/obtained to alleviate or reduce Resident 11's pain during the procedure. During an interview on February 6, 2026, at 12:15 PM, the Director of Nursing was unable to provide evidence that Resident 11's procedural pain during wound treatments had been addressed or that medication administration had been coordinated with treatment to reduce pain. Review of the clinical record revealed Resident 4 was admitted to the facility on [DATE], with diagnoses including osteoarthritis (degeneration of the cartilage, which acts as a protective cushion between bones in joints. It causes chronic pain, stiffness, swelling and reduced range of motion), cervical disc disorder with radiculopathy at the cervicothoracic region (a pinch nerve in the lower neck caused by an issue with the intervertebral disc. This causes pain, numbness, or weakness that radiates from the base of the neck into the shoulder, upper back or down the arm), and Hodgkin's lymphoma (cancer of the lymphatic system, a part of the body's immune system, which causes white blood cells to grow abnormally). Review of Resident 4's quarterly MDS, (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated [DATE], revealed the resident was cognitively intact with a BIMS score of 13. Section J (Health Conditions for Pain) indicated the resident experienced pain in the last 5 days that was almost constant, occasionally affected sleep, frequently interfered with day-to-day activities, and was of moderate severity. During an interview on February 3, 2026, at 10:35 AM, Resident 4 stated he experiences chronic pain all the time. He reported he previously had an order for oxycodone (a narcotic opioid pain medication) PRN (as needed, meaning given when required for symptoms) but now receives oxycodone only once daily at bedtime. He described a recent off-site medical appointment requiring wheelchair van transportation, after which he returned with pain rated 10 out of 10 on a pain scale (a standardized measurement tool used to assess pain intensity, where 0 represents no pain and 10 represents the worst possible pain). The resident stated he requested pain medication but was informed he could only receive Tylenol at that time, which he reported did not relieve his pain. He stated staff did not respond to his statements that the medication was ineffective and that his pain is not adequately controlled, negatively affecting his quality of life. Review of physician orders dated August 30, 2025, revealed an order for oxycodone 10 milligrams by mouth every six hours as needed for moderate pain (rated 4 to 6). Review of physician orders dated October 29, 2025, revealed the PRN oxycodone order was discontinued and replaced with oxycodone 15 milligrams by mouth once daily at bedtime. Nursing documentation dated October 29, 2025, confirmed the change. Review of pain assessments revealed progressive worsening of pain: On October 28, 2025, the resident reported occasional pain that occasionally affected sleep and rarely affected daily activities. On November 17, 2025, the resident reported frequent pain that frequently affected sleep and rarely affected daily activities. On January 15, 2026, the resident reported pain that was almost constant, occasionally affected sleep, and frequently interfered with daily activities. The assessment also documented new symptoms of shortness of breath when lying flat and noted the resident complained of moderate pain. Nursing documentation indicated Tylenol was administered PRN, and the resident was instructed to request pain medication as needed. Despite documented increases in pain frequency and interference with daily functioning, the clinical record revealed no evidence that the resident's pain management regimen was reassessed, revised, or that the attending physician was timely notified to address the resident's escalating pain and reported lack of relief from current interventions. During an interview on February 6, 2026, at 12:07 PM the Director of Nursing (DON) confirmed licensed nursing staff failed to timely notify the resident's attending physician of increased pain complaints and failed to obtain new or revised orders to effectively manage Resident 4's pain. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services 28 Pa. Code 211.10 (c)(d) Resident care policies		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical record review, observations, and staff interviews, it was determined the facility failed to ensure the availability of required emergency dialysis supplies for one resident (Resident 5) and failed to plan individualized care for a resident receiving hemodialysis to ensure the resident's care plan was consistent with physician orders for one resident (Resident 14) out of two residents sampled who received hemodialysis. Findings include: According to the National Kidney Foundation, patients receiving hemodialysis (a machine that filters waste, salts, and fluid from the blood when the kidneys are no longer healthy enough to do this work adequately) should have access to emergency care supplies, including at bedside, to promptly respond to complications such as bleeding from the dialysis access site. For residents with an arteriovenous (AV) fistula, a surgically created connection between an artery and a vein commonly used for dialysis access, rapid access to emergency supplies is critical, as complications such as ruptures or bleeds from the site can result in life-threatening blood loss. A review of the facility policy titled Hemodialysis Care Policy, last reviewed by the facility on January 19, 2026, revealed it is the policy of the facility that licensed staff with demonstrated competence will care for residents who require hemodialysis. Further review revealed that if bleeding occurs at the needle site any time after dialysis, apply moderate pressure over the site with a sterile 4 x 4 gauze pad for 5-10 minutes until bleeding stops, and contact the provider for excessive bleeding uncontrolled by moderate pressure. A clinical record review of Resident 5 revealed the resident was admitted to the facility on [DATE], with diagnoses that included end-stage renal disease (the final stage of kidney decline where the kidneys are no longer able to function to meet the body's needs) with dependence on dialysis (a medical treatment that uses a machine to filter waste, excess fluids, and toxins from the blood when the kidneys can no longer perform this function properly). A review of an annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 30, 2025, revealed Resident 5 was cognitively intact with a BIMS score of 13 (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 to 15 indicates cognition is intact). A physician's order dated April 5, 2024, directed staff to maintain emergency equipment in an E-Kit (emergency supply kit), including hemostats (clamp), gauze, and tape, at the bedside, taped behind the headboard, and on the resident's wheelchair at all times for dialysis access emergencies. An emergency dialysis kit is there to control active bleeding at the fistula site, which can be a medical emergency if not addressed immediately. A care plan initiated May 20, 2024, identified the resident as receiving hemodialysis and included interventions such as avoiding blood pressure measurements or blood draws in the affected arm and ensuring the emergency dialysis kit was available behind the headboard and on the wheelchair. Observation on February 3, 2026, at 11:40 AM revealed no emergency dialysis supplies were present at the bedside or on the wheelchair. During interview at that time, Employee 2, Nurse Aide, confirmed emergency supplies for the dialysis access site were not present and stated they are normally kept behind the headboard and on the wheelchair. The above findings were reviewed during an interview with the Nursing Home Administrator (NHA) on February 5, 2026, at 1:00 PM, and confirmed the facility failed to ensure that emergency dialysis access supplies were available as ordered and required by the residents' care plan. Clinical record review revealed Resident 14 was admitted [DATE], with diagnoses including diabetes and end-stage kidney disease and received hemodialysis three times weekly every Monday, Wednesday, and Friday. A current physician order dated September 19, 2025, indicated the resident had a fistula (surgically created connection between an artery and a vein that allows blood to flow directly from the artery into the vein) dialysis access site in the left arm and directed staff to assess the site each shift for a bruit (a whooshing sound heard with a stethoscope (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicating blood flow through the fistula) and thrill (a vibration felt over the site indicating blood flow). Staff were to notify the physician of abnormal findings. Review of the resident's care plan, initially dated December 31, 2024, and last reviewed December 1, 2025, revealed no interventions addressing monitoring or care of the resident's current fistula dialysis access site. The care plan indicated an intervention initially dated January 5, 2025, for a Permacath (catheter placed into the blood vessel in the upper chest and is threaded to the right side of the heart) to the right chest. Clinical record review confirmed the Permacath had been removed December 4, 2025. During interview on February 5, 2026, at 1:30 PM, the Director of Nursing confirmed Resident 14's care plan did not accurately reflect the resident's current dialysis access or care needs.28 Pa. Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.10 (d) Resident care policies.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of select facility policy, and staff interviews, it was determined the facility failed to adhere to acceptable storage and labeling for multi-dose medications in one of three medication storage rooms (first floor medication room). Findings include: A review of the facility policy titled Storage and Expiration Dating of Medications and Biologicals, last reviewed by the facility January 19, 2026, indicated that if a multi-dose vial of an injectable medication has been opened or accessed, the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. An observation of the first-floor medication room on February 5, 2026, at 10:45 AM, in the presence of Employee 1, Registered Nurse (RN), of medication stored in the medication refrigerator, revealed three multi-dose vials of Aplisol (solution used for screening tuberculosis) that had been opened and available for use but not dated when initially opened. A review of the manufacturer's dosage and administration recommendation for Aplisol revealed that vials in use for more than 30 days should be discarded. An interview with Employee 1 at the time of the observation on February 5, 2026, at 10:45 AM, confirmed the Aplisol had been opened and not dated, and the medications should have been removed from the medication refrigerator and discarded. An interview with the Director of Nursing on February 5, 2026, at 10:50 AM, confirmed that the facility failed to adhere to acceptable storage and labeling practices for multi-dose medications. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to implement procedures for smoking safety, as evidenced by two out of six residents sampled for smoking. (Residents 5 and 53). Findings include: A review of the facility policy titled Smoking Policy, last reviewed by the facility on January 19, 2026, revealed it is the facility policy to establish resident smoking processes that consider both smoking and non-smoking residents and that comply with applicable federal, state, and local laws and regulations regarding smoking, smoking areas, and smoking safety. The policy indicated that any resident that chooses to smoke will be further assessed for smoking safety awareness and the need for reasonable physical or safety accommodations. The assessment is completed thereafter on readmission, quarterly, and with any significant change in the resident's condition. A clinical record review of Resident 5 revealed the resident was admitted to the facility on [DATE], with diagnoses to include diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time). A review of an annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 30, 2025, revealed that Resident 5 was cognitively intact with a BIMS score of 13 (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 to 15 indicates cognition is intact). A clinical record review revealed a care plan initiated on May 20, 2024 indicating Resident 5 currently uses tobacco. Interventions in place to assist Resident 45 to safely smoke include staff supervision while smoking, with use of a smoking apron. A smoking risk observation report dated May 27, 2025, revealed Resident 5 was considered a safe smoker and can follow the facility policy for safe smoking. Further clinical record review for Resident 5 revealed no subsequent smoking risk observation reports or assessments for safe smoking. Following the surveyor inquiry, a smoking safety assessment was completed on February 4, 2026, confirming the resident remained a safe smoker. This assessment occurred 253 days after the prior evaluation, exceeding the 90-day quarterly requirement established by the facility's policy. A clinical record review revealed Resident 53 was admitted to the facility on [DATE], with diagnoses that included anxiety (a mental condition that causes a feeling of worry, nervousness, or unease) and chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). A review of an annual MDS assessment dated [DATE], revealed that Resident 53 was cognitively intact with a BIMS score of 15 (a score of 13 to 15 indicates cognition is intact). A clinical record review revealed a care plan indicating Resident 53 currently used tobacco, initiated on April 30, 2024. Interventions in place to assist Resident 51 to safely smoke included ensuring staff to complete smoking assessments for safety and the use of a smoking apron and cigarette holder. A smoking risk observation report dated July 15, 2025, revealed Resident 53 was considered a safe smoker and was able to follow the facility policy for safe smoking. Further clinical record review revealed no subsequent smoking risk observation reports or assessments for safe smoking. Following the surveyor inquiry, a smoking safety assessment was completed on February 4, 2026, confirming the resident remained a safe smoker. This assessment occurred 204 days after the prior evaluation, exceeding the 90-day quarterly requirement established by the facility's policy. During an interview on February 5, 2026, at 10:00 AM, the Director of Nursing (DON) confirmed it is the facility's policy to assess residents' ability to safely smoke at least quarterly (90 days) or with any significant change, and confirmed it is the facility's responsibility to implement procedures to ensure residents are assessed and monitored for smoking safety. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 209.3 (a) Smoking 28 Pa Code 211.10 (a)(c) Resident care policies.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observation, and staff interviews, it was determined the facility failed to ensure oxygen therapy was administered per physician's orders for one resident out of 25 sampled (Resident 45). Findings include: A review of the facility's policy titled Oxygen Administration Policy, last reviewed January 19, 2026, revealed it is facility policy that licensed clinicians with demonstrated competence will administer oxygen via the specific route as ordered by a provider. Further review of the policy revealed that staff should perform hand hygiene and apply gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures included changing the tubing, mask, or cannula weekly. A clinical record review revealed Resident 45 was admitted to the facility on [DATE], with diagnoses that included asthma (a chronic lung disease causing inflammation and narrowing of the airways), chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe), and dementia (a condition characterized by the loss of cognitive functioning, such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated January 18, 2026, revealed the resident was severely cognitively impaired with a BIMS score of 03 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment). A review of Resident 45's clinical record revealed a physician's order dated January 14, 2026, to administer oxygen at 2.0 liters per minute (L/min) via nasal cannula or mask. A nasal cannula is a flexible plastic tube with two small prongs that fit into the nostrils and is used to deliver supplemental oxygen to assist with breathing. A review of Resident 45's comprehensive care plan, last revised January 14, 2026, indicated the resident had an altered respiratory status (difficulty maintaining normal breathing function) related to asthma (a chronic lung condition that causes airway narrowing), chronic obstructive pulmonary disease or COPD (a progressive lung disease that limits airflow), and an upper respiratory infection (infection involving the nose, throat, or airways). The care plan included interventions such as providing respiratory therapy as ordered and monitoring oxygen saturation (percentage of oxygen carried in the blood) using pulse oximetry (small device placed on a fingertip that estimates oxygen levels in the bloodstream) as ordered. An observation conducted on February 3, 2026, at 11:05 AM, revealed Resident 45 seated in her wheelchair in her room with the oxygen turned off, despite having a physician's order for continuous oxygen. During the observation, Employee 3, a Licensed Practical Nurse (LPN), stated that the resident had an order for continuous oxygen and that it should remain on at all times. The LPN assessed the resident's oxygen saturation using a pulse oximeter and obtained a reading of 94%. Observation of the nasal cannula tubing revealed there was no documented date indicating when the tubing was last changed. The LPN then obtained new oxygen tubing and applied oxygen at 2 L/min via nasal cannula. At the time of the survey on February 3, 2026, the care plan did not specifically indicate that Resident 45 required continuous oxygen use. Following surveyor inquiry, documentation indicated that oxygen at 2 L/min continuous via nasal cannula was initiated on February 4, 2026. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 4, 2026, at 1:55 PM, the above findings for Resident 45 were reviewed. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services		

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 02/06/2026
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interview, it was determined the facility failed to timely act upon a recommendation to reduce an antianxiety medication (medication used to calm the nervous system and balance brain chemistry) for one of 25 residents sampled (Resident 9). Findings include: A review of the facility Psychoactive Medication Policy (medication that affects brain activities associated with mental processes and behaviors, includes antianxiety medication) last reviewed January 19, 2026, indicated that all residents receiving psychoactive medications will have their behaviors, effectiveness of interventions (pharmacological and nonpharmacological) and potential for a gradual dose reduction of psychoactive medication monitored and documented. A review of the resident's clinical record revealed that Resident 9 was admitted to the facility on [DATE], with diagnoses that included a left calcaneus fracture (broken heel bone in the left foot) and anxiety. Review of admission physician orders dated January 5, 2026, revealed an order for Lorazepam 0.25 mg (antianxiety medication) twice per day by mouth for anxiety. Review of a consultant CRNP (certified registered nurse practitioner) psychology note dated January 6, 2026, revealed the resident noted that she was on the antianxiety medication for several years, felt she was no longer anxious, and wanted to try a lower dose of Lorazepam. The consultant CRNP agreed and requested a gradual dose reduction to Lorazepam 0.25 mg once daily. Review of the clinical record revealed no documented evidence that the facility notified the resident's physician to decrease the Lorazepam to 0.25 mg once daily per the consultant's recommendation. Review of a consultant CRNP psychology note dated January 13, 2026, revealed the resident still wished to have the Lorazepam decreased. The note indicated the request from January 5, 2026, was neither approved nor declined. A request to decrease the Lorazepam to 0.25 mg once daily was again noted. Review of a nurses note dated January 14, 2026, noted Gradual Dose Reduction (GDR) of Ativan (Lorazepam) per psych and resident's request due to not feeling anxious. Resident placed on daily charting times two weeks to monitor or any signs and symptoms of anxiety. All parties aware. Further review of the clinical record revealed no documented evidence the physician was notified to decrease Lorazepam to 0.25 mg by mouth to once daily as per the recommendation of the outside CRNP psych consultant and resident request. Review of Resident 9's January Medication Administration Record revealed that Lorazepam 0.25 mg was administered twice daily from January 6, 2026, through January 19, 2026. A physician order dated January 20, 2026 (14 days after the original request to GDR the antianxiety medication), noted an order to decrease Lorazepam 0.25 mg to once daily by mouth for a diagnosis of anxiety. An interview with the Director of Nursing on February 5, 2026, at 1:00 PM failed to provide documented evidence the facility timely reduced Resident 9's antianxiety medication when recommendation was made. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing Services.		