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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>395352 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>09/13/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Broad Acres Health and Rehabilitation |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1883 Shumway Hill Road<br>Wellsboro, PA 16901 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> | <p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to notify a resident and/or their responsible party in writing of a transfer to the hospital with the required information for five of nine residents reviewed (Residents 11, 16, 24, 30, and 50).</p> <p>Findings include:</p> <p>Clinical record review for Resident 16 revealed that they were transferred to the hospital on August 31, 2024, after a change in their condition. There was no documentation that the facility provided written notification to the resident's responsible party regarding the transfer that included the required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred, a statement of the resident's right to appeal, including the name, contact, email, and address, how to obtain and appeal form, assistance completing and submitting the appeal form and hearing request, contact, email, and address information for the Office of the State Long-Term Care Ombudsman, and information for the agency responsible for the protection and advocacy of individuals with developmental disabilities.</p> <p>Clinical record review for Resident 30 revealed that they were transferred to the hospital on January 27, 2024, after there was a change in their condition. There was no documentation that the facility provided written notification to their responsible party as required regarding the transfer that included the required contents listed above.</p> <p>Clinical record review for Resident 50 revealed that they were transferred to the hospital on December 29, 2023, after there was a change in their condition. There was no documentation that the facility provided written notification to their responsible party, or the State Ombudsman as required regarding the transfer that included the required contents listed above.</p> <p>The surveyor reviewed the above information for Residents 16, 30, and 50 during an interview with the Nursing Home Administrator and Director of Nursing on September 12, 2024, at 2:20 PM.</p> <p>Clinical record review for Resident 11 revealed that she was transferred to the hospital on January 30, 2024, after there was a change in her condition. There was no documentation that the facility provided written notification to her responsible party as required regarding the transfer that included all the required contents as listed above.</p> <p>(continued on next page)</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 |
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| <p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>                                   | <p>Clinical record review for Resident 24 revealed that they were transferred to the hospital on June 13, 2024, after there was a change in his condition. There was no documentation that the facility provided written notification to his responsible party, or the State Ombudsman as required regarding the transfer that included the required contents listed above.</p> <p>Interview with Employee 1 (business office manager) on September 13, 2024, at 9:16 AM confirmed these findings.</p> <p>28 Pa. Code 201.14 (a) Responsibility of license</p> <p>28 Pa. Code 201.29(a) Resident rights</p> |  |  |

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| <p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for one of six residents reviewed for mood/behavior (Residents 7).</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 7 on April 19, 2024, and added a diagnosis of Post Traumatic Stress Disorder (PTSD, a mental and behavioral disorder that develops related to a terrifying event) on May 1, 2024.</p> <p>Review of Resident 7's social history and evaluation completed on April 23, 2024, revealed a trauma screening questionnaire (a group of questions related to symptoms that may occur due to a traumatic event) that indicated Resident 7 had difficulty concentrating at least twice in the past week. The questionnaire did not include questions related to her diagnosis of PTSD or triggers that may mitigate re-traumatization.</p> <p>Review of Resident 7's current care plan revealed a history of depression, PTSD, and anxiety. The care plan indicated that the PTSD was related to her husband's death and that she had panic attacks at times. The care plan did not identify what triggers her panic attacks related to her husband's death that occurred approximately [AGE] years ago or how she deals with them.</p> <p>Further review of Resident 7's clinical record contained no evidence the facility collaborated with the resident, and as appropriate, the resident's family, friends, and any other healthcare professionals (such as psychologists, and mental health professionals) to identify triggers to develop and implement individualized interventions to prevent re-traumatization.</p> <p>Resident 7's care plan was revised on September 13, 2024, and a progress note was entered into her clinical record on September 12, 2024, at 7:57 PM indicating a conversation was held with her to determine her potential triggers. This was after the surveyor made the facility aware that her clinical record failed to identify her potential triggers on September 12, 2024, at 2:00 PM.</p> <p>These findings were confirmed with the Director of Nursing on September 13, 2024, at 2:00 PM.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services</p> |  |  |

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| <p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Post nurse staffing information every day.</p> <p>18229</p> <p>Based on observation, review of posted daily nurse staffing data, and staff interview, it was determined that the facility failed to ensure daily nurse staff data was posted for both nursing units (A and B wing).</p> <p>Findings include:</p> <p>Observation on September 11, 2024, at 1:46 PM revealed the facility's posted nursing time did not include the total number and the actual hours worked of licensed and unlicensed nursing staff directly responsible for resident care for first and second shifts.</p> <p>Subsequent observations on September 12, 2024, at 2:48 PM, and September 13, 2024, at 11:12 AM again revealed the facility's posted nursing time did not include the total number and the actual hours worked of licensed and unlicensed nursing staff directly responsible for resident care for first and second shifts. The posting did not include the facility's name.</p> <p>Interview with the Director of Nursing on September 13, 2024, at 11:42 confirmed these findings.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> |