

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER Passavant Retirement and Health		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Burgess Drive Zelienople, PA 16063	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on review of facility policy, clinical records, observations, and staff interviews it was determined that the facility failed to make certain each resident received adequate supervision that resulted in one elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of three residents (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility's policy Elopement Protocol dated 1/24, indicated to promote the safety of all residents and maintains a process to assess residents for risk of elopement, implement prevention strategies for those identified as an elopement risk and conduct a missing resident protocol.</p> <p>Review of the facility's policy Accidents and Incidents-Investigation and Reporting dated 1/24, indicated will provide a safe and secure environment in order to prevent incidents and accidents from occurring.</p> <p>Review of Residents R1's clinical record indicated admission to facility to on 6/29/24.</p> <p>Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 7/6/24, indicated the diagnosis of benign prostatic hyperplasia (enlargement of the prostate gland affecting urinary system), Parkinson's disease (brain condition that causes slow movements, rigidity and tremors) and anxiety</p> <p>Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions:</p> <p>13-15: cognitively intact</p> <p>8-12: moderately impaired</p> <p>0-7: severe impairment</p> <p>Review of Resident 1's MDS assessment dated [DATE], Section C0500-BIMS screening indicated a score of 14 revealing that Resident R1 was alert and oriented to person, place, and situation.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R1's admission elopement risk evaluation completed on 6/29/24, indicated resident was not at risk of elopement.</p> <p>Review of clinical note dated 7/12/24, indicated an employee observed resident walking in hall, heading towards exit, with fishing rod (and no walking device). Redirected resident to room, walking with assist of two.</p> <p>Review of Elopement Risk assessment completed on 7/13/24, indicated resident at risk for elopement wander guard applied.</p> <p>Review of Physician order dated 7/13/24, indicates wander alarm applied to left ankle.</p> <p>Review of daily wander guard checks indicate initiated July 13, 2024, left ankle and wheelchair.</p> <p>Review of Resident R1's care plan dated 7/13/24, indicate elopement risk, wander guard applied to left ankle.</p> <p>Interventions that include but not inclusive to:</p> <ul style="list-style-type: none"> . Resident R1 will be redirected during times of verbalizing attempt to leave or attempting to leave. . Resident R1 will be assessed for any pattern to elopement behavior. . Provide escort for off-unit activities. . Engage Resident R1 in leisure and social activities and provide encouragement for participation. . Provide diversional activities and/or one-on-one visits. . Check visually on rounds. Keep resident's photo and information updated in the Elopement Profile. <p>Review of Resident R1's clinical note dated 9/2/24, 6:42 p.m. indicates Resident R1 left household/facility after asking another residents family member to open the household door. Resident R1 made his way to the employee entrance door, left facility, went down the employee entrance ramp and fell out of wheelchair. Resident was not injured. Personal care staff member saw resident who was able to get off the ground and back into his wheelchair and continued his way toward the maintenance building. Staff caught up with resident and escorted back into the building.</p> <p>Review of incident report statement indicates no injuries noted, Resident R1 was very cooperative, Resident R1 stated he had asked a visitor to hold the door open for him, his wander guard system was in place and working. Resident R1 stated he went out to enjoy fresh air.</p> <p>Review of facility visual checks indicate resident was last observed 9/2/24, at 5:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility clinical note dated 9/2/24, at 11:00 p.m. indicate resident currently on 15-minute visual checks following an elopement incident. Resident stayed in his room for the remainder of the 3-11 shift except around 10:00 p.m. when resident went out to the living room to complain about the noise from a different room.</p> <p>During an interview on 9/10/24, at 11:16 a.m. the first floor Director of Nursing (DON) stated they had a new resident move in who has a brother, the brother opened door and let Resident R1 off the unit. There was not a sign on the inside (exit) of the door at the time it was only on the outside (entrance) door.</p> <p>During an interview on 9/10/24, at 1:08 p.m. Facility Pastor Employee E4 stated if a resident is an elopement risk, they have a bracelet on and the doors will not open, I watch for anyone looking at door trying to get out, there are also boards in the team room with names of resident at risk for elopement. Pink tape is on the wheelchair or walker that indicates elopement risk I look for that.</p> <p>During an interview on 9/10/24 at 1:13 p.m. Nurse Aid (NA) Employee E5 stated the pink tape on the wheelchair or walker shows risk, if a resident is exit seeking, we will redirect. Residents have wander guards on the doors won't open. There is also a sign on door to remind families not to let residents out.</p> <p>During an interview on 9/10/24, at 2:15 p.m. the Nursing Home Administrator stated at the point and time that Resident R1 was let out of the unit, there was not staff in the area for supervision and the facility failed to make certain each resident received adequate supervision that resulted in one elopement for one of three residents (Resident R1).</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing service</p>		