

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2025
NAME OF PROVIDER OR SUPPLIER  Laurel Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE  75 Hickle Street Uniontown, PA 15401	

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 - Immediate jeopardy to resident health or safety</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>(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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, clinical record review, incident reports, facility documents, employee statements, and staff interview it was determined that the facility failed to ensure that a resident received adequate supervision which resulted in an elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge). for one resident (Resident R1). This failure created an immediate jeopardy situation for one of 14 ambulatory residents. This was identified for past non-compliance for Resident R1. Findings include: Review of facility policy Elopement of Patient defined elopement as any situation in which a patient leaves the premises or a safe area without the facility's knowledge and supervision, if necessary. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggests the following distributions: 13 - 15: cognitively intact 8 - 12: moderately impaired 0 - 7: severe impairment Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included sequelae of cerebral infarction (long-term effects and complications that occur after a stroke), high blood pressure, and difficulty walking. Review of Resident R1's Minimum Data Set (MDS- a periodic review of resident needs) dated 7/25/25, indicated the diagnoses were current. Further review of the MDS Section C: Cognitive Patterns; Brief Interview for Mental Status; Question C0500 indicated a BIMS score of 15. Review of facility submitted documentation indicated the following: On 8/2/25, the Director of Nursing (DON) was notified of patient missing. At 12:21 a.m. a facility-wide search revealed Resident R1 was not able to be located in or around the facility. DON directed staff in the facility to notify the police department. The police spotted his car on a traffic camera on 8/2/25, at 11:15 a.m. The police located Resident R1 on 8/2/25, at approximately 5:55 p.m. Review of a physician order dated 7/18/25, indicated resident may leave the facility unaccompanied utilizing transportation arranged by the facility. Review of an Elopement Evaluation assessment completed on 7/18/25, indicated Question 5 Does the resident wander? was answered 'No'. Question 13 Risk for Wandering/Elopement identified indicated a Risk for Wandering/Elopement Identified was checked and initiated a risk for wandering/elopement care plan. Review of the care plan dated 7/18/25, indicated the following: Identify if there is a certain time of day wandering / elopement attempts occur Ensure the safety of resident and others. Evaluate elopement risk. Evaluate medication schedule and possible pharmacological causes of wandering Initiate visual supervision during acute episodes. Provide emotional support regarding new onset wandering. Review of Nurse Aide (NA) Employee E1 undated witness statement indicated after dinner when they picked up Resident R1's meal tray he was lying in bed. Around 6:30 p.m. on 8/1/25, they were at the nurses station and saw Resident R1 walked past them going towards the dining room. They did rounds around 9:15-9:30 p.m. and noticed Resident R1 was still not in bed so they asked NA Employee E5 where he was, and she stated Resident R1 was probably still in the dining room. It was normal behavior for Resident R1, so they continued with their rounds. Review of NA Employee E2's undated witness statement indicated they saw Resident R1 at the front desk on 8/1/25, between 5:30-6:15 p.m. asking for the code to the front door, but they did not hear anyone respond. Review of Licensed Practical Nurse (LPN) Employee E3's witness statement dated 8/2/25, indicated they last saw Resident R1 on 8/1/25, between 4-5:00 p.m. at the nurse's station. Review of NA Employee E4's undated witness statement indicated they last saw Resident R1 walking down the hall on 8/1/25, between 4-4:30 p.m. with a family member. Review of NA Employee E5's witness statement dated 8/2/25, indicated they saw Resident R1 with his mother and the Physician Assistant (PA) before dinner around 5:00 p.m. on 8/1/25. He rang for a blanket around 7:00 p.m. and was given a snack around 7:45-8:00 p.m. They did not see him after that but didn't think anything about it because Resident R1 goes all over the building and outside. Review of LPN Employee E6 witness statement dated 8/2/25, indicated they arrived at work at 11:00 p.m. on 8/1/25. They were alerted by NA Employee E8 that a resident was missing at 12:15 a.m. on 8/2/25. They checked the inside and outside of the facility with other staff members. Review of LPN Employee E7's witness statement dated 8/2/25, indicated when the NA did 12:00 a.m. rounds, Resident R1 was not found in his room or anywhere in the building. They provided Resident R1 with his medication around 7:00 p.m. on 8/1/25. All responsible parties notified of Resident R1 leaving the facility. Review of NA</p>		