STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395300	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wexford Healthcare Center	9850 Old Perry Highway Wexford, PA 15090

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of facility documents, clinical records, and staff interviews, it was determined that the facility failed to fully investigate an incident to eliminate possible neglect for one of two residents (Resident R1). Review of the facility policy Abuse, Neglect and Misappropriation, dated 4/18/24, with a previous review date of 8/21/23, indicated that the facility will provide resident centered care and the intent of the facility is to prevent the abuse, mistreatment or neglect of residents. The accurate and timely identification of any event which would place our residents at risk for potential abuse is the primary concern. Each occurrence of resident incident, bruise, etc., will be identified and reported to the supervisor and investigated immediately. In the event a situation is identified as abuse, neglect, etc., an investigation by the executive leadership will follow. Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/19/25, included diagnoses aphasia (language disorder that affects communication and difficulty speaking), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and history of a stroke. Review of Section B: Hearing, Speech, and Vision indicated Resident R1 rarely understands and is rarely understood. Review of the Nursing Admission Evaluation(s) dated 12/13/24, 12/20/25, and 1/24/25, indicated Resident R1 is at risk for elopement or unsafe wandering. Review of an Wandering Observation Tool completed on 3/20/25, indicated Resident R1 did not have a history of wandering. Review of an Wandering Observation Tool completed on 3/31/25, indicated Resident R1 did have a history of wandering. Review of the physician's orders dated 12/13/24, through 3/29/25, failed to include orders related to wandering or risk of elopement. Review of Resident R1's plan of care for [Resident R1 is an elopement risk] initiated 12/13/24, indicated that Resident R1 will not exit property if unsafe to navigate community. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 3/30/25, at 3:20 p.m. indicated, Called by CNA (nurse aide) that resident is outside of the facility, went directly outside, saw resident with the CNA, assisted back to the facility. Contacted [Doctor's] office ordered to send resident to ED (emergency department) for further evaluation. DON (Director of Nursing) made aware. Sister contacted. 911 activated. EMS (emergency medical service) transported resident via stretcher. Review of a progress note dated 3/30/25, at 10:00 p.m. indicated that Resident R1 returned to the facility at 8:00 p.m. Review of facility submitted information dated 3/31/25 by the Director of Nursing (DON), indicated that on 3/30/25, at 2:30 p.m. [Resident R1] was discovered outside in front of the building on the road. He was talking with a passerby. At that time two CNAs were walking around the building and saw two men talking in the road. It looked like they were arguing. They recognized the one man as [Resident R1]. They went to him and after some encouragement convinced him to go with him into the building. Review on 4/2/25, of the facility-provided investigation documents revealed statements provided by nurse aide and licensed nurses. During an interview on 4/2/25, at approximately 2:25 p.m. the DON confirmed that the facility's investigation concluded that Environmental Services Employee E4 had silenced the alarm, without checking in the stairwell to ensure no residents were present. During an interview on 4/2/25, at approximately 3:15 p.m. EVS Employee E4 stated that he had been in the bathroom, and the alarm had been sounding for approximately five minutes. EVS Employee E4 stated that he did look into the stairwell, but did not observe any residents. EVS Employee E4 confirmed that he did not inform any other staff of the alarm being silenced. During an interview on 4/4/25, at approximately 11:00 a.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to interview and gather a statement from Employee E4, the employee who was central to the resident being able to exit the facility without staff being aware and confirmed that the surveyor interview conducted with EVS Employee E4 contradicted the conclusion of the facility's elopement investigation. The Nursing Home Administrator and the Director of Nursing further confirmed that the facility failed to fully investigate an incident to eliminate possible neglect for one of two residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.20(a)(1) Staff Development. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on facility policy review, clinical and facility record review, facility submitted documents, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent elopement for one of eleven residents (Resident R1). This failure created an immediate jeopardy situation for 1 of 124 residents. Review of the facility policy Elopement Prevention and Management Overview dated 10/24/24, defined elopement as when a resident/patient leaves the premises or a safe area without authorization and/or any necessary supervision and places the resident at risk for harm or injury. Unsafe wandering is defined as when a resident/patient enters an area that is physically hazardous or contains potential safety hazards. Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/19/25, included diagnoses aphasia (language disorder that affects communication and difficulty speaking), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and history of a stroke. Review of Section B: Hearing, Speech, and Vision indicated Resident R1 rarely understands and is rarely understood. Review of the Nursing Admission Evaluation(s) dated 12/13/24, 12/20/25, and 1/24/25, indicated Resident R1 is at risk for elopement or unsafe wandering. Review of a Wandering Observation Tool completed on 3/20/25, indicated Resident R1 did not have a history of wandering. Review of a Wandering Observation Tool completed on 3/31/25, indicated Resident R1 did have a history of wandering. Review of the physician's orders dated 12/13/24, through 3/29/25, failed to include orders related to wandering or risk of elopement. Review of Resident R1's plan of care for [Resident R1 is an elopement risk] initiated 12/13/24, indicated that Resident R1 will not exit property if unsafe to navigate community. Review of a progress note dated 3/30/25, at 3:20 p.m. indicated, Called by CNA (nurse aide) that resident is outside of the facility, went directly outside, saw resident with the CNA, assisted back to the facility. Contacted [Doctor's] office ordered to send resident to ED (emergency department) for further evaluation. DON (Director of Nursing) made aware. Sister contacted. 911 activated. EMS (emergency medical service) transported resident via stretcher. Review of a progress note dated 3/30/25, at 10:00 p.m. indicated that Resident R1 returned to the facility at 8:00 p.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility submitted documentation dated 3/31/25 by the Director of Nursing (DON), indicated that on 3/30/25, at 2:30 p.m. [Resident R1] was discovered outside in front of the building on the road. He was talking with a passerby. At that time two CNAs were walking around the building and saw two men talking in the road. It looked like they were arguing. They recognized the one man as [Resident R1]. They went to him and after some encouragement convinced him to go with him into the building, He was still agitated, upon entering the building the RN (Registered Nurse) Supervisor completed a head to toe assessment. The only injury that was found was a small open area on his right wrist, 1cm x 2cm. Family and physician were notified, an order was obtained to send the resident to the emergency room for a workup to evaluate for cause of altered mental status. Resident returned from the emergency room (ER) later that evening. Upon return from the ER the resident was assessed for wander risk due to his increase in agitation, he was assessed as being a wander risk and a Wanderguard (electronic monitoring bracelet) was place on the resident, the consultant pharmacist was asked to evaluate the residents medication regimen, to check for drug interactions that might have a negative effect. Family being contacted to get a consent for psych consult. On 4/1/25, the report was updated to include that the resident exited the side door. His last elopement risk assessment was done on 3/20/25 and showed he was not at risk. He was last seen by his nurse at 2:15 p.m. The weather was 60 degrees with light drizzle. The resident had on a long sleeve shirt and pants. Review of an employee statement dated 3/30/25, written by the Licensed Practical Nurse (LPN) Employee E1 indicated, Resident with me this shift (7-3). Followed with medication pass. Pacing up and down halls quickly. No attempts to seek exit. [Resident R1] was agitated, unable to sit for 2 minutes. He was pale and looked very perplexed; very short conversations not baseline. Medications were taken along with prn (as needed) Ativan (medication for anxiety), noted Ativan not to be effective as usual, as improving his agitation and speech. Resident's foley (urinary catheter) was patent and emptied often. At end of the shift, [Resident R1] remained agitated, but we were able to redirect him. Seen him last at 2:15 p.m. at nurses station. Review of an employee statement dated 3/30/25, written by Nurse Aide (NA) Employee E2 indicated, Before rounding, [Resident R1] was doing his normal pacing back and forth. I finished my round and everything was normal. I never heard the alarm because I was in a room with the door closed. I went on a 15-minute break. I was walking with a co-worker around the building. I spotted two people in the middle of the road tussling. I noticed it was [Resident R1] because of his clothes. I ran over to help, the resident was fighting the man. I asked him to let go of the resident and I would take over. I then tried talking to the resident to calm him down and let the man go. He wouldn't so I moved the man out the way and allowed the resident to grab hold of me. He was screaming and hitting me so I walked behind him up the hill while he bent my fingers back. I got him to the sidewalk near the front door where supervisor and aides were running. They took him from there. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an employee statement dated 3/30/25, by NA Employee E3 indicated, After doing last rounds I went to the restroom in break area. When finishing up I heard two stairwell alarms going off. One was for [NAME] Tower the other was for Chadsworth. When I came out of the breakroom they turned off. Me and another aide then went on a smoke break. As we were walking around the building we noticed two people in the middle of the street tussling. We were walking to help and noticed it was [Resident R1]. My coworker and I then ran over to help. The resident was fighting the man, as I was calling for help my coworker took over from the man to help [Resident R1]. Once my coworker allowed resident to grab a hold of her, he was screaming and hitting her. I got in touch with the supervisor and supervisor and aides came running out the building. During an interview on 4/2/25, at approximately 2:25 p.m. the DON confirmed that the facility's investigation concluded that Environmental Services Employee (EVS) E4 had silenced the alarm, without checking in the stairwell to ensure no residents were present. During an interview on 4/2/25, at approximately 3:15 p.m. EVS Employee E4 stated that he had been in the bathroom, and the alarm had been sounding for approximately five minutes. EVS Employee E4 stated that he did look into the stairwell, but did not observe any residents. EVS Employee E4 confirmed that he did not inform any other staff of the alarm being silenced. The NHA and the DON were made aware that an Immediate Jeopardy situation existed for residents on 4/2/25, at 3:44 p.m. and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at 3:50 p.m. On 3/26/25, at 6:13 p.m. an acceptable Corrective Action Plan was received which included the following interventions: -On 3/30/25 at 2:30 p.m. Affected Resident was escorted back into the facility. Wanderguard was then placed on resident immediately. Physician was notified at 2:47 p.m. Body assessment completed and skin tear to resident's right wrist was discovered. Treatment applied. Resident was transferred to ED for evaluation and treatment. Resident returned that evening with a positive UA (urinalysis) but not being treated. -On 3/30/25 at 3:00 p.m. Facility Wide Headcount was conducted by nursing department and all residents were accounted for. -On 3/30/25 at 3:15 p.m. All Alarming Doors were audited to ensure functionality. -On 3/30/25 at 8:00 p.m. after return from hospital immediate intervention of 1:1 was placed on resident and will be until adjustment to new medications is accomplished. -On 3/30/25 at 5:00 p.m. Elopement Books were updated to include affected resident. -On 3/31/25 at 7:30 am Elopement Care plan and Orders were updated on all like residents. -On 4/2/2025 at 3:00 p.m. Whole House Education was completed on Elopement Policy, Responding to Alarms, Code [NAME] and inspecting any stairwells or any exit path by Nurse Educator/designee. -On 3/31/2025, Pharmacist Consultant reviewed medications, no medication changes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/1/2025, Psychiatric consultation was made, and medication adjustments were made. Resident was prescribed Lexapro (a medication used to treat depression and anxiety). -Newly admitted residents are screened for elopement risk upon admission, quarterly and as needed and care plans and assessments done accordingly. Any resident deemed at risk for elopement will have a Wanderguard placed. -On 4/2/2025, Facility Medical Director was notified of the Immediate Jeopardy and Abatement Plan. -Daily Door Alarm Audits will continue by Maintenance Department or designee daily. -Elopement Drills will be conducting weekly for two months, alternating shifts for two months. -The Plan of Correction will be monitored at the Monthly QAPI Committee Meetings monthly for the next three months. Reviewing all door audits, elopement drills, new admissions for elopement assessments and reviewing the Elopement Policy as needed. -Results will be submitted to QAPI. Review of the clinical record indicated Resident R1 received a psychiatric evaluation on 4/1/25. Review of the clinical record indicated Resident R1 received a pharmacist review of medications on 4/2/25. On 4/3/25, the elopement binder was verified as complete and accurate. On 4/3/25, updated elopement assessments, care plans, and orders for residents identified as elopement risks were verified as completed. On 4/3/25, daily door alarm audits were verified as completed for 3/31/25, through 4/3/25. On 4/3/25, review of facility documents revealed on 3/31/25, an elopement drill was held on evening shift. On 4/1/25, elopement drills were held on day and overnight shifts. During staff interviews on 4/3/24, between 1:30 p.m. and 3:00 p.m. and on 4/4/25, between 9:00 a.m. and 10:30 a.m. 34 facility staff members from multiple departments were interviewed, and confirmed that they had received education on elopement prevention, door alarms, and actions to take in the event of a suspected or confirmed resident elopement. The Immediate Jeopardy was removed on 4/4/25, at 10:45 a.m. when the action plan implementation was verified. During an interview on 4/4/25, at approximately 11:00 a.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide adequate supervision to prevent elopement for one of eleven residents. This failure created an immediate jeopardy situation for 1 of 124 residents. 28 Pa. Code 201.14(a) Responsibility of licensee. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.20(a)(1) Staff Development. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.