| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395549 | A. Building<br>B. Wing | 09/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sherwood Oaks | 100 Norman Drive<br>Cranberry Township, PA 16066 |

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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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075<br><br>Based on review of clinical record review, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of three residents (Residents R1, R2, and R3).<br><br>Findings include:<br><br>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].<br><br>Review of Resident R1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 9/21/24, indicated diagnoses of hypertension, anemia (too little iron in the body causing fatigue), and atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls).<br><br>Review of the clinical record indicated Resident R1 was transferred to the hospital on 8/30/24 and returned to the facility on [DATE].<br><br>Review of Resident R1's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].<br><br>Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE].<br><br>Review of Resident R2's MDS dated [DATE], indicated diagnoses of osteoporosis (condition when the bones become brittle and fragile), obstructive sleep apnea (disorder that causes breathing to repeatedly stop and start during sleep), and dysphagia (difficulty swallowing).<br><br>Review of the clinical record indicated Resident R2 was transferred to the hospital on 9/20/24 and has not returned to facility.<br><br>Review of Resident R2's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].<br><br>Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE].<br><br>(continued on next page) |

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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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident R3's MDS dated [DATE], indicated diagnoses of hypertension, arthritis (inflammation of one or more joints, causing pain and stiffness), and thyroid disorder (any dysfunction of the butterfly-shaped gland at the base of the neck).<br><br>Review of the clinical record indicated Resident R3 was transferred to the hospital on 9/23/24 and has not returned to facility.<br><br>Review of Resident R3's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].<br><br>During an interview on 9/25/24, at 1:07 p.m. Nursing Home Administrator (NHA) stated, I am not aware of Ombudsman notification for this.<br><br>During an interview on 9/25/24, at 1:15 p.m. NHA confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of three residents (Residents R1, R2, and R3).<br><br>28 Pa. Code 201.29 (a) (c.3) (2) Resident rights. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167<br><br>Based on review of facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to identify a resident's risk for elopement and failed to make certain each resident received adequate supervision that resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one resident (Resident R4) and failed to routinely assess residents for elopement risk for two of five residents reviewed (Resident R5, and R6).<br><br>Findings include:<br><br>Review of facility policy Elopement Prevention reviewed 2/21/24, indicated that the facility will properly assess residents and plan their care to prevent accidents related to wandering behavior or elopement. The admitting nurse will perform an initial evaluation to identify behaviors and collect history. A care plan will be developed that reflects the potential for elopement and preventative measures. Additionally, upon admission, readmission, quarterly and as necessary, nurses will complete a Wandering Risk Evaluation.<br><br>Review of Resident R4's clinical hospital records from 9/2/24, included a Physical Therapy note that stated the following: Resident R4 is only requiring supervision with cues from transferring from sitting to standing and to ambulate (walk, or move about) 150 feet with a wheeled walker.<br><br>Review of clinical records from the hospital indicated that Resident R4 was discharged on [DATE] to a skilled nursing facility.<br><br>Review of the clinical record indicated that Resident R4 was admitted to the facility on [DATE].<br><br>A review Resident R4's Minimum Data Set Assessment (MDS-periodic assessment of care needs) dated 9/9/24, included diagnoses of non-Alzheimer's dementia (a group of symptoms that affects memory, thinking and interferes with daily life), aftercare following joint replacement surgery, and high blood pressure.<br><br>Review of Resident R4's clinical record revealed a Wander Risk Assessment completed on 9/3/24, at 1:43 p. m. which consisted of the following information:<br><br>The following questions are to be asked of the resident and/or responsible party upon admission/reassessment to determine the resident's risk for wandering. If the assessment indicates a yes to any question, consider initiating/update a care/service plan for wander risk.<br><br>1) The resident has attempted to leave a residence or other place unescorted that placed him/her in danger. No<br><br>2) The resident is cognitively impaired with poor decision-making skills (i.e. intermittent confusion, cognitive deficits or disoriented all the time) and independently ambulatory. No<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3) The resident has a history of elopement. No<br><br>4) The resident is on medication to manage the wandering behavior. No<br><br>5)There has been a recent change in this medication. No<br><br>6)Resident has verbalized intent to leave the facility. No<br><br>7)Resident is wandering/seeking to find spouse or family. No<br><br>8)The resident is wandering aimlessly. No<br><br>9) The resident is actively exhibiting exit-seeking behavior. No<br><br>If the assessment indicates YES to any question, consider initiating a care plan for elopement risk.<br><br>Review of clinical record revealed Resident R4 was not initiated for elopement risk at this time per review of her care plan.<br><br>Review of Resident R4's clinical record revealed a nursing progress note dated 9/3/24, at 10:41 p.m. that stated the following: Resident self-transfers repeatedly, reminded often to call for assistance. Found out in hall about 9:15 p.m. by staff. Confusion increases after sundown.<br><br>Review of Resident R4's clinical record revealed a nursing progress note dated 9/4/24, at 7:47 a.m. that stated the following: Reeducated resident to use of call bell related to getting out of bed unassisted.<br><br>Review of Resident R4's clinical record revealed a nursing progress note dated 9/5/24, at 10:55 p.m. that stated the following: Resident walked out of her room by herself with walker asking for help to go to the bathroom. Resident did not utilize call bell or call for assistance prior to walking out of room. Resident reminded importance of utilizing call bell when needing assistance. Resident verbalized understanding, but also has moments of confusion.<br><br>Review of Resident R4's clinical record revealed a nursing progress note dated 9/8/24, at 1:47 a.m. that stated the following: Despite clipping call bell directly to resident's shirt on her chest only several minutes after this RN (Registered Nurse) left room, resident self-transferred and was found starting to attempt to ambulate in hall.<br><br>Review of Resident R4's clinical record revealed a nursing progress note dated 9/9/24, at 2:04 a.m. that stated the following: Resident repeatedly unable to remember nursing re-education on fall/safety precautions and call bell use due to cognitive deficits related to dementia. Despite frequent reminders and frequent checks with resident to assess toileting needs, resident not using call bell to notify staff of need to use bathroom. Instead, resident found self-transferring and either waiting in room doorway or attempting to ambulate down hall with walker instead of using call bell.<br><br>Review of documentation provided by the facility on 9/16/24, stated the following in reference to Resident R4:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | [AGE] year-old resident admitted on [DATE] status post right hip replacement admitted on anterior (front) hip precautions (a set of instructions on how to care for the hip, weight bearing as tolerated, ambulatory with assist of two people. Resident later upgraded to assist of one on 9/6/24. Resident was determined to have eloped from the skilled nursing unit at approximately 3:20pm on 9/14/24 after having been assisted to the bathroom and helped to her reclining chair at approximately 3:15 p.m. At 3:30 p.m. staff walked past residents' room and noticed she was not in her room. A systematic search of the unit and immediate vicinity was conducted. This included checks of all skilled residents' rooms including bathrooms and shared spaces including day rooms, dining spaces, and nursing stations. Campus security was alerted when resident was not located immediately. Search expanded to include neighboring spaces including stairwells, personal care unit, the residents' onsite patio home, lakeside apartments and all common areas of the health center. Radio communications were established with security and resident's descriptions was shared. Additional staff from other departments enlisted to participate in search. At 3:58 p.m.Director of Nursing and administrator notified of missing resident. Call placed to family and voicemail left requesting return call. At approximately 4:10 p.m. family returned the call and were made aware that resident was last seen at approximately 3:30 p.m. and her current whereabouts are unknown. Family stated that she is known to frequent main dining room and spaces adjacent to her patio home. Search of these locations conducted to no avail. Resident found by security walking with rollator (a type of wheeled walker) near adjacent building. She reports having left the skilled unit in an attempt to 'feed her fish'. Resident assisted back to skilled nursing. Family made aware of residents return. Doctor updated. Physical assessment conducted by nursing staff. Resident at baseline. No injury identified.<br><br>Description of Follow-up Action: Follow up action included a Wander Risk Assessment which supported the implementation of a Wanderguard (a device used to alert staff when someone leaves a safe area). This was placed on the resident's ankle. The residents care plan was reviewed and updated. Resident had a Wander Risk Assessment conducted at the time of admission on 9/3/24. At this time, there were no identified concerns for wandering behavior. Resident did not ambulate independently, did not demonstrate exit seeking behavior, and was not on psychoactive medications. Prior to the placement of a Wanderguard following the elopement event on 9/14/24, measures in place to prevent wandering included resident residing in a room near the nursing station to support frequent observation. Additionally, the resident was engaged in group activities and was observed frequently during med pass, meals, activities, during ADL care to include toileting. To prevent future occurrences of wandering, resident was reassessed for wander risk. Based on the results of this assessment, a Wanderguard was placed on the resident. Resident was located at 4:32 p.m. by security ambulating with rollator on the sidewalk near a building across the driveway from the skilled nursing center. Total time resident's physical whereabouts were unknown was approximately 1 hour.<br><br>During an interview on 9/24/24, at 12:06 p.m. RN Employee E1 stated that she worked on the day of Resident R4's elopement and had been her nurse earlier that day until her shift was over at approximately 3:00 p.m. RN Employee E1 stated that she was aware that Resident R4 could walk independently as she had seen her walking in the hallway the day before the elopement. RN Employee E1 stated that the day of the elopement she had walked Resident R4 to an activity and told Activities Staff to escort her back to her room after they were done and this was completed as instructed. When RN Employee E1 was asked why she felt the need to provide Resident R4 with an escort, she replied: I didn ' t trust her to be on her own because of her cognition, she may not make it back.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/25/24, at 11:54 a.m. RN Employee E2 stated that Wander Risk Assessments are completed at admission, re-admission, significant change and reevaluated with increased confusion and increased ambulation, and quarterly. RN Employee E2 stated that any nurse on the unit is able to complete a Wander Risk Assessment.<br><br>Review of the clinical record indicated that Resident R5 was admitted to the facility on [DATE].<br><br>A review of the Resident R5's MDS dated [DATE], included diagnoses of anemia (too little iron in the body causing fatigue), coronary artery disease (damage or disease in the heart's major blood vessels), and high blood pressure.<br><br>Further review of Resident R5's clinical record revealed that a quarterly review had been completed on 5/4/24, however there was no accompanying Wander Risk Assessment completed at this time.<br><br>Review of the clinical record indicated that Resident R6 was admitted to the facility on [DATE].<br><br>A review of the Resident R6's MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) muscle spasm, and high blood pressure.<br><br>Further review of Resident R6's clinical record revealed that a quarterly review had been completed on 5/24/24, however there was no accompanying Wander Risk Assessment completed at this time.<br><br>During an interview on 9/25/24, at 2:19 p.m. Director Nursing confirmed that the facility failed to re-evaluate Resident R4's elopement risk when Resident R4 was able to demonstrate that she could ambulate independently and displayed confusion.<br><br>During an interview on 9/25/24, at 2:21 p.m. the Nursing Home Administrator confirmed that the facility failed to identify a resident's risk for elopement and failed to provide adequate supervision for Resident R4 which resulted in an elopement from the facility, and failed to conduct routine Wander Risk Assessments for two of five residents reviewed (Resident R5, and R6).<br><br>28 Pa. Code 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code 201.18(b)(1)(e)(1) Management.<br><br>28 Pa. Code 211.10(c)(d) Resident care policies.<br><br>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services. |