

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Reformed Presbyterian Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 Perrysville Avenue Pittsburgh, PA 15214	

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** 35785</p> <p>Based on review of facility policy, resident clinical record, facility provided documents, resident and staff interviews, it was determined the facility failed to ensure resident safety and prevent an elopement (a situation in which a resident leaves the premises or a safe area without the facility's knowledge) and failed to complete a thorough investigation after an incident for one of seven sampled residents (Resident R1).</p> <p>Findings include:</p> <p>Based on a review of facility policy titled Elopement prevention guidelines last reviewed 7/22/24, indicated that the facility strives to promote resident safety and protect the rights and dignity of residents. The facility maintains a process to assess all residents for risk for elopement; implement prevention strategies for those identified as elopement risk, and follow a missing resident procedure.</p> <p>Review of Resident R1's admission record indicated he was admitted on [DATE].</p> <p>Review of Resident R1's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 8/4/24, indicated he had diagnoses that included dementia (a progressive disease that impairs memory and other important mental functions), hypertension (a condition impacting blood circulation through the heart related to poor pressure), depression, mild intellectual disabilities, and lack of coordination.</p> <p>Review of Resident R1's care plan dated 10/17/24, indicated that he had impaired memory and to anticipate his needs as much as possible.</p> <p>Review of Resident R1's physician orders dated 9/26/24 to 11/2/24, did not include an order for a Leave of absence (LOA) prior to the incident on 11/2/24.</p> <p>Review of Resident R1's wander risk evaluation dated 10/17/24, indicated a score 2-low risk for wandering and he was scored a 0-No diagnoses of dementia/cognitive impairment.</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 clinical progress note dated 11/2/24, indicated that nurse was notified by staff that the Resident R1 was outside the building. Staff went out to bring Resident R1 back in. Resident R1 was in stable condition; no injuries noted. Resident R1 denied any pain. He stated that he wanted to go. Resident did have a LOA for today but for a later time. His sister was notified of event. Director of Nursing (DON) made aware.</p> <p>The facility investigation documents dated 11/2/24, indicated a statement from Resident R1: I went and wheeled myself down to the one bus stop. I wanted to leave to go home. I don't want to be here.</p> <p>The facility investigation documents dated 11/2/24 did not include the following: a statement from Activity Aide Employee E7, re-education with all staff related to Resident R1's elopement, and an updated posting of Resident R1 as a wander risk.</p> <p>During observations of the security video on 11/22/24, at 10:59 a.m. the following was observed:</p> <p>-On 11/2/24, at 10:33 a.m. Resident R1 was observed on camera exiting the nursing unit and wheeling himself into the hallway near elevator on the Third floor. No staff were observed in the hallway with him.</p> <p>-At 10:35 a.m. Resident R1 entered the elevator to exit to the Third floor.</p> <p>-At 10:42 a.m. Resident R1 exited the elevator to the First floor. He went towards the exit located on the First floor across from the receptionist desk. No staff were observed on the First floor.</p> <p>-At 10:44 a.m. Resident R1 exited the facility. The exit /entrance was without any staff and the doors were unlocked.</p> <p>-At 10:54 a.m. staff (Registered Nurse Employee E3 and LPN Employee E6) were observed bringing Resident R1 back into the facility.</p> <p>During an interview on 11/22/24, at 10:48 a.m. Resident R1 stated: I'm not feeling too bad today. Yes, I got out the front door like any other person. I did not have to push a code. And I was not feeling agitated. Sometimes I go out with my sister to a restaurant. We just go out to restaurants. I was outside, just waiting.</p> <p>During an interview on 11/22/24, at 10:53 a.m. Nurse aide (NA) Employee E1 stated: no behaviors. He stays in his room. Puts a light on to get up. The weekend of 11/2/24, he had no behaviors at all. We were provided re-education.</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>During an interview on 11/22/24, at 11:37 a.m. Registered Nurse (RN) Supervisor Employee E2 stated the following: I was on break. When I came back, two nurses, and someone from therapy spoke to me. Occupational Therapist Employee E5 stated when she stood up in the therapy gym she saw Resident R1 outside. They got him inside and I notified the Nursing Home Administrator (NHA) and let her know that he went out. We put a wander guard on him. We notified the family. He never attempted to elope before. That is why he did not have a wander guard on. We explained to his sister that if he does not follow the rules, that he may not be able to go out on LOA. I spoke to him the next day, on why all of a sudden he wanted to leave. He felt a lack of freedom and he felt caged in. He wanted more freedom.</p> <p>During an interview on 11/22/24, at 11:24 a.m. Registered Nurse (RN) Employee E3 stated the following: I was in the nurse office on a phone call. I was alerted by Occupational Therapist Employee E5 that Resident R1 was at the bus stop unaccompanied. I proceeded to the back door and Occupational Therapist Employee E5 went to the front door. Upon going outside, Resident R1 was escorted back by assigned nurse Licensed Practical Nurse (LPN) Employee E6, Occupational Therapist Employee E5 and myself. I assessed him after the incident and no injuries were found at time of the assessment. He had no behaviors. He said he was trying to go home with sister. He was educated that he cannot leave unaccompanied. He said he was allowed to leave and go by himself. There was an order to go on LOA. He frequently goes out with this family.</p> <p>During a phone interview on 11/22/24, at 12:26 p.m. Occupational Therapist Employee E5 stated the following: basically, I looked out the window. I think it was around 10:50 a.m. on 11/2/24. I saw Resident R1 was sitting out there. I went to the nurse station , asked if Resident R1 should be there by himself. The nurse staff said no. A nurse saw him from the window. I ran immediately to retrieve him back to the building. And then, as I was redirecting Resident R1 back to the building, nurse staff met me outside to help me get him back inside. He had an outing scheduled for that evening and that may have been why he was confused on the times.</p> <p>During a phone interview on 11/22/24, at 12:35 p.m. Registered Nurse (RN) Employee E4 stated the following: That was my assignment that morning. Instead of doing charge nurse, I took a nurse aide assignment. I got Resident R1 washed and dressed and into his wheelchair. They were doing an activity that day, watching a movie. Resident R1 said he was wheeling down to the movie. I saw him go towards the Activity to watch the movie. Activity aide Employee E7 was in and Resident R1 wheeled himself to the dining room. I was a nurse aide that day and I had my hands full. Yes, we did have re-education about elopment. They had the elopement policy. Its in the office. Resident R1 does have some impaired judgement. He is alert to himself. He has never tried to wander off before.</p> <p>During an interview on 11/22/24, at 12:58 p.m. the Director of Nursing (DON) confirmed that there was no documented whole house re-education with staff about the elopement.</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>During a phone interview on 11/22/24, at 1:44 p.m. Licensed Practical Nurse (LPN) Employee E6 stated the following: I do remember I was in the nurse office charting. Occupational Therapist Employee E5 asked if Resident R1 could be outside by himself. We said no, and he had LOA later for that day. Occupational Therapist Employee E5 and another nurse went outside. The other nurse went out the back way. Resident R1 was waiting at the bus stop in his wheelchair. He said he was going home. We said to come back inside and explained to come in. Occupational Therapist Employee E5 and I wheeled him back into the front entrance. We assessed him for bumps and bruises to see if he was ok. He does have slight memory loss. We let the charge nurse know. It was a little Chilly that day. It was between 10:30 a.m. and 11:00 a.m. when this occurred. He had on a blue jump suit, sweat pants, sweat shirt, nothing covering his head and he was at the bus stop. We educated him about being outside with staff. We put wander guard on him.</p> <p>During an interview on 11/22/24, at 3:00 p.m. information was disseminated to the Nursing Home Administrator (NHA) and the Director of Nursing (DON) that the facility failed to ensure resident safety and prevent an elopement and failed to complete a thorough investigation after the incident involving Resident R1 as required.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(e)(1) Management.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		