

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395572	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Fairview Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Manchester Road Fairview, PA 16415	
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 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** Based on review of facility documentation, clinical record, observations and staff interviews, it was determined that the facility failed to implement sufficient safety interventions and supervision to prevent elopement (unauthorized leave from the facility). This failure placed residents at the facility in an Immediate Jeopardy situation for one of 17 residents reviewed who were at risk for elopement with secure care devices from the facility (Resident R1). Findings include: Resident R1's clinical record revealed diagnoses to include: bipolar disorder, unspecified psychosis, impulsiveness, suicidal and homicidal ideations, auditory and visual hallucinations and a re-admission date of 6/29/26, from a hospital stay related to mental health concerns. Review of Resident R1's elopement evaluations revealed the following: Evaluation dated 5/27/26 with a score of 8.0; evaluation dated 6/29/26 with a score of 9.0; an evaluation dated 7/2/26 with a score of 7.0; evaluation dated 7/9/26 with a score of 10.0; and an evaluation dated 7/20/26 with a score of 10.0. A score of 1.0 or higher indicated a risk of elopement. Review of information submitted by the facility dated 7/8/26, revealed that Resident R1 had exited the building and was walking towards the parking lot. Staff saw the resident at the top of the driveway, turning on to the road and proceeded to go after him. When asked why he left, he stated No reason, I just wanted to see how far up I could go. The resident is a known risk for elopement and has an order to wear a secure care bracelet. Upon returning to the building the secure care bracelet was not present on his body. When asked what happened to his bracelet, he stated he had removed it with a dinner knife that he had retrieved from the dining room. The secure care bracelet was later found in the silverware container in the dining room. The resident was ordered to have a one-on-one sitter to begin immediately. Review of information submitted by the facility dated 7/17/26, revealed that Resident R1 had cut his secure care bracelet off and exited the facility. He was found on a road away from the facility up a hill that intersects with another road approximately a quarter of a mile from the facility. The resident has a history of elopement. A one-on-one sitter was an intervention to prevent elopements. The sitter reported he appeared to be asleep in his bed with the secure care bracelet intact and on his left ankle at approximately 8:45 p.m. The sitter reported that he/she went to assist with another resident on the hall and when they returned less than 15 minutes later, [Resident R1] was not in their room. Went to search for Resident R1, another staff member who had left the facility for the day, was bringing Resident R1 back down the driveway. When asked why he left, [Resident R1] stated he just wanted to see how far he could get. When asked what happened to his bracelet, he stated he had removed it with a butter knife that he had retrieved from the dining room prior to exiting the building as he only receives a plastic fork and spoon with his meals. Resident R1 had obtained a knife from the dining area. Review of Resident R1's progress notes revealed the following: 6/29/26 3:22 p.m. Resident readmitted to the unit, secure care applied to left ankle. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395572 If continuation sheet Page 1 of 4

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wandering off/unit6/30/26 12:16 p.m. (Physician assessment note) Resident was admitted to behavioral health hospital on 6/4/26 and returned to the facility on 6/29/26. Resident had voiced suicidal ideations and requested to go to the hospital for help7/1/26 2:45 p.m. Wandering in unit, going on/off dining/kitchen area. Resident cut secure care twice and secure care re-applied each time.7/2/26 11:55 a.m. Elopement evaluation: resident exhibits wandering behavior; resident has a cognitive impairment or diagnosis with impaired judgement; history of attempted leaving the facility without informing staff.7/5/26 12:35 p.m. Dietary aide reported that resident was outside walking up road, up the hill. Stated he just wanted to see how far he could get, his secure care was in his room and noted to resident trash7/5/26 12:40 p.m. Secure care reapplied to right ankle, nurse left room, re-entered room to remove any sharp objects and resident was observed using butter knife to try and remove new secure care, knife removed. 7/5/26 1:10 p.m. Resident walked into suite mate's room and took his butter knife off his tray, nurse aide took butter knife from resident7/5/26 5:50 p.m. Resident constantly going into other residents rooms, arguing with staff, not listening to staff directions7/7/26 11:57 p.m. Resident continues to enter other residents rooms and take things, continues to ignore staff/residents requests of staying out of other rooms.7/8/26 5:03 a.m. Resident up wandering at 2:45 a.m. and attempting to go into another resident room7/8/26 7:26 p.m. Resident was screaming for help at the front door that Resident R1 had cut off his secure care and was heading for the street. Staff responded and brought him back inside. Resident was already at the street walking toward the lake. Held out his leg and said here, put another one on. Secure care was found in the silverware container where he used a utensil to cut his secure care off before he went outside. He returned to his unit and his room but shortly afterward he was roaming the halls7/9/26 9:42 a.m. Elopement evaluation score of 10.07/9/26 2:05 p.m. Resident continues with strange behaviors7/11/26 4:27 a.m. Registered Nurse (RN) was informed by Licensed Practical Nurse (LPN) that the resident had cut secure care bracelet off and requesting a new device be put on resident. The device was found on bed, resident not in room and found sleeping in a bed that was not his own. Secure care placed on resident before waking.7/11/26 11:02 a.m. Resident seen by RN walking up hallway towards the front entrance of the building, writer attempted to redirect resident back towards D hall while heading towards him, resident replied and said hold on one second and kept walking towards the door. This writer had to run towards resident to try to prevent him from leaving the building. Resident made it out of both front doors and was combative when staff went to redirect him back inside. Once back inside this writer noticed the secure care and a pair of scissors sitting on the nurse's station. Another secure care reapplied. 1 on 1 initiated.7/12/26 1:55 p.m. Writer informed by staff while taking resident for a walk around the facility resident tried to hurry and run outside of the front door while other resident's family were leaving. Aide was able to interfere and stop him7/14/26 8:14 a.m. Resident observed putting butter knife in pocket, knife confiscated, nurse stood between resident and silverware, resident again tried to take knife, knife confiscated, resident asked to leave dining room, resident left without incident.7/14/26 8:28 a.m. Resident observed taking butter knife from in front of another resident, other resident didn't say anything about resident taking knife, knife confiscated, resident continued to round dining room, resident observed taking another butter knife from another resident, knife confiscated, resident asked to leave dining room, resident left dining room without incident.7/14/26 8:59 a.m. Resident observed in dining room looking for butter knife, resident bus cart moved into dish room, resident asked to leave dining room, resident returned and immediately went to dish room, dish room locked, resident asked to leave dining room.7/17/26 7:04 a.m. Resident caught attempting to go out front door. When checked for secure care, resident had cut it off (he had it on all 3rd shift). When questioned where secure care was, he stated it was in his room. Secure care found (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	under pillow on bed with 2 butter knives which were used to cut it off. New secure care strap and box reapplied.7/17/26 9:17 p.m. On July 17th resident had a sitter with him for the second shift. At 8:45 p.m. the sitter saw resident sleeping in his bed. Sitter allowed him to sleep and went to help other CNA's [Certified Nurse Aides] on the floor with their work. Fifteen minutes later he returned to find Resident R1 gone. Resident had stolen a butter knife out of the dirty dish bin and cut off his secure care band. Sitter immediately went to the front door to look for him. A car drove up to the front entrance and resident was in the car7/19/26 2:57 p.m. Resident seen headed towards the front door. Staff went after him to see what he was doing. Resident was trying to leave the building. His secure care bracelet was not present. Resident reported that he found a knife in the silverware drawer in the dining room and cut it off. Secure care was replaced.7/20/26 Two Elopement evaluations this date each with score of 10.0Observations on 7/22/26, at 9:35 a.m. in the B Unit Dining room revealed 11 table settings that included butter knives in the dining room on tables. A Unit Dining room had 13 table settings with butter knives. Observations on 7/22/26, at 11:05 a.m. at the C Unit Nurse's Station revealed a pair of scissors, a screwdriver, and pliers accessible to anyone passing through that area.Observations on 7/22/26, at 11:00 a.m. at the B Unit Nurse's Station revealed a pair of fingernail clippers accessible to anyone passing through that area.Observations on 7/22/26, at 12:13 p.m. on the B and D Unit Dining Rooms revealed the dirty dish cart in the dining area with knives present.Interview with the Nursing Home Administrator on 7/22/26, at 12:40 p.m. confirmed that knives shouldn't be left unattended and there was no policy regarding one to one guidelines and that the one to one should be within arm's length and within sight of the resident. An Immediate Jeopardy (IJ) situation was identified to the NHA on 7/22/26, at 2:23 p.m. and the IJ template was provided to the NHA, related to Resident R1's elopement from the facility. The NHA was made aware that Immediate Jeopardy existed for the facility's failure to ensure implementation of adequate safety measures to prevent elopement for residents in the facility and an immediate action plan was requested. On 7/22/26, at 4:41 p.m. an acceptable immediate action plan was approved which included the following interventions: 1:1 supervision in place to prevent elopement and access to knives and scissorsResident room checked for knives and scissorsCharge nurse will check resident room [ROOM NUMBER] times per shift for knives and scissorsNurses stations screened for cutting tools, any items found were removedKnives were removed from all kitchenettes outside of meal times, during meal times, only those residents requesting knives will be provided one.All residents at risk for elopement re-evaluated for risk and interventionsAll Secure Care devices checked for placement and functionAll other residents will have elopement risk assessments re-evaluated, anyone found to be at risk will have proper interventions in placeAll current staff in the facility will be educated on 1:1 expectations, Elopement policy and knife and scissor safety immediately on 7/22/2026. All staff incoming shifts will be educated as they arrive all scheduled staff will be educated by 7/23/26Emergency QAPI meeting will be completed today 7/22/2026. After review of facility documentation, observations, and staff interviews, the implementation of the above stated action plan was confirmed on 7/23/26, at 1:54 p.m. and the NHA was informed that the Immediate Jeopardy situation was removed. 28 Pa. Code 201.14(a) Responsibility of Licensee28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 201.18(e)(1) Management28 Pa. Code 211.12(d)(1)(5) Nursing Services		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of facility records and job descriptions, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to make certain that proper supervision and elopement prevention interventions were effectively implemented in the facility. Findings include: The NHA's job description revealed that the NHA's position summary included: directs the overall operations of the care community in accordance with current local, state, and federal regulations governing long-term care in-order to ensure the highest level of quality care is provided to each resident. The DON's job description revealed that the DON's position summary included: manages and directs resident care within the nursing department in-order to maintain resident standards of care and ensure that each resident functions at his/her highest level. The findings in this report identified that the facility failed to consistently supervise and maintain all safety interventions to prevent elopement for their residents, and the NHA and the DON failed to fulfill their essential job duties to ensure that the federal and state guidelines and regulations were followed.Refer to F68928 Pa. Code 201.14(a) Responsibility of Licensee28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 201.18(e)(1) Management28 Pa. Code 211.12(c) Nursing Services28 Pa. Code 211.12(d)(1)(5) Nursing Services		