

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2024
NAME OF PROVIDER OR SUPPLIER  Transitions Healthcare North Huntingdon		STREET ADDRESS, CITY, STATE, ZIP CODE  8850 Barnes Lake Road North Huntingdon, PA 15642	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39311</p> <p>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 five residents (Resident R1). This was identified as past non-compliance.</p> <p>Review of the facility policy Elopement of Resident dated 2/13/24, indicated residents will be evaluated for elopement risk upon admission, re-admission, quarterly, and with a change in condition as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce the risk and minimize injury.</p> <p>Review of the clinical record revealed Resident R1 was originally admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 2/22/24, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and coronary artery disease (damage or disease in the heart's major blood vessels).</p> <p>Review of an Elopement Risk Assessment completed on 2/4/24, at 9:42 p.m. indicated Resident R1 was at risk for elopement.</p> <p>Review of Resident R1's plan of care for desiring to leave the facility, initiated 2/4/24, indicated the facility will monitor the resident.</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 facility submitted information dated 3/12/24, indicated that on 3/11/24, at 2:25 p.m. The facility received a phone call at 2:25 p.m. from the local [hardware store], which is 0.2 miles (4-minute walk) from the facility, that there was a resident at their store. The facility went to get the resident but upon arrival, the resident had left the store and could not be located. Police notified and search began to locate the resident. Facility staff along with Police searched for the resident and he was found at 3:45 p.m. by the Social Service Director near the gas station located near the resident's previous residence. Resident did not want to return to the facility. The resident refused to get in the car. The Social Worker got out of her car and stood with him on the side of the road. The Social Worker called the Police. The resident refused to go back to the facility and told the Police that he owned the bridge and the railroad, and he wanted to jump off. Resident stated that if they tried to stop him, he would hurt them. The Police officer called for an ambulance and the resident was transported to the local hospital for evaluation of a 302 (involuntary emergency mental health examination).</p> <p>Review of facility investigation information indicated that Resident R1 exited the building via the ambulance entrance hallway. This door is alarmed, and the alarm did sound. Staff member reset the door alarm looked outdoor and saw ambulance with crew members and assumed it was the crew who set the door off and did not see the resident. Per video footage, (Resident R1) went out the door, around the dumpsters, down the back-end parking lot to the street, resident has steady gate and was quick in pace while walking. The receptionist did not see the resident.</p> <p>On 3/12/24, the facility initiated a plan of correction that included:</p> <ul style="list-style-type: none"> <li>-A whole house audit of all residents with updated elopement assessments completed for each resident.</li> <li>-The updated list of residents identified at risk for elopement was completed.</li> <li>-Facility-wide reeducation was completed with all staff on policies and procedures related to elopement.</li> <li>-Daily checks of the Wanderguard (security bracelet that alerts when an identified resident approaches a monitored door) system.</li> <li>-Facility process change in place to eliminate all but essential movement through the ambulance entrance.</li> <li>-Audits to be completed five times per week for two weeks, weekly for six weeks.</li> <li>-Audits to be forward to the monthly Quality Assurance and Performance Improvement Committee for review.</li> </ul> <p>During four interviews on 4/1/24, staff confirmed they received education on elopement prevention and procedures if an elopement occurs.</p> <p>During an interview on 4/1/24, at approximately 2:30 p.m. the Nursing Home Administrator confirmed that the facility failed to provide adequate supervision to prevent elopement for one of five residents.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of licensee.  28 Pa. Code 201.18(b)(e)(1) Management.  28 Pa. Code 201.20(b)(1) Staff Development.  28 Pa. Code 201.29(a) Resident rights.  28 Pa. Code 211.10(c)(d) Resident care policies.  28 Pa. Code 211.11(d) Resident care plan.  28 Pa Code 211.12(d)(1)(2)(5) Nursing services.