

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/16/2024
NAME OF PROVIDER OR SUPPLIER  Wesley Village		STREET ADDRESS, CITY, STATE, ZIP CODE  209 Roberts Road Pittston, PA 18640	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39235</p> <p>Based on review of clinical records, select resident incident report, and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to thoroughly conduct and document the results of a professional nursing assessment regarding the clinical status of a resident following an elopement from the facility for one resident (Resident CR1) out of 4 residents reviewed.</p> <p>Findings included:</p> <p>According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals.</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound nursing judgment based on preparation, knowledge, experience in nursing and competency. The LPN participates in the planning, implementation and evaluation of nursing care using focused assessment in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records.</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>A review of the clinical record of Resident CR1 revealed admission to the facility on [DATE], with diagnoses, which included dementia (a group of symptoms that affects memory, thinking and interferes with daily life), syncope and collapse (fainting or passing out), unsteadiness on feet, weakness, and abnormalities of gait.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a health status note dated May 23, 2024, at 2209 hours (10:09 PM) indicated the resident asked family member of a resident if they could give her a ride to the bus. This resident presented with wander-guard anklet so the family member called facility and made them aware of the request. This nurse responded immediately and redirected the resident to her room and told her that the bus will be back tomorrow for her. This intervention effective thus far, resident has been added to every (q) 15 minute checks for 72 hours for safety. Will continue to monitor and document effectiveness.</p> <p>A review of a health status note dated May 23, 2024, at 2216 hours (10:16 PM) stating MD called, new order received and noted for every (q) 15 minute checks X 72 hours.</p> <p>A review of an incident note dated May 23, 2024, at 2300 hours (11:00 PM) stating that at approximately 2020 hours (8:20 PM) call placed to facility by a visitor. Reported a lady with red hair and a bracelet (wander guard) on her leg is asking for a ride and when is the bus coming. Resident exit seeking, looking for her daughter and attempting to leave the property. Charge nurse was able to redirect resident to her room and informed her the bus will be coming tomorrow. Resident also requested to speak with her daughter. Call placed to daughter and message left. Covering physician notified and order obtained for q15 minute checks X 72 hours. Above interventions effective at this time with monitoring and documentation on going. Continue to await return call from daughter.</p> <p>A review of facility provided incident report (IR - investigation) entitled Elopement, dated May 23, 2024, at 2020 hours (8:20 PM), indicated the incident location is outside. The IR further indicated the resident presented with exit seeking behavior and had asked another family member to give her a ride or show her where to get the bus. Other family member noticed a bracelet on her ankle (wanderguard) and called the facility. Charge nurse immediately responded and redirected resident back to her room and that the resident is ambulatory without assistance. The IR indicated the resident is confused with impaired memory, and active exit seeker.</p> <p>Review of facility provided incident statement (witness statement) undated, by Employee 2, Supervisor Registered Nurse (RN), stating a phone call was received from a visitor stating she was at the doors of the Rehabilitation Unit with a lady with red hair and a bracelet who was asking her for a ride and when was the next bus. I (Employee 2, RN), immediately went to the Rehab unit, and saw Employee 3, RN (the nurse assigned to resident CR 1), and called for her help. We (Employee 2, and 3) went out the Rehabilitation doors and the visitor was still there, and pointed to the direction the lady with red hair went. Employee 3, RN (the nurse assigned to resident CR 1) went to bring Resident CR 1 back. I (Employee 2, RN) went back to unit for help, overhead paged code green, rehab unit. Security and maintenance notified.</p> <p>Review of a second incident investigation statement (witness statement) dated May 23, 2024, by Employee 2, Supervisor Registered Nurse (RN), stating visitor called 5229 stating lady with red hair and a bracelet is with her at the rehabilitation door asking her for a ride and when was the next bus. Immediately went to Rehabilitation door, door alarm was sounding. Resident CR 1 redirected back to room by nurse. Immediate interventions where every 15 minute safety checks for 72 hours, family aware.</p> <p>Review of a third incident investigation statement (witness statement) dated May 23, 2024, by Employee 2, Supervisor Registered Nurse (RN), revealing door malfunction, indicating at 9:00 PM maintenance and security came to assess the glitch in inner door of the Rehabilitation entrance. Door not completely closing, latching and locking post (after) 8:00 PM unless forcibly shut.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on August 16, 2024, at approximately 12:28 PM, with Employee 3 Registered Nurse (RN), confirmed she had worked on the Rehabilitation unit on May 23, 2024, as the charge nurse of Resident CR 1. Employee 3, RN, stated her memory is a little foggy, however, indicated Resident CR 1 was looking for her family (daughter) and a bus. Employee 3, RN indicated a family member who was visiting another resident in the facility, had been asked by Resident CR 1 to give a ride or show her where to get the bus. After exiting the facility, according to Employee 3, RN, the visitor thought about the request and called the facility to notify them of the request. In questioning if Resident CR 1 had exited the facility, got out the outer glass door, Employee 3, RN, replied no, I don't think so.</p> <p>Interview with Employee 2, Supervisor Registered Nurse (RN), on August 16, 2024, at approximately 2:15 PM, confirmed she had worked as supervisor on May 23, 2024. First in questioning, why a family member who was visiting another resident in the facility, needed to call 5229 (supervisors phone extension as stated by Employee 2, RN) and state a lady with red hair and a bracelet is with her at the rehabilitation door asking her for a ride and when was the next bus if she was standing inside the building? In reply, Employee 2, RN stated she was outside the building at the Rehabilitation Unit doors along with Resident CR 1 trying to get back into the locked doors - building. Employee 2 further stated that the facility doors lock at 8:00 PM, and a sign on the outer doors instruct guests to call the facility at this number which is the supervisor's phone for assistance.</p> <p>In further questioning, Employee 2, (RN), stated that upon arrival outside the outer (exterior) door with Employee 3, RN (the nurse assigned to resident CR 1) present at the same time, found only the visiting family member of another resident, and that Resident CR 1 was not in sight. At this point the visitor pointed towards a tree line as too the direction Resident CR 1 headed towards. According to Employee 2, RN, directly outside the Rehabilitation unit door is a horseshoe (U) shaped driveway for resident/guest drop off / pick up. Then a roadway into the campus, a grassy area with benches, then beyond that is a tree line which is where the resident headed. (Approximately 80 - 100 yards as visualized by the state survey team). At this time, Employee 3, RN (the nurse assigned to resident CR 1), took off towards the tree line after resident CR 1, because she is faster than me, stated Employee 2. According to Employee 2, RN - Supervisor, she returned into the building for assistance and at this point either overhead paged code green, rehab unit, or had heard the page overhead (unclear at this point she indicated). In questioning how long the search took for Resident CR 1, Employee 2, RN, indicated not long, as when she returned to the unit doors, she (Employee 2, RN) saw Employee 3, RN returning with Resident CR 1.</p> <p>During a second interview with Employee 2, Supervisor Registered Nurse (RN), on August 16, 2024, at approximately 2:55 PM, the employee stated she was not sure the exact time but, on the evening, shift a visiting family member had exited the building and the resident had exited the building with this visitor. She stated the visitor had then called the nursing supervisor office to let them know they believe a resident is outside who should not be outside since she had a bracelet on her ankle. The employee stated as she was going through the Rehab unit she was yelling for help and saw Employee 3 in the hall. She indicated they ran outside and Resident CR1 was out of sight. The employee stated Employee 3 went running towards the tree line and as she went back inside for more staff to help. The employee indicated at that time she heard a code green called for elopement. As the employee went back outside with more staff, Employee 3 was walking the resident back to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a second telephone interview on August 16, 2024, at approximately 4:00 PM, with Employee 3 Registered Nurse (RN), the employee stated she responded to Employee 2 calling for help due to a visitor calling saying a resident was outside the facility. The employee stated she and Employee 2 went outside and could not see the resident. The employee stated that is when Employee 2 went inside for more help, and she began to look for the resident. The employee stated she found the resident off grounds in a grassy area across from the building. The employee stated she was not aware the resident had eloped because she could not hear the alarms sounding because she was in a resident's room, and they are not audible from in there.</p> <p>Interview with the Nursing Home Administrator (NHA), and Employee 4 (RN) Assistant Director of Nursing (ADON), on August 16, 2024, at approximately 1:18 PM, confirmed the incident statement (witness statement) which is undated, written by Employee 2, Supervisor Registered Nurse (RN), indicated a code green Rehabilitation unit, which indicates a missing resident according to the NHA.</p> <p>A review of nursing progress notes, and assessments in the resident's clinical record, conducted at the time of the survey ending August 16, 2024, revealed no documented evidence in the resident's clinical record that the facility's licensed and professional nursing staff had fully assessed the resident for injury when the resident returned to the facility following the elopement on May 23, 2024.</p> <p>During an interview with Employee 4 (RN - ADON) on August 16, 2024, at approximately 4:10 PM, the state survey team requested the documented evidence from the facility's licensed and professional nursing staff had fully assessed the resident for injury when the resident returned to the facility following the elopement on May 23, 2024.</p> <p>During an interview with Employee 4 (RN - ADON) on August 16, 2024, at approximately 5:50 PM, confirmed the facility is unable to provide the documented evidence that the resident was fully assessed for injury when the resident returned to the facility following the elopement on May 23, 2024.</p> <p>Interview with the Assistant Director of Nursing on August 16, 2024, at approximately 5:51 PM confirmed the facility failed to thoroughly conduct and document the results of a professional nursing assessment of the clinical status of a resident following an elopement from the facility.</p> <p>Cross Refer F689 F835</p> <p>28 Pa. Code 211.12 (c)(d)(5) Nursing services</p> <p>28 Pa. Code 211.5 (f) Clinical Records</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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> 39235</p> <p>Based on observations, a review of clinical records, select facility policy, resident incident/accident report and staff interviews, it was determined that the facility failed to provide adequate staff supervision and effective safety measures to prevent elopement for two residents (Resident CR1 and Resident 2) out of 4 residents reviewed. The facility further failed to identify staff's reliance on the facility's alarm system to prevent elopements and the deficiencies of this system to prevent future unsupervised exits from the facility, which placed residents in immediate jeopardy of future unsupervised exits from the facility and the potential for serious bodily injury or death.</p> <p>Findings include:</p> <p>A review of a policy entitled Wandering and Elopement Risk Identification and Management, dated September 2021, states it is the policy of the facility to maintain facility wide systems and resident specific plans of care to minimize resident risk and potential for harm related to wandering and elopement. Definition: Elopement - the act of a resident leaving the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Procedure: general staff and Resident/Resident Representative Education and Training. Provide staff with general and job -specific education regarding wandering identification, management (including information related to the facility's wandering management system), and elopement prevention and response upon hire, annually, and as needed thereafter.</p> <p>A review of the clinical record of Resident CR1 revealed admission to the facility on [DATE], with diagnoses, which included dementia (a group of symptoms that affects memory, thinking and interferes with daily life), syncope and collapse (fainting or passing out), unsteadiness on feet, weakness, and abnormalities of gait.</p> <p>A review of the resident's admission MDS Assessment (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 20, 2024, revealed that the resident's cognition was severely impaired with a BIMS score (brief interview for mental status - section of MDS that assesses cognition) of 3 (a score of 0 -7 indicates severely impaired cognition).</p> <p>A review of the Resident's plan of care indicated the resident is an elopement risk related to disorientation to place date-initiated May 15, 2024. An intervention is to identify pattern of wandering, such as is wandering purposeful, aimless, or escapist. Is resident looking for something. Does it indicate the need for more exercise, provide structured activities, toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes, wander alert (a device to alarm the facility if the resident tries to leave) to the right ankle date-initiated May 15, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A further review of the Resident's plan of care indicated the resident has a behavior of becoming combative with staff, resistant to medication, and frequently asking where husband is, pulling fire alarm, and exit seeking date-initiated May 21, 2024. An intervention is to administer medications as ordered and monitor/document side effects, anticipate and meet the resident's needs, and educate the resident/family/caregivers on successful coping and interaction strategies date-initiated May 21, 2024.</p> <p>A review of a health status note dated May 14, 2024, at 2113 hours (9:13 PM) revealed Resident CR 1 stated she wants to go home and sleep in her own bed, redirection with only mild effect, concerned resident will attempt to leave, wanderguard placed for resident safety.</p> <p>A review of a health status note dated May 16, 2024, at 07:48 hours (7:48 AM) revealing family member called to inquire about her mother's night. Explained that she was up for several hours until approximately 0130 (1:30 AM). Explained that she (resident CR 1) was looking for her mother and her family to tell them where she was.</p> <p>A review of a health status note dated May 19, 2024, at 11:46 AM, resident requires redirection and cues for activity/taking medications. Resident repetitively questioning where she is, where her parents are.</p> <p>A review of a health status note dated May 22, 2024, at 04:16 hours (4:16 AM) the resident was awake until 0130 (1:30 AM). Attempting to ambulate without assist in room. Asking repetitive questions and becoming agitated. Snacks and fluids offered but declined. Attempted to reorient to time with short periods of success. Sat in front of nurse's station with nursing assistant (NA). Continued with questions and statements such as My daughter would not put me here. Who said I have to be here?</p> <p>A review of a health status note dated May 23, 2024, at 2209 hours (10:09 PM) indicated resident asked another resident's family member if they could give her a ride to the bus. This resident presented with wander-guard anklet, so the family member called the facility and made them aware of the request. The nurse responded immediately and redirected the resident to her room and told her that the bus will be back tomorrow for her. This intervention effective thus far, resident has been added to every (q) 15 minute checks for 72 hours for safety. Will continue to monitor and document effectiveness.</p> <p>A review of a health status note dated May 23, 2024, at 2216 hours (10:16 PM) stating MD called, new order received and noted for every (q) 15 minute checks X 72 hours.</p> <p>A review of an incident note dated May 23, 2024, at 2300 hours (11:00 PM) stating that at approximately 2020 hours (8:20 PM) call placed to facility by a visitor. Reported a lady with red hair and a bracelet (wander guard) on her leg is asking for a ride and when is the bus coming. Resident exit seeking, looking for her daughter and attempting to leave the property. Charge nurse was able to redirect resident to her room and informed her the bus will be coming tomorrow. Resident also requested to speak with her daughter. Call placed to daughter and message left. The covering physician notified and an order obtained for q15 minute checks X 72 hours. Above interventions effective at this time with monitoring and documentation on going. Continue to await return call from daughter.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of facility provided incident report (IR - investigation) entitled Elopement, dated May 23, 2024, at 2020 hours (8:20 PM), indicated the incident location is outside. The IR further indicated the resident presented with exit seeking behavior and had asked another family member to give her a ride or show her where to get the bus. Other family member noticed a bracelet on her ankle (wanderguard) and called the facility. Charge nurse immediately responded and redirected resident back to her room and that the resident is ambulatory without assistance. The IR indicated the resident is confused with impaired memory, and is an active exit seeker.</p> <p>Review of facility provided incident statement (witness statement) dated May 23, 2024, by Employee 1, Nurse Assistant (NA), revealed the resident was last seen at approximately 8:10 PM sitting in the dining room at the table waiting and looking for her daughter.</p> <p>Review of facility provided incident statement (witness statement) undated, by Employee 2, Supervisor Registered Nurse (RN), stating a phone call was received from a visitor stating she was at the doors of the Rehabilitation Unit with a lady with red hair and a bracelet who was asking her for a ride and when was the next bus. Employee 2, RN immediately went to the Rehab unit, and saw Employee 3, RN (the nurse assigned to resident CR 1) and called for her help. Employee 2, and Employee 3 went out the Rehabilitation doors and the visitor was still there, and pointed to the direction the lady with red hair went. Employee 3, RN (the nurse assigned to resident CR 1) went to bring Resident CR 1 back. I (Employee 2, RN) went back to unit for help, overhead paged code green, rehab unit. Security and maintenance notified.</p> <p>Review of a second incident statement (witness statement) dated May 23, 2024, by Employee 2, Supervisor Registered Nurse (RN), stating visitor called 5229(supervisor facility telephone extension) stating the lady with red hair and a bracelet is with her at the rehabilitation door asking her for a ride and when was the next bus. Immediately went to Rehabilitation door, door alarm was sounding. Resident CR 1 redirected back to room by nurse. Immediate interventions where every 15 minute safety checks for 72 hours, family aware.</p> <p>Review of a third incident statement (witness statement) dated May 23, 2024, by Employee 2, Supervisor Registered Nurse (RN), revealing door malfunction, indicating at 9:00 PM maintenance and security came to assess the glitch in inner door of the Rehabilitation entrance. Door not completely closing, latching, and locking post (after) 8:00 PM unless forcibly shut.</p> <p>A review of the clinical record of Resident M 1 (husband of Resident CR 1) revealed admission to the facility on [DATE], with diagnoses to include hypertension, and chronic kidney disease.</p> <p>A review of the resident's quarterly MDS Assessment (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 23, 2024, revealed that the resident was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status a score of 13-15 indicates intact cognition).</p> <p>During an interview with Resident M 1 on August 16, 2024, at approximately 11:25 AM found him sitting in his room, alert, pleasant, and cooperative. In questioning, Resident M 1 stated he has been a resident in the facility for quite sometime and that his wife (Resident CR 1) was also for a short period of time. In further questioning, the alert and oriented resident was not aware of his wife (Resident CR 1) had been outside the facility without staff awareness during her stay at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An observation of the front entrance on August 16, 2024, at approximately 11:40 AM revealed that the entrance to the facility had two sets of sliding, glass doors with a breeze way in between. These doors are alarmed with a keypad, with cameras pointing at the front door. There was a receptionist desk to the right of the front door upon entry into the facility.</p> <p>At approximately 11:50 AM, on August 16, 2024, Employee 4, RN (Assistant Director of Nursing - ADON) obtained a wanderguard upon the request of the state survey team. Employee 4 stated this wanderguard is new, and he personally activated it and confirmed its batteries are charged and that it is fully functioning.</p> <p>At approximately 12:00 PM, on August 16, 2024, in the presence of Employee 4 (RN - ADON), and the Nursing Home Administrator (NHA) after confirmation that the facilities front entrance doors were fully functioning, the state surveyor, while holding the wanderguard in hand, stood at the reception desk, which is approximately 14 - 18 feet away from the first set of the interior, double glass, sliding doors, and slowly proceeded to walk towards the doors. The inner door automatically opened, and the state surveyor continued to slowly walk thru the inner door, and approached the second set of glass sliding doors, which did not automatically open. At this time, the state surveyor applied light pressure to the door, and immediately, without any delay and or sustained pressure, the outer door opened, and the state surveyor proceeded to walk outside the front entrance.</p> <p>An observation of the Rehabilitation unit entrance on August 16, 2024, at approximately 12:08 PM revealed that the entrance also had two sets of glass doors with a breeze way in between. These doors are alarmed with a keypad. There is a glass enclosed nursing station straight ahead of the unit door when entering into the facility.</p> <p>At approximately 12:10 PM, on August 16, 2024, in the presence of Employee 4 (RN - ADON), and the NHA after confirmation that the Rehabilitation entrance doors were fully functioning, the state surveyor, while holding the wanderguard in hand, stood at the glass enclosed nursing station, which is approximately 10 - 14 feet away from the first set of the interior, glass door, and slowly proceeded to walk towards the doors. The inner door automatically opened, and the state surveyor continued to slowly walk thru the inner door, and approached the second set of glass door, which did not automatically open. At this time, the state surveyor applied light pressure to the door, and immediately, without any delay and or sustained pressure, the outer door opened, and the state surveyor proceeded to walk outside the Rehabilitation entrance.</p> <p>During a telephone interview on August 16, 2024, at approximately 12:28 PM, with Employee 3 Registered Nurse (RN), confirmed she had worked on the Rehabilitation unit on May 23, 2024, as the charge nurse of Resident CR 1. Employee 3, RN, stated her memory is a little foggy, however, indicated Resident CR 1 was looking for her family (daughter) and a bus. Employee 3, RN indicated a family member who was visiting another resident in the facility, had been asked by Resident CR 1 to give a ride or show her where to get the bus. After exiting the facility, according to Employee 3, RN, the visitor thought about the request and called the facility to notify them of the request. In questioning if Resident CR 1 had exited the facility, got out the outer glass door, Employee 3, RN, replied no, I don't think so.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on August 16, 2024, at approximately 12:40 PM, in the presence of the NHA, the Maintenance Director, as identified by the facility and caller, indicated the security cameras are programmed to reset every 30 days, and would not be capable at this date (August 16, 2024) to be viewed. In questioning the wanderguard system, the Maintenance Director indicated the inner doors are to lock, not open, when approached by the wanderguard. In further questioning, he confirmed that a resident who is wearing a wanderguard, should not get into the breezeway between the inner and outer doors.</p> <p>Interview with the NHA, and Employee 4 (RN - ADON), on August 16, 2024, at approximately 1:18 PM, confirmed the incident statement (witness statement) which is undated, written by Employee 2, Supervisor Registered Nurse (RN), indicated a code green Rehabilitation unit, which indicates a missing resident according to the NHA. A request for documented evidence of a physician order for the wanderguard, evidence that the facility was checking Resident CR 1's wanderguard for both its presence on the resident (arm - wrist, leg - ankle etc.), and that it is functioning properly. The state survey team also requested the incident statement (witness statement) from Employee 3, RN, who was the charge nurse assigned to Resident CR 1 at the time of the incident.</p> <p>Interview with Employee 2, Supervisor Registered Nurse (RN), on August 16, 2024, at approximately 2:15 PM, confirmed she had worked as supervisor on May 23, 2024. First in questioning, why a family member who was visiting another resident in the facility, needed to call 5229 (supervisors phone extension as stated by Employee 2, RN) and state a lady with red hair and a bracelet is with her at the rehabilitation door asking her for a ride and when was the next bus if she was standing inside the building? In reply, Employee 2, RN stated she was outside the building at the Rehabilitation Unit doors along with Resident CR 1 trying to get back into the locked doors - building. Employee 2 further stated that the facility doors lock at 8:00 PM, and a sign on the outer doors instruct guests to call the facility at this number which is the supervisor's phone for assistance.</p> <p>In further questioning, Employee 2, (RN), stated that upon arrival outside the outer (exterior) door with Employee 3, RN (the nurse assigned to resident CR 1) present at the same time, found only the visiting family member of another resident, and that Resident CR 1 was not in sight. At this point the visitor pointed towards a tree line as too the direction Resident CR 1 headed towards. According to Employee 2, RN, directly outside the Rehabilitation unit door is a horseshoe (U) shaped driveway for resident/guest drop off / pick up. Then a roadway into the campus, a grassy area with benches, then beyond that is a tree line which is where the resident headed. (Approximately 80 - 100 yards as visualized by the state survey team). At this time, Employee 3, RN (the nurse assigned to resident CR 1), took off towards the tree line after resident CR 1, because she is faster than me, stated Employee 2. According to Employee 2, RN - Supervisor, she returned into the building for assistance and at this point either overhead paged code green, rehab unit, or had heard the page overhead (unclear at this point she indicated). In questioning how long the search took for Resident CR 1, Employee 2, RN, indicated not long, as when she returned to the unit doors, she (Employee 2, RN) saw Employee 3, RN returning with Resident CR 1.</p> <p>During the interview with Employee 2, (RN), on August 16, 2024, at approximately 2:15 PM, the state surveyor asked how she thought Resident CR 1 was able to exit the facility while wearing a wanderguard? In reply, it is her belief that there are three (3) possibilities. First, a staff member who would have the code, would allow the resident out. Second, a guest/visitor who may have the code themselves, was in the process of leaving the facility with the door open and a wandering resident was to walk out the building at the same time. And third, the system could malfunction.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a second interview with Employee 2, Supervisor Registered Nurse (RN), on August 16, 2024, at approximately 2:55 PM, the employee stated she was not sure the exact time but, on the evening, shift a visiting family member had exited the building and the resident had exited the building with this visitor. She stated the visitor had then called the nursing supervisor office to let them know they believe a resident is outside who should not be outside since she had a bracelet on her ankle. The employee stated as she was going through the Rehab unit she was yelling for help and saw Employee 3 in the hall. She indicated they ran outside and Resident CR1 was out of sight. The employee stated Employee 3 went running towards the tree line and as she went back inside for more staff to help. The employee indicated at that time she heard a code green called for elopement. As the employee went back outside with more staff, Employee 3 was walking the resident back to the facility.</p> <p>During an interview with the NHA, and Employee 4 (RN - ADON) on August 16, 2024, at approximately 3:55 PM, confirmed that the facility was unable to provide the physician order for the wanderguard, documented evidence that the facility was checking Resident CR 1's wanderguard for both its presence on the resident, and that it is functioning properly, nor an incident statement (witness statement) from Employee 3, RN, who was the charge nurse assigned to Resident CR 1 at the time of the incident. They also confirmed a lack of a functioning operational procedures for monitoring residents who are identified as an elopement risk.</p> <p>During a second telephone interview on August 16, 2024, at approximately 4:00 PM, with Employee 3 Registered Nurse (RN), the employee stated she responded to Employee 2 calling for help due to a visitor calling saying a resident was outside the facility. The employee stated she and Employee 2 went outside and could not see the resident. The employee stated that is when Employee 2 went inside for more help, and she began to look for the resident. The employee stated she found the resident off grounds in a grassy area across from the building. The employee stated she was not aware the resident had eloped because she could not hear the alarms sounding because she was in a resident's room, and they are not audible from in there.</p> <p>A review of the clinical record of Resident 2 revealed admission to the facility on [DATE], with diagnoses, which included dementia and abnormal posture.</p> <p>A review of the resident's Quarterly MDS assessment dated [DATE], revealed that the resident's cognition was severely impaired.</p> <p>A review of an Elopement Evaluation dated May 12, 2024, revealed the resident was at risk for elopement.</p> <p>A review of the resident's current plan of care failed to identify the resident as an elopement risk and had no planned interventions to provide supervision or prevent an elopement.</p> <p>A review of the resident's clinical record revealed there was no documentation that the facility had been checking the residents wanderguard for placement or functioning to ensure the wanderguard bracelet in which the facility was relying on to prevent elopement was on and working correctly.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview with Employee 5 LPN on August 16, 2024, at approximately 2:00 PM revealed the employee stated there is a book on the unit that has the residents that are at risk for elopement on that unit. She stated other residents on the other units are not in their book. When asked if someone from another unit was over on her unit how would she know if that resident was an elopement risk the employee stated she didn't know. When asked how the facility checks that the wanderguard is functioning the employee stated they don't check that.</p> <p>An interview with Employee 6 LPN on August 16, 2024, at approximately 2:05 PM revealed that the employees do not have a tool to check the wanderguard bracelets to ensure they are functioning. She stated they don't check for functioning of the bracelets. She further stated we can take them by a door to see if they are working but we don't do that every day.</p> <p>An interview with Employee 7 LPN and Employee 8 LPN on August 16, 2024, at approximately 2:15 PM revealed the nursing unit does not have a book to identify elopement residents in the facility. Both employees stated that a picture of a resident on their unit was printed out today and given to them. They both indicated that there was no information on their unit to identify all the elopement risks in the building. The employees stated that they do not know who checks the functioning of the wanderguard bracelets, but it was not them.</p> <p>The facility failed to provide any documentation that the residents wanderguard bracelets were checked to ensure functioning. Further there was no documentation that the facility was checking the wanderguard system or the doors to ensure they were working properly.</p> <p>Immediate Jeopardy was called on August 16, 2024, due to the facility's failure to timely identify resident absences from the facility and prevent elopement beginning on May 23, 2024 at 8:20 PM when Resident CR1 was identified outside of the facility. Lack of functioning operational procedures for monitoring residents who are identified as an elopement risk.</p> <p>The facility was notified of the Immediate Jeopardy on August 16, 2024, at 4:03 PM and the IJ template provided to the facility.</p> <p>An immediate plan of correction was requested and received on August 16, 2024.</p> <p>The plan included:</p> <ol style="list-style-type: none"> <li>1. Nursing staff will be educated on how to identify residents who are at risk for elopement and who have wonder guards.</li> <li>2. Every resident with a wonder guard in place will be checked immediately to ensure proper function.</li> <li>3. The main lobby entrance, Rehab entrance, elevator and Employee entrance doors wonder guard locking mechanisms were inspected and repaired as necessary by a contracted communication company on August 16, 2024. At 1502 (3:02 PM) the Rehab door entrance had a new magnetic plate installed.</li> <li>4. Each resident with a wonder guard unit will have their picture posted at those entrances in a discrete way as a part of our Happy Feet Club. This will help ensure that families and staff know to be aware when entering and exiting in these areas.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39235</p> <p>Based on a review of observations, clinical records, investigate reports, staff interviews, and employee job descriptions it was determined the facility's administration failed to effectively use its resources to promote resident safety by failing to implement established procedures to monitor resident whereabouts and prevent an elopement for one out of 4 sampled residents (Resident CR 1).</p> <p>Findings include:</p> <p>Based on review of clinical records, observations, and staff interviews it was determined that the facility failed to provide necessary supervision and effective safety measures to monitor a resident's whereabouts and prevent an elopement by one resident (Resident CR 1) out of 4 sampled residents, placing the 6 residents out of 113 residents residing in the facility, identified at risk for elopement, in immediate jeopardy to their health and safety.</p> <p>A review of the clinical record of Resident CR1 revealed admission to the facility on [DATE], with diagnoses, which included dementia (a group of symptoms that affects memory, thinking and interferes with daily life), syncope and collapse (fainting or passing out), unsteadiness on feet, weakness, and abnormalities of gait.</p> <p>A review of a health status note dated May 23, 2024, at 2209 hours (10:09 PM) indicated resident asked another family member of a different resident if they could give her a ride to the bus. This resident presented with wander-guard anklet so the other family called facility and made them aware of the request. This nurse responded immediately and redirected resident to her room and told her that the bus will be back tomorrow for her. This intervention effective thus far, resident has been added to every (q) 15 minute checks for 72 hours for safety. Will continue to monitor and document effectiveness.</p> <p>A review of a health status note dated May 23, 2024, at 2216 hours (10:16 PM) stating MD called, new order received and noted for every (q) 15 minute checks X 72 hours.</p> <p>A review of an incident note dated May 23, 2024, at 2300 hours (11:00 PM) stating that at approximately 2020 hours (8:20 PM) call placed to facility by a visitor. Reported a lady with red hair and a bracelet (wander guard) on her leg is asking for a ride and when is the bus coming. Resident exit seeking, looking for her daughter and attempting to leave the property. Charge nurse was able to redirect resident to her room and informed her the bus will be coming tomorrow. Resident also requested to speak with her daughter. Call placed to daughter and message left. Covering physician notified and order obtained for q15 minute checks X 72 hours. Above interventions effective at this time with monitoring and documentation on going. Continue to await return call from daughter.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of facility provided incident report (IR - investigation) entitled Elopement, dated May 23, 2024, at 2020 hours (8:20 PM), indicated the incident location is outside. The IR further indicated the resident presented with exit seeking behavior and had asked another family member to give her a ride or show her where to get the bus. Other family member noticed a bracelet on her ankle (wanderguard) and called the facility. Charge nurse immediately responded and redirected resident back to her room and that the resident is ambulatory without assistance. The IR indicated the resident is confused with impaired memory, and active exit seeker.</p> <p>Review of facility provided incident statement (witness statement) undated, by Employee 2, Supervisor Registered Nurse (RN), stating a phone call was received from a visitor stating she was at the doors of the Rehabilitation Unit with a lady with red hair and a bracelet who was asking her for a ride and when was the next bus. I (Employee 2, RN), immediately went to the Rehab unit, and saw Employee 3, RN (the nurse assigned to resident CR 1), and called for her help. We (Employee 2, and 3) went out the Rehabilitation doors and the visitor was still there, and pointed to the direction the lady with red hair went. Employee 3, RN (the nurse assigned to resident CR 1) went to bring Resident CR 1 back. I (Employee 2, RN) went back to unit for help, overhead paged code green, rehab unit. Security and maintenance notified.</p> <p>Review of 2nd incident statement (witness statement) dated May 23, 2024, by Employee 2, Supervisor Registered Nurse (RN), stating visitor called 5229 stating lady with red hair and a bracelet is with her at the rehabilitation door asking her for a ride and when was the next bus. Immediately went to Rehabilitation door, door alarm was sounding. Resident CR 1 redirected back to room by nurse. Immediate interventions where every 15 minute safety checks for 72 hours, family aware.</p> <p>Review of 3rd incident statement (witness statement) dated May 23, 2024, by Employee 2, Supervisor Registered Nurse (RN), revealing door malfunction, indicating at 9:00 PM maintenance and security came to assess the glitch in inner door of the Rehabilitation entrance. Door not completely closing, latching and locking post (after) 8:00 PM unless forcibly shut.</p> <p>An observation of the front entrance on August 16, 2024, at approximately 11:40 AM revealed that the entrance to the facility had two sets of sliding, glass doors with a breeze way type between. These doors are alarmed with a keypad, with cameras pointing at the front door. There was a receptionist desk to the right of the front door when you walk into the facility.</p> <p>At approximately 11:50 AM, on August 16, 2024, Employee 4, RN (Assistant Director of Nursing - ADON) obtained a wanderguard upon the request of the state survey team. Employee 4 stated this wanderguard is new, and he personally activated it and confirmed its batteries are charged and that it is fully functioning.</p> <p>At approximately 12:00 PM, on August 16, 2024, in the presence of Employee 4 (RN - ADON), and the Nursing Home Administrator (NHA) after confirmation that the facilities front entrance doors were fully functioning, the state surveyor, while holding the wanderguard in hand, stood at the reception desk, which is approximately 14 - 18 feet away from the first set of the interior, double glass, sliding doors, and slowly proceeded to walk towards the doors. The inner door automatically opened, and the state surveyor continued to slowly walk thru the inner door, and approached the 2 nd set of glass sliding doors, which did not automatically open. At this time, the state surveyor applied light pressure to the door, and immediately, without any delay and or sustained pressure, the outer door opened, and the state surveyor proceeded to walk outside the front entrance.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of the Rehabilitation unit entrance on August 16, 2024, at approximately 12:08 PM revealed that the entrance had two sets of glass doors with a breeze way type between. These doors are alarmed with a keypad. There is a glass enclosed nursing station straight ahead of the unit door when you walk into the facility.</p> <p>At approximately 12:10 PM, on August 16, 2024, in the presence of Employee 4 (RN - ADON), and the NHA after confirmation that the Rehabilitation entrance doors were fully functioning, the state surveyor, while holding the wanderguard in hand, stood at the glass enclosed nursing station, which is approximately 10 - 14 feet away from the first set of the interior, glass door, and slowly proceeded to walk towards the doors. The inner door automatically opened, and the state surveyor continued to slowly walk thru the inner door, and approached the 2 nd set of glass door, which did not automatically open. At this time, the state surveyor applied light pressure to the door, and immediately, without any delay and or sustained pressure, the outer door opened, and the state surveyor proceeded to walk outside the Rehabilitation entrance.</p> <p>Interview with the Nursing Home Administrator (NHA) on August 16, 2024, at approximately 1:18 PM, confirmed the incident statement (witness statement) which is undated, written by Employee 2, Supervisor Registered Nurse (RN), indicated a code green Rehabilitation unit, which indicates a missing resident according to the NHA.</p> <p>Interview with Employee 2, Supervisor Registered Nurse (RN), on August 16, 2024, at approximately 2:15 PM, confirmed she had worked as supervisor on May 23, 2024. First in questioning, why a family member who was visiting another resident in the facility, needed to call 5229 (supervisors phone extension as stated by Employee 2, RN) and state a lady with red hair and a bracelet is with her at the rehabilitation door asking her for a ride and when was the next bus if she was standing inside the building? In reply, Employee 2, RN stated she was outside the building at the Rehabilitation Unit doors along with Resident CR 1 trying to get back into the locked doors - building. Employee 2 further stated that the facility doors lock at 8:00 PM, and a sign on the outer doors instruct guests to call the facility at this number which is the supervisor's phone for assistance.</p> <p>In further questioning, Employee 2, (RN), stated that upon arrival outside the outer (exterior) door with Employee 3, RN (the nurse assigned to resident CR 1) present at the same time, found only the visiting family member of another resident, and that Resident CR 1 was not in sight. At this point the visitor pointed towards a tree line as too the direction Resident CR 1 headed towards. According to Employee 2, RN, directly outside the Rehabilitation unit door is a horseshoe (U) shaped driveway for resident/guest drop off / pick up. Then a roadway into the campus, a grassy area with benches, then beyond that is a tree line which is where the resident headed. (Approximately 80 - 100 yards as visualized by the state survey team). At this time, Employee 3, RN (the nurse assigned to resident CR 1), took off towards the tree line after resident CR 1, because she is faster than me, stated Employee 2. According to Employee 2, RN - Supervisor, she returned into the building for assistance and at this point either overhead paged code green, rehab unit, or had heard the page overhead (unclear at this point she indicated). In questioning how long the search took for Resident CR 1, Employee 2, RN, indicated not long, as when she returned to the unit doors, she (Employee 2, RN) saw Employee 3, RN returning with Resident CR 1.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on August 16, 2024, at approximately 12:28 PM, with Employee 3 Registered Nurse (RN), confirmed she had worked on the Rehabilitation unit on May 23, 2024, as the charge nurse of Resident CR 1. Employee 3, RN, stated her memory is a little foggy, however, indicated Resident CR 1 was looking for her family (daughter) and a bus. Employee 3, RN indicated a family member who was visiting another resident in the facility, had been asked by Resident CR 1 to give a ride or show her where to get the bus. After exiting the facility, according to Employee 3, RN, the visitor thought about the request and called the facility to notify them of the request. In questioning if Resident CR 1 had exited the facility, got out the outer glass door, Employee 3, RN, replied no, I don't think so.</p> <p>During a second interview with Employee 2, Supervisor Registered Nurse (RN), on August 16, 2024, at approximately 2:55 PM, the employee stated she was not sure the exact time but, on the evening, shift a visiting family member had exited the building and the resident had exited the building with this visitor. She stated the visitor had then called the nursing supervisor office to let them know they believe a resident is outside who should not be outside since she had a bracelet on her ankle. The employee stated as she was going through the Rehab unit she was yelling for help and saw Employee 3 in the hall. She indicated they ran outside and Resident CR1 was out of sight. The employee stated Employee 3 went running towards the tree line and as she went back inside for more staff to help. The employee indicated at that time she heard a code green called for elopement. As the employee went back outside with more staff, Employee 3 was walking the resident back to the facility.</p> <p>During a second telephone interview on August 16, 2024, at approximately 4:00 PM, with Employee 3 Registered Nurse (RN), the employee stated she responded to Employee 2 calling for help due to a visitor calling saying a resident was outside the facility. The employee stated she and Employee 2 went outside and could not see the resident. The employee stated that is when Employee 2 went inside for more help, and she began to look for the resident. The employee stated she found the resident off grounds in a grassy area across from the building. The employee stated she was not aware the resident had eloped because she could not hear the alarms sounding because she was in a resident's room, and they are not audible from in there.</p> <p>An interview with Employee 5 LPN on August 16, 2024, at approximately 2:00 PM revealed the employee stated there is a book on the unit that has the residents that are at risk for elopement on that unit. She stated other residents on the other units are not in their book. When asked if someone from another unit was over on her unit how would she know if that resident was an elopement risk the employee stated she didn't know. When asked how the facility checks that the wanderguard is functioning the employee stated they don't check that.</p> <p>An interview with Employee 6 LPN on August 16, 2024, at approximately 2:05 PM revealed that the employees do not have a tool to check the wanderguard bracelets to ensure they are functioning. She stated they don't check for functioning of the bracelets. She further stated we can take them by a door to see if they are working but we don't do that every day.</p> <p>An interview with Employee 7 LPN and Employee 8 LPN on August 16, 2024, at approximately 2:15 PM revealed the nursing unit does not have a book to identify elopement residents in the facility. Both employees stated that a picture of a resident on their unit was printed out today and given to them. They both indicated that there was no information on their unit to identify all the elopement risks in the building. The employees stated that they do not know who checks the functioning of the wanderguard bracelets, but it was not them.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the job description for the Nursing Home Administrator (NHA) dated May 1, 2023, states the Administrator of the facility directs the daily operations of Skilled Nursing Facility (SNF). Responsible for implementing operational policies, administrative procedures, and rules/regulations for a skilled nursing facility in accordance with State and Federal standards and the mission of the (name of organization). Manages and coordinates all services and departments to establish/maintain an environment and program conducive to a high quality of care for all residents. Coordinate the development and execution of the facility budget. Develops, in partnership with department heads, corporate resources, and other campus administrators, policies and procedures for the effective operation of the facility. Completes periodic and unscheduled rounds of the entire facility to inspect operations and programs, visit residents and families, confer with staff to determine needs/requirements and resolve operating problems in a timely manner to facilitate a quality enhance environment for the facility's residents and staff. Meets with State and Federal surveyors and provides tools/information as required to facilitate surveys. Oversees and coordinate the development of any plan of correction necessitated by a survey outcome. Remains current on changes in State and Federal regulations. Ensures the facility remains in compliance with all State and Federal regulations. Monitors all Quality Measures and the QAPI program, in partnership with the Director of Quality Management, to maintain or exceed a CMS Star rating of 4 for both QMs and Overall. Serves as the resident's advocate on issues that refer to quality of life and residents' rights.</p> <p>A review of the job description for the Director of Nursing (DON) dated July 1, 2023, states the DON is to direct the daily operations of nursing department by planning, directing, organizing, and evaluating the nursing staff in accordance with current federal, state and local standards. Develops, reviews, and implements policies and procedures of the nursing department. Coordinates the staffing plan. Makes final review of incident/accident reports to assure appropriate investigation/follow-up has occurred. Participates in resident selection for facility admission. Reviews concerns, complaints, grievances made by residents, families and staff. Organizes and directs all aspects of reimbursements systems (Medicare determinations and cuts, Medicaid PRI's, MDS). Acts as liaison with the interdisciplinary team. Coordinates and participates in research activities and strives to move the facility in a progressive manner. Participates in Quality Assurance committee. Participates in budget process for the nursing departments. Manages the Assistant Director of Nursing and Unit Managers. Interviews, trains, plans assigns and directs work assignments for nursing staff. Serves as the resident's advocate on issues that refer to quality of life and residents' rights. Performs other assignments as directed.</p> <p>The deficiency cited under the Code of Federal Regulatory Groups for Long Term Care, Quality of Care (F689) 483.12(a)(1) , revealed that the NHA and DON failed to fulfill the essential job duties for ensuring the safety of the residents and adherence to regulatory guidelines.</p> <p>Refer F689</p> <p>Refer F 684</p> <p>28 Pa. Code: 201.18 (e)(1) Management</p> <p>28 Pa. Code 211.12 (c) Nursing services</p>		