STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395679	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove at Washington, The	1198 W. Wylie Avenue Washington, PA 15301

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 - Minimal harm or potential for actual harm 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** 39311 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 four residents (Resident R1). Review of the facility policy Resident Elopement dated 1/31/24, indicated cognitively impaired residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement is defined as a resident leaving the physical structure of the facility without knowledge of facility staff. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record indicated Resident R was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 6/27/24, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and a seizure disorder. Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed Resident R1's score to be 07. Review of an Elopement Risk Assessment completed on 7/31/24, indicated Resident R1 was at risk for elopement. Review of the plan of care for Potential for Elopement initiated 6/9/22, indicated Resident R1 had exit-seeking behaviors, and documented attempts to exit the facility on 7/3/23, and 7/13/24. Interventions included for staff to check resident's whereabouts frequently, redirect from exits as needed based on behavior, and to encourage group activity and attempt to keep occupied. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 8/8/24, at 9:47 p.m. indicated, About 5:30 p.m. two of the aides went out the front door to get the food they ordered. They first saw the wheelchair in the grass, then they saw the resident sitting in the grass in front of the wheelchair. They assisted him back to his wheelchair, then brought him back inside. Review of facility submitted documents on 8/9/24, indicated On 8/8/2024 at approximately 5:45 pm Staff was exiting the front entrance and noted a wheelchair upon moving closer to the wheelchair noted resident (Resident R1) sitting in the grass. Resident is alert with periods of confusion, staff notified the RN supervisor of the circumstance, resident was assisted back into the building. RN supervisor asked resident how he got outside, and resident responded he pressed buttons and the door opened. Door was evaluated and functioning approximately (appropriately), without means of opening without password. Review the facility incident report dated 8/8/24, indicated two nurse aides went outside to get a personal food delivery, and noticed Resident R1 sitting in the grass in front of his wheelchair. Resident R1 stated he punched the numbers in. Review of an employee statement written by NA Employee E3 dated 8/8/24, indicated, Around 5:30 p.m. I walked out to grab my Doordash & noticed a wheelchair in the front yard, headed down the hill. When I walked out to look, (Resident R1) was sitting in the yard in front of his chair. I asked if he fell , he said, No, I am going home. I got another aide and we got him in his chair and brought him to the nurses station. Review of an employee statement written by NA Employee E4 dated 8/8/24, indicated, Last time saw (Resident R1) at 5:50 when he left dining room and we did walking round and I was walking with another aide to pick up her Doordash out front and she seen a wheelchair out in the grass and we walked over and (Resident R1) was in the grass. We made sure he was okay and we picked him up of the grass into his chair and took to the nurse. Review of an employee statement written by Registered Nurse (RN) Employee E2 dated 8/9/24, indicated that on 8/8/24, About 5:45 - 6 pm Two of the nurse aides came down the hall with this resident. They told me that he had been outside sitting on the grass in front of his wheelchair. I asked the resident how did he get outside. He didn't answer. He just laughed. I tried to explain to him that this was a serious matter, I explained to him that he could have hurt himself. I then called you to let you know what had happened. Then I started neuro-checks and started getting statements for the staff that was working. I called his brother then his sister neither answered and I could not leave a message with either. Review of an employee statement written by Licensed Practical Nurse (LPN) Employee E5 dated 8/8/24, indicated, Two nurse aides came down the hall pushing the resident in his wc (wheelchair). Stated they found him out the front door. This nurse attempted to find out how resident got out of the building. Explained to resident other residents could get out & get hurt. Resident stated, I just punched some buttons and it just unlocked. During an interview on 8/17/24, at approximately 12:38 p.m. RN Employee E1 stated that exit-seeing is a frequent behavior for Resident R1. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grove at Washington, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1198 W. Wylie Avenue Washington, PA 15301	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/17/24, at approximately 1:20 p.m. RN Employee E2 stated, they think a visitor let him out. During an interview on 8/20/24, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide adequate supervision to prevent elopement for one of six residents. 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 211.11(d) Resident care plan. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of facility documentation and staff interviews, it was determined that the facility failed to provide documentation of an effective training program, that included training topics based on the resident population for one of four residents (Resident R1). Findings include: Review of the facility policy, Staff Development dated 1/31/24, indicated, the facility must ensure that facility employees are competent in skills and techniques necessary to care for residents' needs and/or complete assigned job tasks. There shall be an ongoing coordinated education program which is planned and conducted for the development and improvement of skills of the facility personnel including training related to problems, needs and rights of the residents. Review of the Facility assessment dated [DATE], indicated the facility will maintain an adequately trained and competent staff. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 6/27/24, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and a seizure disorder. Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed Resident R1's score to be 07. Review of the plan of care for Potential for Elopement initiated 6/9/22, indicated Resident R1 had exit-seeking behaviors, and documented attempts to exit the facility on 7/13/23, and 7/3/24. Review of an Elopement Assessment completed on 7/31/24, indicated that Resident R1 was at risk for elopement. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility submitted documentation on 8/9/24, indicated On 8/8/2024 at approximately 5:45 pm Staff was exiting the front entrance and noted a wheelchair upon moving closer to the wheelchair residents noted resident (Resident R1) sitting in the grass. Resident is alert with periods of confusion, staff notified the RN supervisor of the circumstance, resident was assisted back into the building. RN supervisor asked resident how he got outside, and resident responded he pressed buttons and the door opened. Door was evaluated and functioning approximately (appropriately), without means of opening without password. Further review of the facility submitted information indicated, Re-education provided to staff on policy and procedures related to elopement, identifying residents at risk for elopement. During an interview on 8/17/24, at approximately 1:20 p.m. Registered Nurse (RN) Employee E2 stated, they think a visitor let him out. When asked what was done by the facility to ensure that didn ' t happen again, RN Employee E2 stated, they put up brighter signs on the doors. During an interview on 8/19/24, at approximately 11:30 a.m. the Nursing Home Administrator (NHA) confirmed Resident R1 was appropriately documented and care planned as an elopement risk, and had exited the building by either entering the correct door code or being let out of the facility by another person. The NHA further confirmed that the facility provided education to the staff addressed identification and care planning of residents at risk for wandering and elopement, and did not address the actual method used by Resident R1 to exit the facility. During an interview on 8/20/24, at approximately 1:00 p.m. the NHA confirmed the facility failed to provide documentation of an effective training program, including additional training topics based on the resident population for one of four residents. 28 Pa. Code 201.19(7) Personnel policies and procedures. 28 Pa. Code 201.20(a) Staff development.\