STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395695	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenery Center for Rehab and Nursing	2200 Hill Church-Houston Road Canonsburg, PA 15317

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** 31343 Based on review of facility policy and documents, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision which resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one resident. This failure created an immediate jeopardy situation for one of 15 residents who were identified as high risk for elopement (Resident R1). The facility also failed to make certain that four of 15 residents had appropriate data including pictures and identification of risk for elopement available to staff for review (Resident R2, R3, R4 and R5). Findings include: Review of the facility Wandering and Elopements policy last reviewed 8/9/24, indicated that the facility will identify residents who are at risk of unsafe wandering and exit seeking behavior and develop individualized prevention and management interventions based on assessment. The facility procedure includes the assessment of potential risk factors such as exit doors and the door alarms and wander control systems are to be maintained in working order. The facility is to maintain a current list of names and photographs of residents identified to be at risk for elopement and monitor the whereabouts of the at risk residents. Residents identified as at risk have a monitoring bracelet and an order identifying where the monitor is placed and that it is to be checked every shift for placement and functioning and documented on the Medication Administration Record/Treatment Administration Record (MAR/TAR). The resident's plan of care is reviewed and revised as needed. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, 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 Resident R1's admission record indicated she was originally admitted on [DATE], with a re-admitted [DATE]. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395695	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenery Center for Rehab and Nursing	2200 Hill Church-Houston Road Canonsburg, PA 15317

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	Review of Resident R1's Minimum Data Set assessment (MDS -a periodic assessment of resident care needs) dated 1/13/25, included diagnoses of dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), anxiety disorder, Stage 3 kidney disease with urinary retention. Review of Section C0500-BIMS screening indicated a score of 2, which indicated Resident R1 was not alert and oriented, and had severe cognitive impairment. Review of the clinical record indicated Resident R1 had a recent hospitalization due to a fall at home requiring admission to the facility. Review of Resident R1's admission Elopement Risk Assessment completed on 1/9/25, indicated that Resident R1 was cognitively impaired with poor decision making skills, exhibited wandering behaviors and wandering is likely to affect herself and others and the elopement score was 4, which indicated she exhibited wandering behaviors and was at risk for elopement. Review of a progress note dated 1/9/25, at 12:10 p.m., Licensed Practical Nurse (LPN) Employee E1 documented Resident R1 wandering in the hallways and into other resident rooms and placed a Wanderguard (electronic monitoring bracelet) on Resident R1's right ankle and notified the family. Review of a progress note dated 1/9/25, at 12:28 p.m. (the same day, not less than a half hour later), LPN Employee E1 documented that Resident R1 was not exhibiting exit seeking behaviors, so the Wanderguard was removed, and staff were to monitor her. Documentation in the clinical record did not include any interventions of the monitoring completed by staff. During an interview on 1/29/25, at 11:17 a.m., the Director of Nursing (DON) stated, I told the LPN to remove the Wanderguard as the resident was not exhibiting exit seeking behaviors. Review of facility submitted documentation dated 1/11/25, indicated on Saturday, 1/11/25, at approximately 7:15 a.m., Resident R1 was observed by staff outside of the building walking on the sidewalk in front of the building near the parking lot of the facility. The weather that day was sunny and cold at 26 degrees Farenheit. A staff member who was coming in found her and immediately walked her back into the building. There were no injuries and when asked Resident R1 did not respond to where she was going. Resident R1 was last seen at approximately 7:10 a.m., inside the facility in the cafeteria waiting for breakfast. Review of LPN Employee E1's witness statement dated 1/11/25, indicated that Resident R1 was standing near the breakroom near the main entrance and LPN Employee E2 walked her into the cafeteria and sat her in a stationary chair. LPN Employee E1 notified cafeteria staff and the other staff in the cafeteria. At approximately 7:15 a.m., LPN Employee E1 was in report and overheard a nurse aide state that Resident R1 was outside and had been brought back into the building. During an interview on 1/28/25, at 3:26 p.m., LPN Employee E1 stated that she remembered her statement during the investigation and that the resident wandered all over the place in all the halls and into other resident rooms. On the date of the elopement, LPN Employee E1 stated that she had to walk Resident R1 from the entrance area to the cafeteria where she had last seen her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395695	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenery Center for Rehab and Nursing	2200 Hill Church-Houston Road Canonsburg, PA 15317

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	Review of Agency LPN Employee E2's statement dated 1/11/25, indicated that when she came in Resident R1 was walking out of the double front doors and LPN Employee E2 met her and asked where she was going. Resident R1 did not respond and LPN Employee E2 walked Resident R1 back inside. LPN Employee E2 got a nurse aide's attention and the nurse aide returned Resident R1 to the nurses station and the Registered Nurse Supervisor was made aware. During a phone interview on 1/28/25, at 3:30 p.m., LPN Employee E2 stated she remembered what happened and stated she was running late getting to the facility and Resident R1 was in a sweatsuit with slippers on. LPN Employee E2 stated there was no staff at the front desk and she is unsure what could have happened had she not come in when she did. Review of Resident R1's clinical record after the elopement on 1/11/25, included a complete full body assessment immediately after the incident. Resident R1 had an elopement bracelet placed and her plan of care was updated. During an observation on 1/28/25, at 8:53 a.m., the Wanderguard alarm was tested which locked when near the front door, however, the Maintenance Director Employee E4 demonstrated that the doors break away to open if pushed. During an interview on 1/28/25, at 8:55 a.m., Restorative Aide / Front Desk staff Employee E3 stated that there are no staff posted at the front desk after hours and on weekends. She stated that the front desk has a Elopement Book with all the resident's identified as an elopement risk listed and their information with a picture to identify them. The book also contains the facility policy and procedures for wandering/elopement risk. During an interview on 1/28/25, at 8:57 a.m., the Nursing Home Administrator confirmed that there is a book left at the front desk and the Director of Nursing has one as well. During an observation on 1/28/25 at 8:59 a.m., Resident R2 approached the doors wearing a Wanderguard, the lock sound was heard but the doors opened which could have allowed Resident R2 to exit. This was attempted three times. Review of clinical record indicated that Resident R2 was admitted to the facility 11/19/21, with diagnoses which included Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior) and falls. Review of an elopement evaluation dated 1/21/25, indicated a 5, at risk for elopement. Review of the Elopement Book did not include Resident R2's information and her picture. Review of the Elopement Book at the front desk which is to include all residents at risk for elopement on a list, their elopement assessment, a picture and personal data and the policies/procedures for elopement: During an observation on 1/28/25, at 9:04 a.m., Resident R3 approached the front entrance doors with the door lock sounding and alarm sounding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395695	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenery Center for Rehab and Nursing	2200 Hill Church-Houston Road Canonsburg, PA 15317

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	Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease and falls. Review of an elopement evaluation dated 12/25/24, indicated a 3, at risk for elopement. Review of the Elopement Book at the front desk did not include a picture to identify Resident R3. During an observation on 1/28/25, at 9:10 a.m., Resident R4 approached the front entrance doors with the door lock sounding and alarm sounding. Review of the Elopement Book at the front desk did not include a picture, an elopement risk assessment, or personal data to identify Resident R4. During an observation on 1/28/25, at 9:17 a.m., Resident R5 approached the front entrance doors with the door lock sounding and alarm sounding. Review of the clinical record indicated that Resident R5 was admitted to the facility on [DATE], with diagnoses which included dementia and difficulty walking. Review of an elopement evaluation dated 11/16/24, indicated a 3, at risk for elopement. Review of the Elopement Book at the front desk did not include Resident R5 listed as at risk, but did include a picture, assessment and personal data. During an interview on 1/28/25, at 11:50 a.m., the Nursing Home Administrator and the DON confirmed that Resident R1 was identified as a wander risk on 1/9/25, confirmed that the facility relied on the Wanderguard system to provide elopement supervision, although the front doors are not always monitored after hours and on the weekend, and will release if pushed. On 1/28/25, NHA and the DON were notified that Immediate Jeopardy was called due to the elopement of Resident R1 on 1/11/25, and facility staff were provided an Immediate Jeopardy template at 11:53 a.m., and a corrective action plan was requested. On 1/28/25, at 3:53 p.m. an immediate action plan was received and accepted which included the following interventions: 1. Resident R1 had been discharged . 2. Elopement reassessments of all residents currently identified as elopement risk by 1/29/25. 3. Complete whole house education with all staff on elopement policy/procedure, the elopement binder, and appropriate supervision by 1/29/25. 4. The door vendor was onsite 1/28/25, to evaluate doors for repairs. 5. All residents upon admission will be evaluated for elopement risk and interventions. The DON will audit two residents weekly for appropriate interventions for four weeks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395695	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenery Center for Rehab and Nursing	2200 Hill Church-Houston Road Canonsburg, PA 15317

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	On 1/29/25 at 2:44 p.m., all residents' assessments for elopement risk were reviewed and found to be completed, and care plans were reviewed and updated if needed. The elopement policy was updated, and documentation verified all current residents' Wanderguard's functioned correctly. During interviews of staff working on 1/29/25, between 12:15 p.m. and 1:50 p.m. staff (27 out of 52 staff persons) confirmed they were trained on the updated elopement policy, what to do during an elopement, the location and purpose of the elopement book at the nurse's station, and appropriate resident supervision. Staff education was verified with dated sign-in sheets and review of all current staff and agency staff utilized in the facility having signed and/or educated over the phone as indicated. The NHA sent out a broad text to the Agency as well indicating any staff that had not been in the facility will have to be educated prior to their shift start. Verification of the facility's Corrective Action Plan revealed all elements of plan were met with all staff signatures and review of education with 27 of 52 staff currently in the building on the date of review which included agency staff. The Immediate Jeopardy was lifted on 1/29/25, at 2:44 p.m. During an interview on 1/28/25, at 10:55 a.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to provide adequate supervision resulting in Resident R1's elopement. This failure created an immediate jeopardy situation for Resident R1 and potentially put her at risk of harm or injury. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18 (e)(1)(3) Management. 28 Pa. Code 207.2(a)Administrators Responsibility. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(a)(c)(d)(3)(5) Nursing services.