

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395705	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2025
NAME OF PROVIDER OR SUPPLIER Hempfield Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1118 Woodward Drive Greensburg, PA 15601	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 nine residents (Resident R1).</p> <p>Review of the facility Missing Resident Policy dated 12/4/24, indicated the facility will complete all necessary steps to locate any resident that is missing from a community.</p> <p>Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 4/1/24, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), high blood pressure, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Review of an Elopement Risk Assessment completed on 3/19/25, indicated Resident R1 was at risk for elopement.</p> <p>Review of the physician's order dated 2/18/25, indicated Resident R1 was ordered a Secure Care Bracelet (security bracelet that alerts when an identified resident approaches a monitored door).</p> <p>Review of Resident R1's plan of care for Risk for Elopement initiated 2/16/25, indicated Resident R1 will remain safe and secure within the facility, and the intervention that staff will be aware of resident 's location at all times.</p> <p>Review of a progress note dated 4/8/25, at 11:42 a.m. indicated, Resident was noted to be outside facility, walking down the driveway to main road. Hospice CNA (nurse aide) had arrived at facility to see another resident and noted this resident walking. [Hospice nurse aide] called to [Resident R1] he turned and headed back up hill, [Hospice nurse aide] was able to redirect resident back into facility. Head to toe checks completed. No injuries noted. was wearing a sweater over a polo shirt, slacks, socks and shoes. Weather was around 29 degrees outside. Unable to determine length of time resident had been outside the facility. Resident had no clear reason for being outside. Was unable to report which door he had exited from. Resident was taken to the dining room and daughter was made aware of resident being outside. [Resident R1] could not recall where he was going or how he got outside the facility. Given warm coffee, resident placed on Q 15 minute checks to confirm presence.</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 4/8/25, indicated that on 4/8/25, at 9:08 a.m. resident was observed outside facility going down drive toward street. CNA from Hospice had arrived for her shift to care for another resident in facility and noted [Resident R1] walking, she called to him and walked to get him and bring him inside facility. [Resident R1] was very cooperative and walked with CNA without incident. Action: Front door alarm from Wander guard system was assessed and not functioning appropriately. Delay for door closing is very long, side door locks are battery operated and alarm with a different pitch and all functioning correctly. PT/OT (physical therapy / occupational therapy) door alarm is also working appropriately. Call placed to head of [corporate] to ask where to call for repairs since the door in front were just installed. Resident was placed on Q15 minute (every 15 minute) checks until tomorrow when alarm company is in house to fix from door alarms. Family is aware and has offered to assist with supervision.</p> <p>Review of an employee statement (undated) from Nurse Aide Employee E1 stated, Around 9:05 I last saw [Resident R1] he was walking off the unit. I was dealing with a bathroom flooding and did not see him after.</p> <p>Review of an employee statement dated 4/8/25, from Registered Nurse Employee E2 stated, I was the med nurse on C Hall cart for 7-3 shift today. At around 0905, [Resident R1] came up to me and stated he was looking for a newspaper. I told him activities usually has them and told him to check with them. He walked away from this nurse towards the nurses station at 0906.</p> <p>Review of an employee statement dated 4/8/25, from Licensed Practical Nurse Employee E3 stated, Around breakfast time, [Resident R1] came down D Hall and ask me if firemen came in that door, pointing to door at end of D Hall. I told him I did not see firemen. He then walked back toward C Hall.</p> <p>Review of a statement (undated) from Hospice Aide stated, On April 8th 2025 I [Hospice Aide] arrived at [facility]. As I was sitting in my car I seen resident [Resident R1] walking down the driveway making his way onto the side of the main street. I got out and yelled [Resident R1] stop. He then stopped and started walking up the grass hill after I said [Resident R1] come here. I walked [Resident R1] to the front main entrance and handed him off to facility staff.</p> <p>Review of a facility provided invoice indicated that on 4/9/25, the door security vendor completed emergency repair service and testing to ensure door was functional and alarming at the correct distances.</p> <p>During an interview on 4/22/25, at approximately 11:15 a.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide adequate supervision to prevent elopement for one of nine residents.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(e)(1) Management.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p> <p>28 Pa Code 211.12(d)(1)(2)(5) Nursing services.</p>		