STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395705	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hempfield Manor	1118 Woodward Drive Greensburg, PA 15601

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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** 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 that created an immediate jeopardy situation for one of 29 cognitively impaired residents (Resident R1).Findings Include: Review of the facility, Missing Resident Policy dated 12/2/25, indicated the facility will take all necessary steps to locate a resident that is missing. Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and high blood pressure. Review of Section C: Cognitive Patterns indicated that Resident R1 has severe cognitive impairment. Review of the facility diagnosis list included acquired absence of the right upper limb. Review of an Elopement Evaluation assessment completed on 1/31/26, indicated Resident R1 was not at risk for elopement. Review of a progress note dated 4/10/26, at 2:09 p.m. indicated Resident R1 attempted to exit the front door of the facility. Review of Resident R1's plan of care developed on 4/10/26, indicated that he was an elopement risk as evidenced by exit-seeking behaviors. Attempting to exit the front door, stating going to the courthouse, watching for flying ships from the window. Included in the interventions was the use of an electronic monitoring device (SCD). Further review of the care plan failed to include a plan of care developed for wandering/elopement prior to 4/10/26. Review of a progress note dated 4/10/26, at 6:39 p.m. indicated a change in condition, Confused, applied for a marriage license at front desk of [facility]. States he is waiting on his ship to pick him up and stated the Germans are coming. The progress note further stated that Resident R1 complained of abdominal pain, and the physician ordered that he be sent to the hospital for evaluation. Review of an Elopement Evaluation assessment completed on 4/10/26, indicated Resident R1 was at risk for elopement. Review of a physician's order dated 4/10/26, indicated Resident R1 was ordered an SCD (secure care device - electronic monitoring device). Review of a progress note dated 4/11/26, at 2:12 a.m. indicated Resident R1 was admitted to the hospital. Review of the physician's order for the SCD indicated that it was discontinued on 4/11/26, due to the resident being admitted to the hospital. Review of a progress note dated 4/14/26, at 10:13 p.m. indicated that Resident R1 was readmitted to the facility. Review of an Elopement Evaluation assessment completed on 4/14/26, indicated Resident R1 was not at risk for elopement. Review of Resident R1's physician's orders for April 2026, indicated that Resident R1's SCD was not reordered upon his readmission to the facility. Review of information submitted by the facility dated 6/13/26, indicated that on 6/12/26, At 7:02 p.m. RN was notified by staff leaving facility after shift that [Resident R1] was on the lower walking track on the far end approximately 0.3 miles from the facility in his power wheelchair. RN Charge called Code Brown, and available staff reported to location [Resident R1] had been witnessed at on the walking track. At 19:16 (7:16 p.m.) staff located [Resident R1] on the walking track near [intersection by the facility]. The weather was sunny and warm at this time. Staff escorted [Resident R1] back to the (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility. On shift staff report seeing [Resident R1] near the front entrance inside the building at 18:16 (6:16 p.m.). Staff on the unit report seeing [Resident R1] heading off the unit towards vending machine after 18:00 (6:00 p.m.). [Resident R1] pushed the handicap paddle to open the front door and exited the facility through the front door. Review of a progress note dated 6/12/26, at 7:02 p.m. indicated, Notified by staff that the resident was seen on the lower (furthest) walking track in front of the facility in his power wheelchair at 1902 (7:02 p.m.), heading toward [Street]. The weather was sunny and warm at around 79 degrees. When asked why he went down to the track and down the road, he stated to this RN, Well, I was trying to go to Youngwood. If I'd made it over the hill past the tracks, I would have gone to [local pizza restaurant], if it is even still open. I would have gone past there. When asked again why he was out on the track, he stated If I'd gone the other way, I would have been caught. He was asked again why he left the facility and he stated, It was a spur of the moment to get moving. He kept laughing when he was told that it was dangerous to go out across the roads. CODE BROWN was called. Staff searched the building while other staff searched outside of the facility and along the walking track. Staff located the resident at 1916 (7:16 p.m.) at the corner of [intersection], near a UPS Drop Box. Code [NAME] cleared. He was sitting in his power chair with his flashlight attempting to wave down cars passing by him. Staff turned off the power to his chair and pushed him back into the facility. Review of an employee statement (undated) written by Nurse Aide Employee E1 indicated, At 7pm the ADON (Assistant Director of Nursing) came to A Hall and told me [Resident R1] was outside, that [Dietary Employee E2] from the Kitchen was leaving and seen him across the trail. I then ran outside and ran down the hill I then ran back and got my car and drove to find him, I went around the circle twice; up the street and back, I then went to the end of the circle, out of our building, to the stop sign and seen [Resident R1] across the street to my left, on the side of the road (half way out), waving his hand with his flash light. I then pulled in the gravel beside him as I was calling [Nurse Aide Employee E3] because she was the most recent person on my call list, she notified everyone and multiple people came to help. When I got out of the car I said [Resident R1] where are you going. He told me he was glad to see a familiar face but he was trying to scare us all and that he wanted to go to Youngwood. I backed him up and waited for them to come. I then drove back while [Licensed Practical Nurse (LPN) Employee E4] and [LPN Employee E5] pushed him back to the building. Review of an employee statement (undated) written by LPN Employee E5 indicated, After being relieved of my post I crossed the building to assume another position at which point a nurse approached me asking where a resident is. After searching the entire building in each accessible room, I headed outside and searched the parking lot. After not finding the resident, I began following other cohorts on their search at which point the party located the resident across the road in his motorized wheelchair. Resident was unable to return due to the chair battery losing its charge. The resident was visually observed to be calm and without complaints of pain / injury. Resident was then manually posted in his wheelchair by me and another nurse back to the facility. Resident arrived at facility at 1943 (7:43 p.m.). Resident was put in bed by staff and assessed by charge nurse. Review of an employee statement (undated) written by Dietary Employee E2 indicated, On Friday night, (June 12th), after left work I noticed [Resident R1] on the lower-track in front of our facility but not on the premises. Obviously. I called [Dietary Employee E6] to ask if our residents were even allowed to be there, I wasn't 100% sure. She called the facility right away Review of an employee statement dated 6/12/26, written by Dietary Employee E6 indicated, [Dietary Employee E2] called me Friday night after her shift. She was leaving and saw [Resident R1] on the track. She asked me if he was allowed to be there - I asked who was in charge, [Dietary Employee E2] was not sure. I told her I was going to call the facility. I called after we got off the phone and [Registered Nurse (RN) Employee E7] answered and I told her [Dietary Employee E2] saw [Resident R1] at the tracks. [RN Employee E7] called back and asked where she saw him exactly. I wasn't completely sure - I guess I was just concerned on calling the [facility] asap. I talked to [RN Employee E7], and she said they found him. Review of an employee statement dated 6/12/26, written by NA Employee E8 indicated, Was notified (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that [Resident R1] was missing at 1915 (7:15 p.m.). NA Employee E9, LPN Employee E5, and I went looking was on C and D side also in also in back parking. [NA Employee E3] got a call he was down the street by [business], by pull off area. He was found safe at 1930 (7:30 p.m.). He was waving at cars asking for a ride to Youngwood. Review of an employee statement dated 6/12/26, written by LPN Employee E4 indicated, ?I arrived at work and clocked in at 6:45pm. I got report at 6:55pm on B hall from LPN Employee E5. At about 7:03 ADON reported to me that a resident [Resident R1] was seen on the walking track in his motorized wheelchair. I immediately alerted staff as I ran out the building to begin searching for him outside in the parking lot and the front road. I returned into the building to continue to check the smoke area and empty rooms. After not finding him returned outside with 2 CNAS (nurse aides) to continue to search. Another CNA called from a block away stating she found him, he was safe and she was waiting with him. Upon reaching the resident he said he was trying to see how long it took someone to stop and help him. Review of an employee statement dated 6/12/26, written by NA Employee E3 indicated, ?[NA Employee E1] called me at 7:15pm she had found [Resident R1] at the end of the road. I was on D hall & went to grab other aides and nurses to help. When I got to him [NA Employee E1] had him safe with her. When asked what he was doing he said Trying to get a ride to Youngwood to scare you guys. During an interview on 6/30/26, at 10:13 a.m. NA Employee E9 stated that recently Resident R1 has been more confused. We would put Wanderguards (SCD) on and he would try to cut them off. During an interview on 6/30/26, at 10:15 a.m. LPN Employee E10 stated, One time they came and got the extra one (SCD) I keep in my cart for new admits because the nurse said he cut it off. During an interview on 6/30/26, at 10:33 a.m. RN Employee E11 confirmed that Resident R1 has been confused and had been sent out in April for attempting to leave the facility. During an interview on 6/30/26, at 2:40 p.m. LPN Employee E12 stated that recently Resident R1 has been more confused since his roommate passed approximately one year ago. I think his dementia is definitely getting worse. During an interview on 6/30/26, at 2:46 p.m. NA Employee E13 stated, Some days he's really out of it. The other day he was talking about a motorcycle that was in his room. During an interview on 6/30/26, at 3:05 p.m. NA Employee E1 stated that she has heard staff speaking of Resident R1 cutting his SCD off, and they have tried to put it on his chair. During an interview on 6/30/26, at 3:08 p.m. NA Employee E14 stated that Resident R1 gets confused at random times, that he had days when he makes sense, and others when he does not. During an interview on 6/30/26, at 3:27 p.m. LPN Employee E15 stated that Resident R1 doesn't want anyone to tell him what to do. He is ex-military, rough and tumble. When asked if Resident R1 had been more confused recently, LPN Employee E15 stated, I think so, for the past few weeks. On 6/30/26, at 9:28 a.m. the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were made aware that an Immediate Jeopardy situation existed and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at this time. On 6/30/26, at 12:30 p.m. an acceptable Corrective Action Plan was reviewed which included the following interventions: Investigation initiated following elopement revealed resident was observed by staff at 6: 16pm near front entrance.At 7:02pm off shift staff observed this resident on walking path below facility. Off shift staff contacted her supervisor to inform her a resident was on the walking path. Supervisor contacted facility to inform them this resident was seen on the walking path. Supervisor on shift called Code [NAME] (elopement) and staff began searching for this resident.Resident was found in power wheelchair on far end of walking trail at 7: 16pm. He was escorted back into the facility. Resident appeared to be laughing with staff and stated he was trying to go to Youngwood.The resident was assessed by RN for injury and change in condition by Assist Director of Nursing on 6/12/26. The resident was not harmed and alert and oriented. MD and family made aware of elopement.MD ordered therapy evaluation Psych evaluation and Med review which have been completed.Resident was ordered Secure Care Device and removed resident from power wheelchair until therapy could evaluate, Standard wheelchair put in place. All recommendations are put into place.Assessments completed for skin, BIMs, Elopement, and Nursing Physical Device by RN (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on 6/12/26.Therapy evaluation completed for motorized wheelchair on 6/16/26, by Therapy Manger. Resident's plan of care updated with all findings and appropriate interventions.Care plan meeting was held and reviewed with family and IDT team on 6/17/26. Immediately following elopement-all residents were accounted for by the competition of a head count and elopement drill on 6/12/26, by Assistant Director of Nursing at 7:45pm.Elopement binder and photos of residents at risk for elopement updated immediately following elopement by ADON on 6/12/26.Elopement evaluation assessment and Care plans were completed on all residents on or before 6/30/26 at 9:00am by the Interdisciplinary Team to ensure all residents were evaluated for elopement risk and appropriate interventions were in place.re-admission elopement assessments reviewed by IDT team during Clinical report meeting following elopement on 6/12/26 and ongoing to ensure accuracy with orders and assessments.IDT team will review Behaviors during clinical report on-going, and Activities Director will update Elopement Binders as needed.Education to registered nurses for accuracy in elopement assessment completion completed by Nursing Home Administrator or designee by 6/30/26 at 11 :25am.Elopement drills were conducted weekly x 1 week all 3 shifts by Environmental Service Supervisor by 6/25/26 at 7:00am. Elopement drills will be completed monthly thereafter by ESS.All staff Educated on elopement policy by Director of Nursing or Designee on 6/30/26 by 4pm.Audits completed to ensure Elopement Drills were completed weekly x 1 weeks by NHA or designee before 6/30/26 at 9:00am, monthly audits thereafter x 6 months. Audit results of audits will be presented and reviewed during QAPI meetings. Review of resident clinical records on 6/30/26, confirmed that all residents were reevaluated for elopement risk on 6/16/26. Review of facility-provided sign-in sheets, dated 6/29/26, and 6/30/26, confirmed reeducation was provided to all facility staff on elopement prevention and actions to take in the event of an elopement. Review of facility-provided sign-in sheets, dated 6/29/26, and 6/30/26, confirmed reeducation was provided to all registered nurses on completing elopement evaluations accurately, reviewing prior evaluations, behavior notes, and checking cognitive scores and diagnoses. Review of facility documents confirmed elopement drills were completed on 6/17/26, at 8:40 p.m.; 6/18/26, at 1:00 p.m.;6/19/26, at 6:00 p.m.; 6/22/26, at 5:00 a.m.; 6/24/26, at 10:22 a.m.; and 6/25/26, at 5:30 a.m. During interviews conducted on 6/30/26, confirmed 15 of 15 facility staff received reeducation on the elopement prevention and actions to take. During interviews conducted on 6/30/26, confirmed two of two registered nurses received reeducation on the accurately completing elopement evaluations. The Immediate Jeopardy was lifted on 6/30/26, at 3:20 p.m. when the action plan implementation was verified. During an interview on 6/30/26, at approximately 3:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide adequate supervision to prevent a resident exiting the building unsupervised. This failure created an Immediate Jeopardy situation for one of 29 cognitively impaired residents. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211.12(d)(1)(2)(5) Nursing services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed effectively manage the facility to protect residents from elopement. This failure resulted in a resident exiting the building unsupervised (Resident R1). This failure created an Immediate Jeopardy situation for one of 29 cognitively impaired residents (Resident R1).Findings include:Review of the facility-provided Nursing Home Administrator (NHA) job description indicated the NHA, directs the overall operations of the care community in accordance with current local, state, and federal regulations governing long-term care in-order to ensure the highest level of care is provided to each resident.Review of the facility-provided Director of Nursing (DON) job description indicated the DON, Manages and directx resident care within the nursing department in-order to maintain standards of resident care and ensure each resident functions at his/her highest level.Based on findings identified in this report, the facility failed to prevent the failed protect residents from exiting the facility unsupervised. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed.During an interview on 6/30/26, at approximately 3:45 p.m. the NHA and DON confirmed that facility administration failed to effectively manage the facility to protect residents from elopement. This failure resulted in a resident exiting the building unsupervised (Resident R1). This failure created an Immediate Jeopardy situation for one of 29 cognitively impaired residents. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.