STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395784	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Letort Spring Nursing and Rehab LLC	801 N. Hanover Street Carlisle, PA 17013

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 - Some	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 clinical record review, observations, facility document review, staff interviews, and facility policy review, it was determined that the facility displayed past non-compliance by failing to implement interventions, supervision, and effective safety measures to prevent elopement of a resident identified as being at risk for elopement and exhibiting exit seeking behaviors (Resident 1). Resident 1 was found approximately one half mile from the facility approximately 17.5 hours following his elopement with injury to his forehead. This failure placed an additional 16 residents, who were identified as being at risk on their elopement risk evaluations, in an immediate jeopardy situation (Residents 2, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20). Findings include: Review of facility policy, titled Elopement, revised June 2023, read, in part; It is the policy of this facility to provide a safe and secure environment for our residents and to be proactive in preventing resident elopement. Residents at risk for elopement will be appropriately monitored to reduce the potential for injury . Residents that are identified at moderate or high risk for elopement will have an intervention implemented for their safety. Those residents identified as low risk will have an Interdisciplinary review to determine if intervention/s are necessary . Elopement risk will be care planned with individualized approaches to reduce the potential for elopement and/or to redirect the resident in the event that an elopement attempt is made . Electronic monitoring systems may be implemented as possible interventions as appropriate. Review of Resident 1's clinical record revealed diagnoses that included alcohol dependence with alcohol-induced persisting dementia (caused by long-term, excessive consumption of alcohol, resulting in neurological damage and impaired cognitive function) and Alzheimer's disease (progressive neurological disorder characterized by a gradual decline in memory, thinking, and behavior due to the build-up of proteins in the brain, leading to death of brain cells). Further review of Resident 1's clinical record revealed that he was admitted to the facility from the hospital on April 9, 2025. Review of hospital treatment notes dated March 31, 2025, through April 4, 2025, indicated that Resident 1 required a sitter as an elopement precaution while hospitalized . (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 1's elopement/wander risk evaluation completed on April 9, 2025, revealed a score of 11 (high risk) with suggested care plan intervention to provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Review of Resident 1's nursing progress notes revealed the following: April 9, 2025 15:20 - Resident pushing on exit doors, increasingly agitated, asking how the hell do I get out of here. Resident began banging on doorway to steps. Staff attempting to redirect with little effect. April 10, 2025 12:43 - Resident sitting in his winter coat, saying he needs to go get in his truck. Resident pushing on exit doors. April 16, 2025 09:47 - Actively exit seeking all morning. Staff provided redirecting, provided snack/drinks, 1:1 conversation, activity with no effect. Resident banging on doors. Resident asking how to leave to get to his truck. Resident increasingly agitated and becoming tired. April 16, 2025 11:26 - Stated he wanted to get out of here, cont.[continuing] to exit seek. Attempting redirection, taken to TV room for monitoring. April 19, 2025 12:48 - Pacing the unit all day. Frequently states he is looking for a way to get out so he can 'get to his truck.' April 20, 2025 11:33 - Resident Eloped on 4/19/25 - Search party continues at this time. Resident is not in facility. Review of facility incident report revealed that on April 19, 2025, at 9:25 PM, staff identified that Resident 1 was missing. A facility search was conducted and a resident count was completed at that time. After Resident 1 was not able to be located, 911 was called at 9:50 PM. Police arrived at 10:00 PM and began their investigation. At 10:15 PM, additional police personnel, [NAME], and K9 support arrived and continued the search. IT personnel arrived and pulled video from the facility lobby, which showed Resident 1 left the facility via the front doors at 6:33 PM. Around noon on April 20, 2025, fire police entered the building and informed staff that Resident 1 was located approximately one half mile from the facility attempting to get into a truck, and was being sent to the emergency department for evaluation and treatment of scratches on his head. Resident 1 returned to the facility from the emergency department at 5:47 PM. Further review of the incident report revealed that, upon investigation, it was determined that no alarms sounded nor did anything else bring Resident 1's exit to staff's attention. It was determined that Resident 1 likely exited the locked unit where he resided by following a visitor or staff person who had entered the exit code to the doors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of emergency department treatment notes dated April 20, 2025, revealed that Resident 1 was brought to the emergency department by Emergency Medical Services (EMS) and that he had superficial lacerations and abrasions to his forehead. It was noted that Resident 1 did not recall if or how he fell. Resident 1 was able to tell his name, but did not know where he was or the date. Resident 1 believed he lived at home with his wife. Additional review revealed that Resident 1 was treated for a 2 cm (centimeter) U-shaped laceration to the right forehead. During an interview with the Director of Nursing (DON) on April 23, 2025, at 11:35 AM, she revealed that after investigation they were not able to conclusively state how Resident 1 was able to exit the locked unit, but it's assumed that he followed, or was let out by, a visitor since he could have been easily mistaken for a visitor himself. The DON also revealed that until the incident, it had been the practice that family members and visitors knew and could independently enter the codes needed to exit the locked unit doors. Additionally, the DON revealed that the use of wanderguard monitors for residents residing on the locked unit was discontinued by the prior administration. During a later interview with the DON on April 23, 2025, at 11:55 AM, she confirmed that the front lobby doors were not locked from the inside. She also revealed that the lobby was not routinely monitored since the receptionist position is vacant, and administrative staff with offices in that area are not typically present after normal work hours. During an additional interview with the DON on April 24, 2025, at 9:15 AM, she confirmed that no staff were present in the offices nearest to the lobby when Resident 1 exited the building on April 19, 2025. She also revealed the expectation that Resident 1 would not have left the building unaccompanied. The facility is located on a main road. There are parking lots on each side of the front entrance, and a portico located at the main front entrance outside of the door that vehicles can drive through. Clinical record review for Residents 1, 2, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 revealed that they resided on the locked unit and scored greater than zero on their elopement risk evaluations. Per the aforementioned interview with the DON, wanderguards were not in use for residents residing on the locked unit. The facility failed to implement interventions, supervision, and effective safety measures to prevent elopement. The Nursing Home Administrator was provided the immediate jeopardy template on April 23, 2025, at 1:16 PM, and an immediate action plan was requested. On April 23, 2025, at 3:32 PM, the facility's immediate action plan was accepted, which included: 1) The facility completed a new resident elopement evaluation and updated Resident 1's care plan . Resident 1 was issued an electronic monitoring device. 2) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility completed new elopement evaluations on all current residents in house. Care plans were updated based on the risk score. Other residents identified at risk for elopement were issued an electronic monitoring device. 3) The egress time on the locked unit doors was reduced from 20 to 10 seconds. 4) The egress code was changed for the locked unit doors. 5) Additional signage was posted near the locked unit exits to remind visitors and staff not to allow residents to exit the unit unassisted. 6) Staff were educated on the current elopement policy, including the code changes and escorting all non-employees off the locked unit. 7) The DON or designee will audit new admission elopement scores to determine if appropriate interventions are in place. The audits will be reviewed at QAPI (Quality and Process Improvement) meetings. The Immediate Jeopardy was lifted on April 23, 2025, at 3:32 PM, after ensuring that the immediate action plan had been implemented. The facility demonstrated past non-compliance by initiating immediate interventions starting April 20, 2025, following the incident. Documents and actions provided by the facility to address the Immediate Jeopardy were reviewed on April 23, 2025, during the onsite survey and included: - A new elopement risk assessment was completed for Resident 1 on April 20, 2025. His care plan was updated and an electronic monitoring device was issued. Resident 1 was placed on 1:1 supervision during waking hours and 15 minute checks when sleeping. - An audit of all residents was completed on April 20, 2025 to identify those at risk for elopement. Electronic monitoring devices were issued to those residents determined to be at risk for elopement. Care plans were updated accordingly. - The code to the locked unit door was changed on April 21, 2025, and the escort time was shortened from 20 seconds to 10 seconds. - Staff were educated not to share the new codes with visitors and to assist them off of the unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Additional signage was placed at the locked unit doors to notify visitors and staff not to allow residents to exit the unit unassisted. - Staff were educated on the facility elopement policy. - An elopement drill was conducted on April 22, 2025. - Audits were initiated on April 21, 2025, and will be done daily on new admissions to determine if elopement risk is present and appropriate interventions are in place. During the onsite survey on April 23, 2025, no additonal concerns related to elopement were identified based on observations, clinical record review, interviews with staff, review of audits, and review of education provided to staff. 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)(3)(5) Nursing services