STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395795	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lafayette Manor, Inc	147 Lafayette Manor Road Uniontown, PA 15401

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** 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 five residents (Resident R1). This was identified as past non-compliance.Findings include: Review of the facility policy Elopement - Missing Resident dated 1/29/25, indicated the facility will provide a safe environment for all residents regardless of orientation status and to supervise those residents at risk for elopement. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, 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 intact8-12: moderately impaired0-7: severe impairment Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 5/29/24, included diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), unsteadiness on feet, muscle weakness, and Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior). Review of Section C: Cognitive Patterns indicated Resident R1 had severe cognitive impairment. Review of a progress note dated 1/6/26, at 6:01 p.m. indicated that Resident R1 was admitted to the facility. Review of a progress note dated 1/6/26, at 9:30 p.m. indicated, [Nurse Aide Employee E1] noticed that resident was not in her room. After checking resident's room for resident, she notified [Registered Nurse Employee E2], that resident was missing. When this RN asked resident what she was trying to do when she left the building, resident said when was that?'. I asked her if she remembered leaving the building she said no. Resident is alert with confusion, does not always follow commands. This RN notified all nursing staff on 1st and 2nd floors that resident had eloped and to do a thorough search of the facility, including kitchen, dining room, lobby, common areas, basement, parking lots. [Attached personal care home] notified of missing resident at [facility]. 911 called after resident not located after 15 minutes, PA (Pennsylvania) State Police notified. [Director of Nursing] notified of elopement, she notified [Nursing Home Administrator]. Resident was found at [Attached personal care home] in basement by time clock by [Personal Care Assistant Employee E3] at [personal care home] and [facility] was notified that resident had been found. Resident returned facility. Review of facility submitted information submitted 1/7/26, indicated that on 1/6/26, at 9:30 p.m. during routine rounds, staff became aware that the resident was not in her room. An immediate search was initiated. The resident was located at 2150 (9:50 p.m.) on the ground floor of the facility in the activities room. The resident was sitting in a chair. No behaviors noted. Staff immediately assessed resident for injuries where none was noted. Resident denied pain. Resident was transferred via wheelchair back to her room. We are unable to determine exact exit path. However, obvious exit route would be out the front doors into [attached personal care (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
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	home] and down elevator to lower level. Resident has no history of elopement/elopement attempts from home/previous facility/current facility. Review of an employee statement written by PCA Employee E3 dated 1/6/26, indicated, On 1-6-26 at 9:50 pm, I just started to walk in [Assisted Living Facility] to start work and I saw workers looking for someone who was missing. I went to clock in and found missing client sitting down by clock in the basement. I then took her upstairs and [facility] was notified that she was found. Review of an employee statement written by Nurse Aide Employee E1 dated 1/7/26, indicated, I went in to check on the resident I seen her about 20 minutes before I'd say around 9:10. I kept checking in on her because she kept getting up we all aides kept redirecting her back in her room. I went in her room around 9:30 to check on her and do her inventory sheet and she wasn't in her bed. I looked in the bathroom she wasn't in there I checked residents room she wasn't there I then yelled and said resident is missing I need help everyone then got up and started looking. I doubled checked gold hall then went to the basement checked the laundry room the fire exits where we keep supplies. I ran back upstairs to get my phone because its pitch dark outside. I checked the little rooms that was open went outside checked the back the rooms ran around the building went by the [other buildings on campus] was everywhere I could walk. I walked back up they said they found her in the basement. The RN had us do a head count. I did blue hall all 10 residents was accounted for and also my other 4 was accounted for after we found her. On 1/6/26, the facility initiated a plan of correction that included:-Immediate count of all facility residents.-Elopement assessment completed.-Application of a Wanderguard (security bracelet that alerts when an identified resident approaches a monitored door).-Update to Resident R1's baseline care plan.-Audit of all facility residents for elopement risk.-Update of elopement binders located at the front desk and the first and second floor nurses' stations.-Education for all licensed nursing staff on resident orientation to the facility, admission audit tool, and admission policy.-Education for all staff on the facility elopement policy and elopement prevention.-Ad hoc QAPI (Quality Assurance and Performance Improvement) meeting, with resolutions to purchase/install concave mirrors and complete audits.-Audits of admissions to be completed by Director of Nursing or designee five times per week for four weeks, to be reviewed at next QAPI meeting. Review of Resident R1's clinical record completed on 1/28/26, revealed the elopement assessment and care plan had been updated to include information on his elopement, risk for further elopement, and interventions. During four interviews on 1/28/26, licensed nurses confirmed they received education on resident orientation to the facility, admission audit tool, and admission policy. During eight interviews on 1/28/26, staff confirmed they received education on elopement prevention and procedures if an elopement occurs. During an interview on 1/28/26, at approximately 1:00 p.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 five 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 211.10(c)(d) Resident care policies. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.