

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395796	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Montgomeryville Skilled Nursing and Rehabilitati		STREET ADDRESS, CITY, STATE, ZIP CODE 640 Bethlehem Pike Montgomeryville, PA 18936	
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** Based on facility policy review, clinical record review, review of facility documentation, observation, and resident representative and staff interviews, it was determined that the facility failed to provide adequate interventions and supervision to prevent elopement (unauthorized departure from the facility) and failed to conduct a thorough investigation for one of 24 sampled residents (Resident 14). This failure resulted in an Immediate Jeopardy situation. Findings include: Review of the facility policy entitled, Elopement of Patients, last reviewed June 12, 2025, revealed that elopement was defined as any situation in which a patient leaves the premises or safe area without the facility's knowledge and supervision. The policy further stated that the nurse would document the elopement in the nurse's notes, which would include the date, time, place, notification, and other pertinent information. Clinical record review revealed that Resident 14 was admitted to the facility on [DATE], and had diagnoses that included dementia and hearing loss. According to the Minimum Data Set (MDS) assessment (a periodic evaluation of resident care needs), dated July 15, 2026, the resident had memory impairment, displayed wandering behavior, and could walk independently. An elopement assessment dated [DATE], revealed Resident 14 was at risk for elopement. Review of the care plan revealed the resident was at risk for elopement due to a history of attempted elopements at another facility. On July 13, 2026, a nurse documented that the resident's responsible party was concerned about the resident eloping. On July 13, 2026, the physician ordered staff to apply a wander guard (electronic monitoring device that alarms/locks doors when the wearer is in close proximity) to her left ankle. On July 15, 2026, a nurse documented that the resident eloped and was returned to the facility around 8:00 p.m. The nurse's note did not include time, place, notification, or any other pertinent information per facility policy. Review of facility documentation dated July 15, 2026, revealed that Resident 14, who resided on the second floor, exited through a stairwell door causing the alarm to sound (this is a fire door) at 6:30 p.m. At the bottom of the stairs, the exit door to the outside front parking lot was unlocked and unalarmed and the resident exited the facility without supervision. Staff did not respond to this alarm. In an interview on July 21, 2026, at 10:20 a.m., the Director of Nursing (DON) stated the resident was found 500 yards away from the facility by police and returned to the facility by ambulance at 8:30 p.m., two hours after Resident 14 exited the facility unsupervised. The DON also stated that the facility had no documentation or information from the police or ambulance regarding the exact location of where or how the resident was found. In a telephone interview on July 21, 2026, at 11:08 a.m., Resident 14's responsible party stated that the police department notified him that Resident 14 was found hitchhiking (after crossing a four lane highway) on a road over half a mile from the facility. Review of a police report dated July 15, 2026, revealed that officers responded to Bethlehem Pike (Route 309, a busy four lane highway) and [NAME] Road (an intersection over a half (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 - Few	mile away from the facility) at 7:11 p.m. Resident 14 was attempting to hitchhike with her thumb up and stated she was being kidnapped. The police report additionally stated that the facility did not contact emergency services until 7:25 p.m., one hour after she exited the facility and 15 minutes after she was observed on these main roads by a passerby. Observations on July 21, 2026, at 7:38 a.m., 8:02 a.m., 9:28 a.m., and 10:22 a.m., revealed the exit doors in the first floor dining room were unlocked, unalarmed, and unattended. At 8:02 a.m., the survey team was able to exit the doors and exit to the side parking lot through an unlocked gate, unnoticed. In an interview on July 21, 2026, at 10:22 a.m., the Administrator and Regional Nurse confirmed the secured exterior exit doors in the dining room were unlocked and unalarmed, and should have been locked and alarmed. The facility failed to provide adequate supervision and interventions to prevent Resident 14 from elopement, and failed to conduct a thorough and complete investigation to determine the circumstances and whereabouts of Resident 14 after the elopement. On July 21, 2026, at 11:35 a.m., the Administrator was notified that the failure to provide adequate supervision and interventions to prevent elopement constituted an Immediate Jeopardy situation at F689-J, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. The facility implemented the following corrective action plan: 1. Resident 14 was placed on one to one observation on July 15, 2026. 2. Resident 14's wander guard was reassessed on July 15, 2026. 3. Resident 14's elopement assessment was updated on July 15, 2026. 4. The facility elopement binder of at risk residents was updated by the DON on July 15, 2026. 5. All facility residents were reassessed for elopement risk on July 15 and 16, 2026. 6. Resident 14 was assessed by psychology services on July 17, 2026. 7. Exit doors were checked by maintenance for vulnerability on July 15 and 21, 2026. 8. Staff assigned to monitor the unlocked exit door starting on July 15, 2026 until repaired. Door repair was completed on July 21, 2026. 9. Elopement education for all staff began on July 15, 2026. 90 percent of staff completed with the remaining 10 percent to be educated prior to the start of their next shift. 10. The dining room exit door was staffed beginning on July 21, 2026, until the repair was completed on July 21, 2026. 11. Door code education began on July 21, 2026. Available staff were educated. All staff will be educated prior to the start of their next shift. 12. All doors with magnetic locks were checked by maintenance on July 21, 2026. 13. Audits of residents will be completed weekly to assess for elopement risk for four weeks, then monthly for two months. Residents will then be assessed quarterly. Audits will be reviewed at the Quality Assurance and Performance Improvement (QAPI) meeting. 14. The facility elopement binder of at risk residents will be updated weekly. 15. All facility wander guard systems, door alarms, and door key pads will be audited weekly. 16. All audits will be reviewed at the facility's QAPI meeting. The survey team validated that the Immediate Jeopardy was removed on July 21, 2026, at 4:30 p.m., through review of the facility training, observations of doors and equipment, and review of facility procedures following the facility's implementation of the corrective action plan for removal of the Immediate Jeopardy. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(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 facility job descriptions, clinical record review, review of facility documentation, observation, and staff interview it was determined that the Nursing Home Administrator (NHA) and Director of Nursing (DON) did not effectively manage the facility to ensure that adequate supervision and interventions were provided to prevent elopement for one of 10 sampled residents at risk for elopement. (Resident 14) In addition, the NHA and DON failed to ensure that a thorough and complete investigation was completed following an elopement. Findings include: Review of the NHA's job description revealed that the Administrator was responsible for planning and was accountable for all activities and departments of the facility to ensure proper health care services to residents, and was responsible for assuring that the facility operates in full compliance with Federal and State regulations. In addition, the Administrator would work in close collaboration with the Director of Nursing and Medical Director, and would develop appropriate measures to minimize the risk of adverse incidents to residents. Review of the DON's job description revealed that the Director of Nursing was responsible for providing leadership, direction, and administration of day-to-day operations associated with direct patient care activities, nursing practice, and clinical education and development, including continuous improvement of nursing services and staff to meet patients/residents and their families' needs and expectations. Clinical record review and facility documentation review revealed that Resident 14 eloped from the facility on July 15, 2026, through an unlocked and unalarmed exit door of the facility. Observations on July 21, 2026, from 8:02 a.m., through 10:22 a.m., revealed the exit door in the first floor dining room was not locked, alarmed, or monitored. The facility failed to ensure that exit doors were locked and alarmed to ensure residents did not elope from the facility. The facility also failed to provide accurate Medical Director information as needed. Review of the facility documentation dated July 15, 2026, related to Resident 14's elopement revealed that their documentation contained no information regarding who located Resident 14 or where she was located following the elopement. In an interview on July 22, 2026, at 11:45 a.m., the Director of Nursing stated that the facility did not request or obtain any information from the police department or ambulance company involved in locating and returning Resident 14 back to the facility. The facility failed to thoroughly investigate the elopement, and did not obtain details or reports from the police department and ambulance company who located the resident. The NHA and DON failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and regulations were followed. 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.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and staff interview, it was determined the facility failed to ensure that essential equipment was in safe operating condition for two of 12 secured exterior exit doors. Findings include: Review of the facility documentation dated July 15, 2026, revealed that Resident 14, who resided on the second floor, exited through a stairwell door causing the alarm to sound at approximately 6:30 p.m. At the bottom of the stairs, the exit door to the outside front parking lot was unlocked and unalarmed and the resident then exited the facility. Observations on July 21, 2026, at 7:38 a.m., 8:02 a.m., 9:28 a.m., and 10:22 a.m., revealed the exit doors in the first-floor dining room, that were not in working order, remained unlocked and unalarmed. In an interview on July 21, 2026, at 10:22 a.m., the Administrator confirmed the secured exterior exit doors were unlocked and unalarmed. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management.		