STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395845	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranberry Place	5 Saint Francis Way Cranberry Township, PA 16066

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care by failing to have physician orders, resident specific care plans, and correct complete assessments for wander guards (a bracelet that alarms when close to an exit door) for four of four residents (Resident R4, R5, R6, and R7), and failed to accurately transcribe a medication upon admission for one of three residents (Resident R8). Findings include: Review of the facility Wandering and Elopements dated 6/1/25, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the residents care plan will include strategies and interventions to maintain the resident's safety. Review of the facility Reconciliation of Medications on Admission dated 6/1/25, indicated the purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes, and dosages upon admission or readmission to the facility.Review of Resident R4's clinical record indicated the resident was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and dementia (a group of symptoms that affect memory, thinking and interferes with daily life). Resident R4's MDS assessment section C0200 BIMS score was a 12 indicating Resident R4 was moderately impaired. Review of Resident R4's Elopement Evaluation Form dated 3/4/25, 5/6/25, 6/25/25, and 8/10/25, indicated resident scored a 0, indicating resident was not at risk for elopement. Review of Resident R4's physician orders on 9/24/25, failed to list any wander guard orders. During an interview on 9/24/25, at 4:45 p.m. the Director of Nursing confirmed that Resident R4's physician orders failed to include any wander guard orders and confirmed the dates and scores of the Elopement Evaluations. Review of Resident R5's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], indicated diagnoses of high blood pressure, cerebral infarction, and epilepsy (disorder of the brain characterized by repeated seizures). Resident R5's MDS assessment section C0200 BIMS score was a 14 indicating Resident R5 was cognitively intact. Review of Resident R5's Elopement Evaluation Form dated 2/15/25 and 5/7/25, indicated resident scored a 3, indicating resident was at risk for elopement. Review of Resident R5's Elopement Evaluation Form dated 8/7/25, indicated resident scored a 0, indicating resident was not at risk for elopement. Review of Resident R5's physician orders dated 1/7/25, indicated resident is ordered a security guard. Check placement every shift. Resident R5 failed to have orders to check wander guard battery weekly. Review of Resident R5's care plan dated 1/7/25, indicated Risk for wandering/elopement identified. Interventions - failed to include check wander guard battery weekly. During an interview on 9/24/25, at 4:50 p.m. the DON confirmed that Resident R5's care plan failed to check wander guard battery weekly, physician orders failed to include check wander guard battery weekly, and confirmed the dates and scores of the Elopement Evaluations. Review of Resident R6's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of cerebral infarction, diabetes, and aphasia (language disorder that affects communication). Resident R6's MDS assessment section C0100 BIMS indicated a 0, indicating resident is rarely/never understood. Review of Resident R6's Elopement Evaluation Form dated 4/29/25, indicated resident scored a 1, indicating resident was at risk for elopement. Review of Resident R6's Elopement Evaluation Form dated 8/1/25, indicated resident scored a 0, indicating resident was not at risk for elopement. Review of Resident R6's physician orders dated 12/18/24, indicated resident is ordered a security bracelet. Check placement every shift. Check the function of security bracelet every night shift. During an interview on 9/24/25, at 4:55 p.m. the Director of Nursing confirmed the dates and scores of Elopement Evaluations. Review of Resident R7's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R7's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and anxiety. Resident R7's MDS assessment section C0200 BIMS score was a 9 indicating Resident R5 was moderately impaired. Review of Resident R7's Elopement Evaluation Form dated 6/4/25, indicated resident scored a 0, indicating resident was not at risk for elopement. Review of Resident R7's Elopement Evaluation Form dated 7/9/25, indicated resident scored a 4, indicating resident was at risk for elopement. Review of Resident R7's Elopement Evaluation Form dated 8/26/25, indicated resident scored a 0, indicating resident was not at risk for elopement. Review of Resident R7's physician orders dated 7/10/25

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 review of facility policy, clinical record reviews, and staff interview it was determined that the facility failed to provide adequate supervision to prevent elopement for one of five residents (Resident R1). Findings include: Review of the facility Wandering and Elopements dated 6/1/25, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the residents care plan will include strategies and interventions to maintain the resident's safety. During an interview on 9/24/25, at 10:30 a.m. the Director of Nursing stated that residents should have orders for a wander guard, check placement of wander guard every shift, and check wander guard battery weekly if they are deemed at risk for elopement. Elopement assessments should be completed at least quarterly. Review of Resident R1's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R1's MDS (minimum data set a periodic assessment of resident needs) dated 8/31/25, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). Resident R1's MDS assessment section C0200 Brief Interview for Mental Status (BIMS, a screening test that aids in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident R1's BIMS score was a 9 indicating Resident R1 was moderately impaired. Review of Resident R1's Elopement Evaluation Form dated 8/30/25, indicated resident scored a 0, indicating resident was not at risk for elopement. During a review of Resident R1's progress note dated 9/14/25, indicated the following: - Resident was outside in the parking lot sitting under the roof by a bench per front desk. She was in her wheelchair with her bag packed. The husband called the facility due to resident texting him. Resident came back in via wheelchair. Nurse Assistant (NA) was present with resident upon returning to unit. During a phone interview on 9/24/25, Receptionist Employee E1 stated that she received a phone call from Resident R1's husband stating she is out front waiting for him to pick her up and resident stated she was too weak to get back into building. I looked up and observed Resident R1 sitting out front with her bag packed and went out and brought her back into the building and notified nursing staff. During a review of facility provided documentation dated 9/14/25, indicated resident was assessed upon returning to the nursing unit. A new elopement assessment was completed. Resident R1 scored a 4, indicating resident was at risk for elopement. The physician was notified and a new order for a wander guard (a bracelet worn by residents that will alarm close to an exit door) was received. Wander guard placed on resident. Review of Resident R1's physician orders dated 9/15/25, indicated check wander guard placement every shift, and check wander guard battery weekly. Review of Resident R1's care plan dated 9/14/25, indicated Risk for wandering/elopement identified. Goal- The resident will not leave the facility unattended. Interventions-Clearly identify residents' room and bathroom, Engage in purposeful activity, and wander guard in place. During an interview on 9/24/25, at 4:30 p.m. the DON confirmed that Resident R1's care plan failed to have resident specific interventions to decrease the risk of elopement, failed to have a check wander guard placement daily, and failed to check wander guard battery weekly. During an interview on 9/24/25, at 4:35 p.m. the Nursing Home Administrator confirmed that the facility failed to provide adequate supervision to prevent elopement for one of five residents (Resident R1). 28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.18 (b)(1) Management28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services