STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395853	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crawford Care Center	20881 State Highway 198 Saegertown, PA 16433

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 review of facility policies, clinical records, facility documents, observations, and staff interview, it was determined that the facility failed to implement sufficient monitoring and supervision to prevent elopement (when a resident leaves a safe care setting without staff knowledge) and failed to adequately implement search procedures related to an elopement. This failure placed residents at the facility in an Immediate Jeopardy situation for one of one residents reviewed (Resident R1). Findings include: Review of facility policy entitled Elopements and Wandering Residents dated 1/22/26, indicated This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement., implementing interventions to reduce hazards and risk. and Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the residents care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. Resident R1's clinical record revealed an admission date of 5/11/26, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), delusional disorder (a mental health condition that includes delusions a false belief based on an incorrect interpretation of reality), and hypertension (high blood pressure). Review of Resident R1's admission records sent from the hospital indicated that Resident R1 was sent to the hospital due to increasing paranoid delusions [false beliefs that one is being threatened or harmed] in association with his/her dementia which has been a problem in the past. The hospital physician indicated that Resident R1 was admitted to the hospital for new onset of A-Fib (atrial fibrillation-irregular heartbeat) however the physician indicated that Resident R1 needed more supervision than what he/she was being provided at home due to his/her worsening dementia. Review of Resident R1's wandering risk assessment dated [DATE], indicated that he/she was a moderate risk for wandering. Review of Resident R1's plan of care revealed no plan of care for wandering/elopement. Review of Resident R1's progress notes revealed the following notes:admission progress note dated 5/11/26, indicating Resident R1 was alert and oriented on arrival but short time after arrival unable to relate info about him/herself. His/her level of orientation varied from moment to moment.Progress note dated 5/13/26, revealed Resident R1's Brief Interview for Mental Status (BIMs - a short cognitive screening tool to assess a person's orientation and short-term memory) score was a 9 (8-12 moderately impaired the person shows clear memory or thinking deficits and needs help with complex task).Progress note dated 5/13/26, at 1:59 p.m. indicated the Resident R1 was banging on the window trying to get through it. He/she was brought out in the hall in his/her wheelchair, and he/she was angry and yelling at staff that he/she was being held against his/her will.Progress note dated 5/14/26, at 10:00 a.m. indicated that Resident R1 was noted to be outside the building leaning against a tree waving at traffic at approximately 9:50 a.m. He/she was visibly confused and unstable while walking back to the building with staff. He/she was (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	saying help me, help me, I do not want to be here I want to go home. He/she was wearing pajama pants and a sweatshirt with non-skid socks and no shoes. Interview on 5/20/26, at 10:45 a.m. with Nursing Assistant (NA) Employee E1 revealed that he/she said On 5/14/26, I was giving a bed bath to another resident and heard an alarm going off. I thought it was a bathroom bell going off so I went out into the hall to check the alarm. I heard an alarm and seen a light blinking. I went down the hall and realized it was the exit door. I looked out the door and did not see anyone, so I went back to finish providing care. He/she also said, when I received report that morning, I was told that the resident was trying to climb out his/her window. Interview on 5/20/26, at 11:00 a.m. with Social Service Director revealed he/she was in the conference room on 5/14/26, getting ready for a 10:00 a.m. care plan meeting for Resident R1 when he/she saw a person outside leaning against a tree and waving at cars. The Director of Nursing (DON) and Social Service Director went outside and found Resident R1 leaning against a tree very close to the highway and assisted him/her back into the building. Interview on 5/20/26, at 1:00 p.m. with the DON revealed that on 5/14/26, around 10:00 a.m. he/she was in the conference room for a care plan meeting, and a person was seen outside. He/she and the Social Service Director went outside and found Resident R1 leaning against a tree waving at cars. He/she stated that when they got to Resident R1 that a state trooper pulled up to see if everything was alright. He/she then stated that they assisted Resident R1 back into the facility. The DON revealed that she was unaware of Resident R1 trying to climb out his/her window the night before. The DON confirmed that the resident left the facility without any staff knowledge. Interview on 5/20/26, at 3:25 p.m. with the Nursing Home Administrator (NHA) and Licensed Practical Nurse Assessment Coordinator revealed that the exit door alarm was never turned off until the Maintenance Director turned it off. They revealed that no other staff came outside to assist with Resident R1 until Resident R1 was on his/her way back into the facility. Interview on 5/20/26, at 3:50 p.m. with the Maintenance Director, revealed that the alarms on the exit doors have to be turned off by a key. He/she stated that the only staff that have access to the key to turn off the exit door alarms are the Nursing Supervisor and him/herself. The Maintenance Director further stated that after Resident R1 was brought back into the facility he/she went to ensure the door alarm was functioning. When they got to Resident R1's hall he/she could hear an alarm going off. He/she stated that they shut off the exit door alarm which was never shut off throughout the incident. Observation on 5/20/26, at 10:30 a.m. of the hall the exit door that was sounding on 5/14/26, revealed that the exit door was approximately 75 feet from the highway. Further observations revealed Resident R1 had walked approximately 500 feet from his/her hall exit door and crossed the parking lot to a tree which was approximately 10 feet from the highway. Observations on 5/20/26, at 11:00 a.m. with the Social Service Director revealed that the tree that Resident R1 was leaning against was approximately ten feet from the highway. Review of information submitted by the facility to the Department of Health revealed the elopement incident of 5/14/26, was not reported until 5/20/26. Review of elopement incident investigation dated 5/14/26, revealed the following information from three staff statements: The first statement from staff revealed Resident R1 was in his/her room refusing medication when he/she was last observed and staff were with another resident providing care when Resident R1 left the building. The second statement indicated that Resident R1 was sitting on his/her bed the last time he/she was seen. The third statement indicated that Resident R1 refused his/her medications and was sitting on their bed talking about wanting to go home. During an interview on 5/20/26, at 1:00 p.m. the DON confirmed that the Resident R1 left the facility without any staff knowledge on 5/14/26, and also confirmed that the facility failed to properly supervise Resident R1 and failed to respond appropriately related to the exit door alarm, by going outside of the facility and looking thoroughly. On 5/20/26, at 3:52 p.m. the NHA was made aware that Immediate Jeopardy existed for one of one residents in the facility and that a corrective action plan was required. The IJ template was provided to the NHA at that time. On 5/20/26, at 6:16 p.m. an acceptable corrective action plan was approved which included the following interventions:All Current staff will be immediately educated on properly and timely responding to door (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	alarms. Staff that are currently in the facility will immediately be educated on Elopement and Wandering Policies. Any employee not currently in the facility will be educated within 24 hours prior to them working or the next time they are scheduled to work in the facility if it is over 24 hours.All current residents not on the locked unit will immediately have a new elopement assessment completed.All new admissions will be assessed for the risk of Wandering and Elopement. Those at risk will either be moved to the locked unit or provided with a wander guard.The facilities Elopement binder will be updated immediately on every resident assessed as a risk resident for elopement with current informationAll resident care plans for residents at risk for elopement will be updatedThe Maintenance Supervisor and Maintenance Staff will be educated to ensure proper working conditions of the facility door alarms.The Maintenance Dept. will check all doors to ensure all doors with alarms are functioning properly and document their tests.The Maintenance Dept. will check all wander-guard devices to ensure they are in proper working order and functionalityThe facility will conduct an Elopement drill immediately after educating the current in-house staff to ensure staff's prompt responsiveness. The facility will conduct an AD HOC QAPI on 5/21/26. On 5/21/26, between 12:45 p.m. and 3:20 p.m. review of staff education, new elopement assessments, new admissions, elopement binder, resident care plans, door test documentation, wander-guard function, elopement drill, AD HOC QAPI, and staff interviews confirmed the facility implemented the above stated action plan. On 5/21/26, at 3:35 p.m. NHA and DON were informed that the Immediate Jeopardy had been lifted. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(c)(d)(1)(5)(3) Nursing services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of facility records and job descriptions, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to implement sufficient monitoring and supervision to prevent an elopement.Findings include: The job description for the NHA revealed that the NHA's purpose is to establish and maintain systems that are effective and efficient to operate the facility in a manner to safely meet resident needs in compliance with federal, state, and local requirements. The primary functions and responsibilities of the nursing home administrator include overseeing staff, personal, financial matters, medical care, medical supplies, and facilities. The job description for the DON revealed that the DON's primary purpose is to provide nursing management, set resident care standards for all direct care providers and provide complete supervision and management for the nursing department. The primary functions and responsibilities of the DON include setting resident care standards in accordance with acceptable current standards of care in order to provide the high quality care to residents, develop and implement policies, and supervise and manage all aspects of the nursing department. Based on the findings in this report that identified the facility failed to properly supervise a resident and failed to respond appropriately to an elopement, the NHA and the DON failed to fulfill their essential job duties 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)(3)(5) Nursing Services