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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>395882 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                           | (X3) DATE SURVEY COMPLETED<br><br>05/15/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Longwood at Oakmont |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>500 Route 909<br>Verona, PA 15147 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577</b></p> <p>Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision that resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of two residents (Resident R1).</p> <p>Findings include:</p> <p>Review of facility policy Elopement last reviewed 11/9/23, indicated staff shall investigate and report all cases of missing residents. When a departing individual returns to the facility, the Director of Nursing or Charge Nurse shall examine the resident for injuries, obtain vital signs, notify the attending physician, notify the resident's legal representative of the incident, and complete and file the report of the incident/accident, note length of time gone and outside temperature.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/14/24, indicated diagnoses of cerebral infarction (also known as an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain), muscle weakness, and dysphagia (condition with difficulty in swallowing food or liquid)</p> <p>Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions:</p> <p>13-15: cognitively intact</p> <p>8-12: moderately impaired</p> <p>0-7: severe impairment</p> <p>Review of Resident R1's MDS assessment dated [DATE], Section C0500-BIMS screening indicated a score of 13 revealing that Resident R1 was cognitively intact.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of Resident R1's plan of care, initiated 11/14/23, revised 1/31/24, indicated a focused risk for wandering/elopement was identified, goals for resident not to leave facility unattended and maintain safety, with interventions to clearly identify Resident's room and bathroom, identify if there is a certain time of day wandering/elopement attempts occur, and schedule time for regular walks/appropriate activity.</p> <p>Review of a progress note dated 4/26/24, at 11:19 p.m., stated At 7:08 p.m., this writer was called by RN Country side to report security informed him that the resident (R1) was in the Commons (Continuing Care Retirement Community campus main entrance) with security. Upon arrival to the security desk this writer noted resident was sitting in her wheel chair. It was reported that the resident was brought to security by a caregiver from Parkview (PC unit on campus). Initial assessment of resident, no visible injury and no c/o (complaint) pain. Resident safely returned to [NAME] health care center (SNF unit on campus). Upon arrival to the entrance to Countryside (SNF neighborhood) the resident started to have behaviors and stated 'You don't know how hard it was for me to escape from here.' Resident was returned to bed and full head to toe assessment completed by Countryside nurse, with no injury noted. Resident remained 1:1 the rest of the evening shift for safety and q (every) 15 minute checks while resident is sleeping tonight for continue safety. The DON, (physician), and resident's son made aware of elopement. Since returning to the neighborhood resident has been calm and cooperative with no behaviors and currently reported to be sleeping at current time.</p> <p>Review of facility provided incident report dated 4/27/24, at 12:24 a.m., stated Countryside nurse was approached by security on the neighborhood and was informed resident was in the Commons. At 7:08 p.m., this writer was called by (nurse) and made aware of resident's elopement. It was reported by security that a caregiver from Parkview brought resident to security.</p> <p>Review of facility provided witness statement dated 7:25 p.m., 4/26/24, Personal Care (PC) Employee E1 stated At approximately 6:50 p.m., I was walking to my car and I noticed what appeared to be a resident struggling to get on the curb. I offered to help her. I asked where she was going and she said over here, pointing to the Commons. I wheeled her to the Commons and asked security where she was supposed to be and who she was. They took over from there to get her where she was supposed to be. Resident was found in the employee parking lot headed to the front door in the Commons. She was found in the parking lot, trying to get her wheelchair on the sidewalk. Resident wheeling herself towards the main entrance door.</p> <p>Review of facility provided witness statement dated 4/26/25, Registered Nurse (RN) Supervisor Employee E2 stated I was working in Gardenside nurse's office for several hours admitting new resident, dealing with visitors, and resident's stopping at office many different times. At approximately 6:50 p.m., I was finishing admission. Do to the office setting I did not have a view of Gardenside hallway. At 7:08 p.m., I was called by RN Countryside and made aware of (Resident R1's) elopement.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of facility submitted event report dated 4/27/24, at 2:06 p.m., indicated that Resident R1 was observed outside approximately 6:40 p.m. across the street from her residence in [NAME] Healthcare by an employee working in Personal Care which is across the street from [NAME] Healthcare. The personal care employee indicated that the resident was attempting to get on the curb after having crossed the street. The personal care employee assisted the resident to the main desk at the Longwood campus where campus security was located. The nursing staff on the Countryside neighborhood where resident resides previously seen the resident at dinner and evening medicines at 6:00 p.m., and resident was heading back toward her room. Team members on the neighborhood saw resident go toward her room her room after dinner but did not actually see her go into her room. After dinner, team members were working with other residents and did not round on each resident within the 45 minutes when she was last seen. At the time of the elopement, team assumed incorrectly that the resident was in her room. Resident remembers leaving and said she was able to open the double doors to the neighborhood. The double doors open to another general hallway and not directly outdoors. The statements from the staff in Gardenside neighborhood indicated that no one saw resident pass through. Resident apparently turned the corner near the beauty shop hallway and exited that door and proceeded to cross the street. She (Resident R1) shared that she was familiar with the campus and didn ' t tell anyone she was leaving because I knew they would stop me.</p> <p>During an interview conducted on 5/15/24, at 2:15 p.m., Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to make certain each resident received adequate supervision that resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of two residents (Resident R1).</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p> |