STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395948	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center at Jefferson Hills, The	540 Coal Valley Road Jefferson Hills, PA 15025

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** 50158 Based on review of facility policy, 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 three residents (Resident R1). This failure created an immediate jeopardy situation for 1 of 42 residents. Review of the facility policy Resident Rights dated 12/20/24, indicated the facility will promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. Review of the clinical record revealed Resident R1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of the facility medical diagnosis list dated 4/28/25, included diagnoses of hemothorax (condition where blood collects in the space between the chest wall and lung), Atrial Fibrillation (condition where the upper chambers of the heart beat out of rhythm causing an irregular and rapid heart rate), hypertension (condition where the force of blood against the artery wall is too high), anxiety and depression. Review of an Elopement Risk Assessment completed on 4/29/25, indicated Resident R1 was cognitively impaired, had poor decision-making skills, demonstrated exit seeking behavior, and wandered oblivious to safety needs. Review of the physician's orders reviewed on 5/5/25, indicated Resident R1 was not ordered any interventions to prevent elopement. Review of Resident R1's plan of care dated 4/29/25, did not indicate risk for elopement nor did it have interventions to prevent elopement. Review of the Police report dated 5/1/25, by Police Officer E1 indicated that on 5/1/25, at 8:18 p.m., RN Supervisor (RNS) Employee E2 stated Resident R1 was placed in a recliner in the community room then later found in another resident's room. Resident R1 was then placed in a wheelchair and taken back to his room around 7:30 p.m. Further review of the police report indicated that Resident R1 was unsupervised from approximately 7:30 p.m. to 7:55 p.m., when the police arrived on site. (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	Further review of progress notes failed to indicate Resident R1 had any wandering behaviors documented as mentioned in the police report. Review of the facility provided incident report dated 5/1/25, at 8:00 p.m. indicated, Received a call from the 911 Center asking if we had a resident with this man's name. Answered that we did and told them last time I rounded he was sitting at the nursing station for visual rounding. Was told by the dispatcher that the police and EMS were out with a man of this name. They stated he was not hurt or injured; however he stated that he had to get away from someone wash trying to shoot at me. He was located at [address provided]. EMS took the resident to the hospital for an eval and treat. Spoke with [registered nurse] a the hospital in reference to resident baseline and medication list. Head count was immediately performed throughout the building and we found at that time the resident was indeed missing, and he was our resident Resident was last seen around 1930 hours (7:30 p.m.) when he was taken back to his room in his wheelchair. Call placed to the sister-in-law who was listed as his emergency contact. She was explained the situation, and she advised, I'm not surprised, I hate to say that; however, he has done this at every facility he has been in with the exception of one and that was following a surgery.' Spoke with nurse at [hospital] approx 2200 hours (10:00 p.m.), stating they were running some test, blood work, and a CT scan, he as acting his baseline. Hospital stated the were waiting on results of UA C&S and if those were clear they would be sending resident back to the facility. Information passed along to all involved in house. Waiting resident return at this time. Further review of the incindent report failed to include the time that EMS service contacted the facility. Review of a progress note dated for 5/1/25, at 11:05 p.m. indicated that the facility received a call from the 911 call center inquiring if Resident R1 was a resident of the facility. An immediate head count was completed, and it was confirmed that Resident R1 was not in the facility. The facility was made aware that Resident R1 was currently at the Emergency Department. The progress note indicated that Resident R1 was last seen by facility staff around 7:30 p.m. Also indicated that MD and family were made aware at that time. The time of the call from the 911 Call Center was not documented within the note. Review of an employee statement dated 5/1/25, at 10:08 p.m., by Nursing Aide (NA) Employee E3 indicated, On 5/1/25 I, [NA Employee E3], was working South Hall on the 3:00-11:00 [p.m.] shift. I last observed patient [Resident R1] sitting in the recliner in the lounge area of the unit around 7:10 p.m. At that time, I started a round on my assignment. When coming out of a patient's room after doing care, I was notified that he was found by the police at 7:50 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an employee statement dated 5/1/25, at 10:26 p.m., by NA Employee E4 indicated, Last time I remember seeing resident was around 19:15 [7:15 p.m.]. I remember leaving a resident's room after attending to a call light on the 200 hall. I witnessed two residents standing by the side double doors to the right of the nurse's station. I then directed the resident in question to sit down in the black recliner chair and continue to watch TV. After a few minutes of completing some small random task, I then went in room [ROOM NUMBER] around 7:20-7:30ish (new admit) to check on and prepare to bed completed full bed change, emptied cath [urinary catheter], changed clothes, and completed person inventory check list with resident. While with the new admit resident about 20 min[utes] in, the nursing supervisor walked down the hall asking us to count the residents. I advised I will do count soon as soon as I finish the inventory check list I was working on. The count (comment) did not sound or feel urgent or immediate. Few moments later approximately 20:00 [8:00 p.m.] I finished with [resident in room] 201 and that's when I was told that the resident in question was gone/ had left and was found by the police. I still then walk out the front door to still check and look. And I was told that it was confirmed that resident had been picked up by police. Review of RNS Employee E2's statement written on 5/1/25, at 10:45 p.m., by the Acting-Nursing Home Administrator (NHA) indicated, I was outside in my car when I saw the resident walk outside. He had told staff he wanted to go to the ER to visit a friend. Staff reported they offered him a ride and he refused and wanted to walk. Police called and stated they took him to the ER. He returned from the ER a few hours later. During a follow-up interview on 5/5/25, at 9:38 a.m. Acting-NHA and Director of Nursing (DON) indicated that RNS Employee E2 statement was proved to be inaccurate per video footage. Acting-NHA and DON stated that RNS Employee E2 left front desk, which then left the front door unsupervised and Resident R1 left through the front door. During an interview on 5/5/25, at 10:10 a.m., the Police Officer indicated that a passer-by saw Resident R1 with no shoes on and called the police. The Police Officer stated that facility never called the local precinct or 911 call center. The Police Officer found resident one street over (approximately four blocks) in residential back yard with no shoes on and no memory of how he arrived there. Resident R1 was taken to the Emergency Department by police. The Police Officer stated while Resident R1 was in the emergency room that a complaint was filed with The Department of Aging related to a bruise on his upper left arm that appeared to be older. The NHA and the DON were made aware that an Immediate Jeopardy situation existed on 5/5/25, at 1:39 p. m. and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at 2:00 p.m. On 5/5/25, at 7:29 p.m. an acceptable Corrective Action Plan was received which included the following interventions: 1. Immediate action(s) taken for the resident(s) found to have been affected include: -On 5/1/2025 at approximately 7:30 PM the facility was in formed a resident was taken by police to the local emergency room . -On 5/1/2025 a root cause analysis was completed, and it validated the resident walked out the front door because there was no one monitoring the lobby area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 5/1 2025 a head count was completed all residents were accounted for. -On 5/1/2025 resident returned from the hospital at approx. 10:30PM were re assessed, no skin issues, no negative outcomes, no issues noted. The residents put on q 30 min checks. -On 5/1 2025 all elopement books were audited, and no issues were found. -All residents will be reviewed and assessed for elopement risk, wondering, and care plans and orders reviewed to include appropriate interventions. completed -Head counts completed. 2. Identification of other residents having the potential to be affected was accomplished by: -All residents in house will be assessed for elopement risk by the Director of Nursing or designee by 5/2/25. -All care plans for residents identified with elopement risks will be reviewed and updated with elopement risks will be reviewed and updated with interventions to prevent elopement by the Director of Nursing or designee by 5/2/25. -All residents identified to be elopement risk will be added to Elopement Binder per protocol by 5/2/25. -House audit on all doors and exit points will be conducted by Maintenance to ensure that facility is secure and alarms are functional by 5/2/25. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: -Facility Director of Nursing or designee will conduct education to all facility staff regarding dementia/behavior in LTC residents, Elopement risk and mitigation, and Elopement Policy and Procedures to include keeping doors secure prior to the start of the next shift. -All staff will be educated on elopement interventions such as responding to alarms, reorient wandering patients, encourage activities, monitoring the front lobby and sign in sheet, and code 10 this is the facility overhead announcement code for an elopement and safety checks. Staff will be educated that all residents assessed as an elopement risk will have their picture and face sheet in the elopement book prior to the start of the next shift. -Elopement Books with identified resident photos will be placed on all nurses' stations in addition to the current one at the receptionist's desk by the Administrator or designee, which has been completed. - Newly admitted residents were screened for elopement risk on admission quarterly and as needed and care plans will be updated appropriately. New admission and any resident that is assessed as an elopement risk will be placed in the elopement book that includes photograph and face sheets. Book is available for staff to review and monitor 24 hours a day 7 days a week. (continued on next page)

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