STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396056	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William Penn Care Center	2020 Ader Road Jeannette, PA 15644

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 - Minimal harm or potential for actual harm 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 policy, facility documents, clinical record review, and staff interviews, it was determined that the facility failed to reassess an elopement risk and implement interventions to prevent elopement after displaying exit-seeking behaviors, and the facility failed to ensure proper supervision for a resident (Resident R1) resulting in an elopement for one of five residents reviewed (Resident R1). Findings include: Review of facility policy Elopements and Wandering Residents dated 1/6/26, indicated the facility will ensure that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of are a dressing the unique factors contributing to wandering or elopement risk. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification, and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions as necessary. 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 resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent elopements. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses of vascular dementia with mild behavior disturbance, adjustment disorder, and anxiety. Review of Resident R1's care plan dated 7/24/25, revised 12/3/25, indicated the resident is an elopement risk as evidence by disoriented to place, history of attempts to leave facility unattended, and impaired safety awareness due to vascular dementia. Interventions included to conduct welfare monitoring every 15 minutes, document wandering behavior and attempted diversional intervention in behavior log. It was indicated to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/2/26, indicated diagnoses were current. Review of Section C-Cognitive Patterns, revealed a Brief Interview for Mental Status should not be conducted because the resident is rarely/never understood. Review of Resident R1's elopement risk assessment dated [DATE], revealed the resident was at risk for elopement. It was indicated the resident's care plan was initiated/updated to reflect interventions. A review of Resident R1's care plan failed to include evidence it was updated. Review of Resident R1's progress note dated 6/11/26, revealed the resident attempted to exit the facility through the side door. Resident threw a cup of coffee at staff member. Redirection and reassurance was not effective. The Registered Nurse, physician, and family were notified of behaviors. Safety and comfort measures maintained, plan of care ongoing. The resident was provided with 2 milligram (mg) of Ativan. Review of Resident R1's clinical record revealed the facility failed to reassess resident for elopement risk and implement interventions to prevent resident from eloping after displaying exit-seeking behaviors. Review of Resident R1's progress note dated 6/19/26, revealed the resident was yelling, hitting and attempting to elope. Resident did make it out of the building was brought immediately back in by staff. Review of the Director of Nursing (DON) (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	witness statement dated 6/19/26, stated Resident R1 was last seen a few minutes prior to elopement. The resident was agitated because the DON was trying to educate her about going out the door. Resident R1 ripped the DON's [NAME] out. Review of Licensed Practical Nurse (LPN), Employee E1 witness statement dated 6/19/26, revealed the morning of the start of the shift, Resident R1 was yelling and trying to exit the unit. She was stopped and tried to redirect but resident became irate and hitting staff. After trying to intervene and bring resident back to nurses stations she sat there for a while before continuing. LPN, Employee E1 began passing medications and heard another staff member yell she's outside. At that time, I ran to where they were to find two staff members trying to push her back in while she was physically hitting and trying to bite them. LPN, Employee E1 pulled her wheelchair from behind to bring her back down the hall when she began trying to grab the LPN's arms and scratch them. The supervisor stayed with resident until family arrived. Review of Nurse Aide (NA), Employee E2 witness statement dated 6/19/26, revealed during breakfast meal tray pick up, Resident R1 was wandering up and down the hall. She got to the emergency door and made it outside down the small part of the sidewalk. NA, Employee E2 and two other aides and a therapist and both cart nurses came down the hall to help get the resident back in the building. The supervisor was also notified. Review of incidents submitted to the State field office on 6/19/26, revealed Resident R1 eloped out the door on the west unit around 8:30 a.m. The resident self-propels in wheelchair and is an assist of one/ She can also ambulate very short distances independently. The resident was in the hall ambulating in her wheelchair and managed to open emergency exit door and cross the threshold. She was observed sitting outside the door on the sidewalk by staff. The resident stated she was going to get her car to go home. Resident was brought back inside, and assessed. Resident did not suffer any injuries or make it beyond sidewalk outside of door. During a phone interview on 6/30/26, at 10:08 a.m. LPN, Employee E1 stated on 6/19/26, Resident R1 was irritable, irate, and verbally yelling at staff. It was indicated staff was able to get her to calm down a little with redirection, but she started back up. As LPN, Employee E1 began passing medications, it was indicated she was notified Resident R1 went out the doors. LPN, Employee E1 stated Resident R1 kept saying she needed to see her mom, thought there was a building in across the street from us. It was revealed Resident R1 wasn't outside long and never made it off the sidewalk. LPN, Employee E1 was asked how staff prevent residents from eloping and stated there are certain residents that are elopement risks, and staff must check on them every 15 minutes. During an interview on 6/30/26, at 10:29 a.m. NA, Employee E2 confirmed she was assigned Resident R1 on 6/19/26. When NA, Employee E2 came in that day, Resident R1 was a little agitated. NA, Employee E2 was feeding another resident in their room, and seen Resident R1 approaching the exit doors. NA, Employee E2 redirected the resident and took her to the nursing station. NA, Employee E2 stated she was unsure if the nurses were aware she was headed for the door and the resident continued to yell, hit, and kick. During an interview on 6/30/26, at 10:47 a.m. NA, Employee E3 stated most of the time Resident R1 is easily redirected. On 6/19/26, she was aggressive and yelling. As NA, Employee E3 was exiting out of a residents room, he threw his linens in the laundry and turned to throw trash away when he seen Resident R1 was outside. He immediately yelled to other staff Resident R1 was outside and went to retrieve resident. During an interview on 6/30/26, at 12:13 p.m. the DON and admission Director, Employee E4 stated elopement risk assessments are completed upon admission, quarterly, and with any exit seeking behavior. During an interview with the DON and Nursing Home Administrator (NHA) on 6/30/26, at 2:15 p.m. it was determined that the facility failed to reassess Resident R1's elopement risk and implement interventions to prevent elopement after displaying exit-seeking behaviors, and the facility failed to ensure proper supervision for a resident (Resident R1) resulting in an elopement. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing Services.