

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395671	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/02/2025
NAME OF PROVIDER OR SUPPLIER: SOUTHMONT OF PRESBYTERIAN SENIORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE: 835 SOUTH MAIN STREET WASHINGTON, PA 15301		
STATE LICENSE NUMBER: 422902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0689 SS=D	<p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0689	Past noncompliance: no plan of correction required.	<p>Completion Date: 01/13/2025</p> <p>Status: APPROVED</p> <p>Date: 01/21/2025</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0689 SS=D	Continued from page 1 Based on facility policy review, 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 four residents (Resident R1). This was identified as past non-compliance. Findings include: Review of the facility policy "Skilled Nursing - Elopement" dated 12/16/24, indicated "that those who have been diagnosed with dementia are at increased risk." Review of the clinical record revealed Resident R1 was originally admitted to the facility on 12/11/24. Review of the referral received from the hospital, dated 12/9/24, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).	F 0689		

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F 0689 SS=D	Continued from page 2 Review of an "Elopement Observation" assessment completed on 12/11/24, at 9:52 p.m. indicated Resident R1 was not at risk for elopement. Review of facility submitted information dated 12/13/24, indicated, "On 12/13/24 therapist brought Resident R1 back from therapy to the South Hall nurses' station on the 3rd floor. Shortly after staff heard her chair alarm sounding and began looking for Resident R1. The staff continued searching for about 10 minutes until our supportive housing apartments located on campus, called and said that she had walked over to their building. Resident R1 had her purse, coat and shoes with her. She said she was trying to catch the bus. Resident R1 was brought back to [the facility]. Vitals were taken and an assessment was completed all indicating that Resident R1 was "ok." A wander guard (electronic monitoring bracelet) was added to Resident R1, and she is being moved to the 5th floor so the doors to the lobby will not be as accessible. Resident R1 had an elopement score on admission of 0 (indicating not	F 0689		

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F 0689 SS=D	Continued from page 3 an elopement risk). Another elopement risk assessment will be completed." On 12/13/24, the facility initiated a plan of correction that included: -A second elopement risk assessment was completed. -A Wanderguard was placed on Resident R1. -Resident R1 ' s care plan was updated. -Elevator and front door Wanderguard alarms were rechecked for functionality. -Reeducation of staff on the elopement policy and upkeep of the elopement binders. -Monthly audits to be completed for three months to ensure at risk residents have proper Wanderguards, orders, care plans, and information placed in the elopement binder. -Results will be brought to QAPI (Quality Assurance and Performance Improvement committee) for review. Review of Resident R1's clinical record on 1/2/25, revealed the elopement assessment and care plan	F 0689		

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F 0689 SS=D	Continued from page 4 were updated to include information on her attempted elopement, risk for further elopement, and interventions. During four interviews on 1/2/25, staff confirmed they received education on elopement prevention and procedures if an elopement occurs. During an interview on 1/2/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide adequate supervision to prevent elopement for one of four residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 201.20(b)(1) Staff Development. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies.	F 0689		

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F 0689 SS=D	Continued from page 5 28 Pa. Code 211.11(d) Resident care plan. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.	F 0689			



Certified End Page

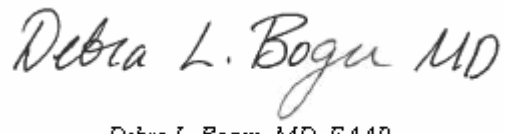
SOUTHMONT OF PRESBYTERIAN SENIORCARE

STATE LICENSE NUMBER: 422902

SURVEY EXIT DATE: 01/02/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY