

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395790</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/02/2024</b>
NAME OF PROVIDER OR SUPPLIER: <b>SENECA PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5360 SALTSBURG ROAD VERONA, PA 15147</b>		
STATE LICENSE NUMBER: <b>453302</b>				
(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	Based on an Abbreviated Survey in response to a complaint, completed on December 2, 2024, it was determined that Seneca Place was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0689		

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  483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices  §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  §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:	F 0689	1. The facility increased visual monitoring of Resident R1 and assigned staff to monitor for all residents including R1 usage of elevator during the times of reception employee vacancy. 2. All residents in the facility were reassessed for wandering and elopement risk. Resident care plans were reviewed and updated as needed. Security bracelet list was reviewed. 3. All facility staff are educated by Director of Nursing/Designee on elopement, security bracelet function, behaviors, and how to identify a resident exiting unaccompanied. 4. The Director of Nursing/designee will audit all residents with identified exit seeking behaviors for exit seeking behaviors relating to elevator use daily.	Completion Date: <b>12/09/2024</b> Status: <b>APPROVED</b> Date: <b>12/10/2024</b>

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F 0689  SS=D	Continued from page 2  Based on review of facility documents, facility policy, clinical records, facility tour, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision that resulted in an elopement (leaving an area without permission) for one of six residents (Resident R1).  Findings include:  Review of facility policy "Wandering and Elopements" last reviewed 5/18/24, indicated that the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.  Review of the clinical record revealed that Resident R1 was admitted to the facility on 9/27/23.  Review of Resident R1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 11/5/24, indicated diagnoses of high blood pressure,	F 0689		

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F 0689  SS=D	Continued from page 3  dementia (neuro-cognitive disorder impacting reasoning, judgment, and memory), and psychotic disorder (a mental disorder characterized by a disconnection from reality).  Review of clinical record revealed that on 5/13/24, Resident R1's care plan included a problem that Resident R1 was identified as an elopement risk/wanderer related to a history of attempts to leave facility unattended, and has impaired safety awareness.  Review of clinical record revealed that on 9/23/24, a physician's order was written for Resident R1 to receive a Security Bracelet (a device applied to the resident that alerts staff when they leave a safe area) underneath the wheelchair seat.  Review of the clinical record revealed a progress note dated 11/6/24, that Resident R1 "attempted to leave facility twice, becoming very combative and hostile towards staff both times. Began swinging at and scratching this writer when I attempted to keep	F 0689		

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F 0689  SS=D	Continued from page 4  her from getting on the elevator, began swearing loudly, stated she has no problem hitting anyone and that she would punch me in the head. A nurse aide came and convinced her to go to her room to "get a few things" hoping it would calm her down for a while".  Review of the clinical record revealed a progress note dated 11/24/24, that Resident R1 "brought back to the unit at 8:30 p.m. by nurse aide after being found in the parking lot in her wheelchair. Resident R1 with a Wanderguard (security bracelet) attached to her wheelchair due to the resident repetitively in the past removing it from her wrist and ankle. Incident reported to nurse supervisor. Resident in no distress. DON (Director of Nursing) notified of incident by nurse supervisor. DON wants resident to have a one to one (direct supervision) nurse aide assigned to her. Nurse aide assigned to watch resident as of 8:30 p.m. Medications given to resident and presently resting quietly in her wheelchair by the nurse aide near the nursing station. Will continue to monitor".	F 0689		

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F 0689  SS=D	Continued from page 5  Review of a facility document included a Camera Review of footage from the 11/24/24 elopement that stated the following: <ul style="list-style-type: none"> <li>· Third Floor Nurse's Station 8:02 p.m. Resident R1 heads toward the elevator from the East Hall.</li> <li>· Third Floor Nurse's Station 8:05 p.m. visitors with name tags head towards the elevator.</li> <li>· Lobby 8:06 p.m. Resident R1 enters the lobby.</li> <li>· Lobby Elevator 8:08 p.m. Visitors exit elevator and head towards the front door.</li> <li>· Lobby 8:09 p.m. Visitors attempt to exit lobby but could not as doors are locked after 8:00 p.m. Resident R1 observed in wheelchair directly behind visitors.</li> <li>· Lobby 8:11 p.m. Visitor leaves lobby and returns with Dietary Supervisor Employee E1 who used her identification badge to open the door to let them out. Dietary Supervisor Employee E1 returned to office prior to visitor/resident exit.</li> <li>· Lobby 8:12 p.m. Visitors get in their car</li> </ul>	F 0689		

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F 0689  SS=D	Continued from page 6  and pull away. · Lobby 8:13 p.m. Resident R1 crosses threshold and alarms activate. Door closes. Dining Services Servers (DSS) Employee E1 and E2 attempt to leave through front doors but are unable due to alarm activation. · Lobby 8:14 p.m. RN (Registered Nurse) Supervisor Employee E4 responds to lobby and attempts to reach Resident R1. · Ambulance Entrance 8:14 p.m. DSS Employees E3, E4, and E5 exit. · Ambulance Entrance 8:15 p.m. DSS Employee E5 reenters the building. RN Supervisor Employee E3 exits the building. · Lobby 8:16 p.m. Employee E6 responds to alarm in lobby. · Lobby 8:16 p.m. Employee E6 exits lobby toward the Dietary/Laundry Departments. · Ambulance Entrance 8:20 p.m. Nurse Aide (NA) Employee E6 and RN Employee E7 exit. · Ambulance Entrance 8:22 p.m. RN Supervisor Employee E3, NA employee E6, and	F 0689		

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F 0689  SS=D	Continued from page 7  RN Employee E7 enter the building with Resident R1.  Review of Dietary Supervisor Employee E1's written Witness Statement dated 11/25/24, at 1:50 p.m. indicated the following: "I was in my office and the visitor came and said that she couldn't get out. I went to the door with her and saw the car outside, so I swiped my badge (which allows the door open). I thought they were together because they were in a group at the door. I heard the alarm going off, but they all left together. The visitors never said that Resident R1 wasn't with them. The visitors started to leave so I turned around and went back to my office."  Review of DSS Employee E5's written Witness Statement dated 11/26/24, at 11:40 a.m. indicated the following: "I saw Resident R1 near the door when I went to clock out and there were a few people around her, so I didn't think anything was strange. I clocked out and the door wasn't working when I went to leave through the Main Entrance, so	F 0689		

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F 0689  SS=D	Continued from page 8  I went to the Side Door with DSS Employees E3 and E8. DSS Employee E3 and I looked over and saw Resident R1 outside in a green shirt and a wheelchair. I got worried at the point because it was cold, and I didn't know why she would be outside by herself. I asked her why she was outside, and she said she was looking for her daughter. DSS Employee E3 stayed outside when I went back in to get somebody. I found a nurse in the lobby because the alarm was going off and she came back outside with me, and I went home."  Review of NA Employee E9's written Witness Statement dated 11/26/24, at 3:15 p.m. indicated the following: "Resident R1 was up and in a pretty good mood. I gave her a bag of chips around 7:30 p.m.. I didn't see her until they brought her back up."  Review of NA Employee E10's written Witness Statement dated 11/26/24, at 3:35 p.m. indicated the following: " I was on break when everything went down. I came back from break and the door	F 0689		

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F 0689  SS=D	Continued from page 9  was locked. They had just gotten her back upstairs. I ended up being one on one with her for the rest of the shift."  During an interview on 12/2/24, 9:55 a.m. DON stated that Dietary Supervisor Employee E1 let the visitors out with her badge, and thought that Resident R1 was with them.  During an interview on 12/2/24, at 12:01 p.m. Maintenance Director (MD) Employee E11 was able to demonstrate how the Wanderguard system worked to prevent residents that were administered a Wanderguard from leaving the building. As MD Employee E11 approached the Front Entrance with a Wanderguard device, an alarm sounded when he was approximately six feet from the door which serves as a warning, and the doors locked. He continued walking towards the door and when he reached the doorway a louder alarm sounded which further alerts the staff that someone with a Wanderguard is attempting to leave the building. MD Employee E11 stated that the system is in	F 0689		

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F 0689  SS=D	<p>Continued from page 10</p> <p>proper working order per the demonstration, however when an identification badge is utilized to open the door, it overrides the system, and the doors can be opened.</p> <p>During an interview on 12/2/24 at 2:35 p.m. RN Employee E12 stated that all residents have a white wrist band to help identify them as a resident and the visitors wear name tags that are given to them when they sign in at the front desk.</p> <p>During an interview on 12/13/24, at 3:30 p.m. DON confirmed that the facility failed to identify Resident R1 as a resident of the facility when she was left out of the facility by staff, therefore failed to provide adequate supervision which resulted in an elopement for Resident R1.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>	F 0689		

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H 0009	51.3 (g)(1-14) NOTIFICATION  51.3 Notification  (g) For purposes of subsections (e) and (f), events which seriously compromise quality assurance and patient safety include, but not limited to the following: (1) Deaths due to injuries, suicide or unusual circumstances. (2) Deaths due to malnutrition, dehydration or sepsis. (3) Deaths or serious injuries due to a medication error. (4) Elopements. (5) Transfers to a hospital as a result of injuries or accidents. (6) Complaints of patient abuse, whether or not confirmed by the facility. (7) Rape. (8) Surgery performed on the wrong patient or on the wrong body part. (9) Hemolytic transfusion reaction. (10) Infant abduction or infant discharged to the wrong family. (11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence. (12) Notification of termination of any services vital to continued safe operation of the facility or the	H 0009	1. Facility notified the local state agency of the reportable event for Resident R1 on December 5, 2024 after recommendation by local state survey. 2. The Director of Nursing will be educated by Regional Director of Clinical Support on timely event reporting. 3. The Director of Nursing/designee will audit all events for reporting criteria daily for 2 weeks during morning meetings, weekly for 2 weeks, and monthly for 2 months. Audit results will be reviewed at monthly QAPI meetings.	Completion Date: <b>12/09/2024</b> Status: <b>APPROVED</b> Date: <b>12/10/2024</b>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

Pennsylvania Department of Health

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H 0009	Continued from page 1  health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange of telephone service. (13) Unlicensed practice of a regulated profession. (14) Receipt of a strike notice.  This REGULATION is not met as evidenced by:	H 0009		

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H 0009	Continued from page 2  Based on review of clinical records, review of facility provided documents and staff interviews, it was determined that the facility failed to notify the local State Agency of a reportable event in a timely manner for one of six residents (Resident R1).  Findings include:  Review of Resident R1 admission record indicated that she was admitted to facility 9/27/23, with diagnoses that included degeneration of nervous system due to alcohol, diabetes mellitus (endocrine disease characterized by sustained high blood sugar levels), and epilepsy (a brain condition that cause recurring seizures).  Review of Resident R1's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 11/5/24, indicated that the diagnoses remain current.  Review of Resident R1's progress note dated 11/24/24, indicated that Resident R1 was brought	H 0009		

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H 0009	Continued from page 3  back to unit at 8:30 p.m., by Nurse Aide, after being found in the parking lot in her wheelchair.  Review of reports submitted to the local State field office from 11/24/24 to 12/2/24, did not include a notification to the State Agency field office related to the elopement event by Resident R1.  During an interview on 12/2/24, at 2:45 p.m., the Director of Nursing confirmed that Resident R1 eloped out lobby front doors to the parking lot, and that the facility failed to notify the local State Agency of a reportable event in a timely manner.	H 0009		



# Certified End Page

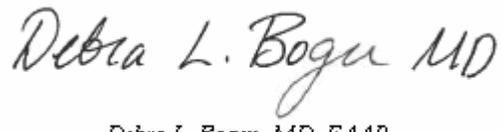
**SENECA PLACE**

**STATE LICENSE NUMBER: 453302**

**SURVEY EXIT DATE: 12/02/2024**

**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