STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395674	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uniontown Nursing and Rehab	129 Franklin Avenue Uniontown, PA 15401

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49646 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 for one of 4 residents (Resident R76). Findings include: Review of facility policy Wandering and Elopements last reviewed September 13, 2023, indicated 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. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain resident's safety. A complete elopement risk assessment will be completed on admission, readmission, quarterly, and with significant change. If identified as an elopement risk, the facility will utilize a Wanderguard (a monitoring device worn on the wrist or ankle that alerts staff when the resident leaves a safe area). Review of clinical record indicated Resident R76 was admitted to the facility on [DATE], with diagnoses that included vascular dementia (brain damage caused my multiple strokes, causes memory loss), diabetes (too much blood sugar in the blood), and high blood pressure. A review of the MDS dated [DATE], indicated that the above diagnoses remain current. Review of clinical record indicated that Resident R76 had an Elopement Evaluation completed on admission, quarterly, and annually, which the last two placed resident to be at risk for elopement. The most recent Elopement Evaluation was completed on 6/24/24, and interventions included, but are not limited to the following: Wanderguard, alarm bracelets checked every shift, weekly maintenance checks on system, and staff aware of the resident's wander risk. Review of facility documents indicated that Resident R76 was found to be outside of the facility at approximately 6:15 a.m. by the Registered Nurse Employee E1, who had stepped in the hallway and was able to see outside on sidewalk outside of main entrance doors. A review of facility documents also revealed that staff members had just assisted Resident R76 with morning care and got her into her wheelchair, she then self-propelled around the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Nursing Home Administrator (NHA), on 8/7/24, at 10:44 a.m., it was revealed that there are seven exit doors consisting of five units, dining area and front entrance which are equipped with a Wanderguard alarm system to detect the Wanderguard bracelets. All doors are equipped with a keypad that must have a code entered into them to allow the door to open after an alarm is triggered. During an interview with Employees E2 and E3 on 8/7/24, at 12:22 p.m. and 12:24 p.m., it was confirmed that Registered Nurse Employee E1 found Resident R76 outside. When Resident R76 was approached she stated that she just wanted to go outside, then she just wanted to go home, and then wanting to go to Korea. Registered Nurse Employee E1 redirected the resident back into the facility where it was discovered that her Wanderguard was not working and a new one was placed on her left ankle. During the interviews with Employees E2 and E3 they both stated that the Wanderguard's are checked every shift for placement and to see if they are blinking, they are checked for activation every week by maintenance with a wand. During an interview on 8/7/24, at 12:15 p.m. Nurse Aid (NA) Employee E4 stated the NAs do not apply or check the wanderguard for the residents. During an interview on 8/7/24, at 12:22 p.m. Licensed Practical Nurse (LPN) Employee E5 stated when they check the wanderguard on residents they check to make sure the light is on. Maintenance has something that they use to check the alarms, but stated nursing only checks to make sure the wanderguard is in place and has a light on, indicating the unit is functional. During an interview on 8/7/24, at 12:24 p.m. Registered Nurse (RN) Employee E6 stated the wanderguard's are checked each shift for placement and flashing light. Maintenance is responsible for doing weekly checks, but they were unsure what that process involved. During an interview on 8/7/24, at 1:10 p.m. the NHA confirmed that the facility failed ensure the wanderguard system was working correctly for Resident R76. 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.