

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Hospitality Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 North Monroe Drive Xenia, OH 45385	
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** 42492 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on review of the medical record, review of a facility self-reported incident (SRI), observations, resident and staff interviews, and policy review, the facility failed to provide supervision and intervention to prevent Resident #31, who had impaired cognition, was at risk for elopement and resided on a secured behavioral unit, from leaving the facility unsupervised. This resulted in Immediate Jeopardy when one resident (Resident #31) was placed at potential risk for serious life-threatening harm and/or injury when the resident eloped from his bedroom window without staff knowledge and was found 2.6 miles from the facility pushing a shopping cart in a shopping center parking lot. This affected one (#31) of five residents reviewed for risk for elopement. The facility identified a total of 11 residents who were at risk for elopement. The facility census was 45. On 06/20/24 at 2:01 P.M., the Administrator, Director of Nursing (DON), Regional Registered Nurse (RRN) #20, and Regional Director of Operations (RDO) #25 were notified Immediate Jeopardy began on 06/04/24 at approximately 4:14 A.M. when Laboratory (Lab) Technician #09 reported to Licensed Practical Nurse (LPN) #154 that she was unable to locate Resident #31 in his room to draw his blood for labs. LPN #154 accompanied Lab Technician #09 to Resident #31's room and discovered the bedroom window was open and both the screen and the resident were missing. Staff on duty searched the building and the building perimeter and discovered Resident #31 was missing from the facility. Staff contacted the DON on 06/04/24 at 4:54 A.M. and the DON contacted the police at 5:07 A.M. Police located Resident #31 on 06/04/24 at 12:49 P.M. approximately 2.6 miles from the facility pushing a shopping cart in a shopping center parking lot. Resident #31 was sent to the hospital via emergency medical services (EMS) for evaluation before returning to the facility on [DATE] at approximately 3:50 P.M. with no injuries. Upon returning to the facility, Resident #31 was placed on one-on-one supervision and voiced concerns thought someone was trying to kill him and he stated he was trying to return home to Columbus, Ohio. The Immediate Jeopardy was removed on 06/04/24 when the resident returned to the facility and was placed on one-on-one supervision and all resident windows were secured with special hardware to ensure they were not able to be opened greater than six inches. The deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until the deficiency was corrected on 06/11/24, when the facility implemented the following corrective actions: (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	On 06/04/24 at approximately 4:14 A.M., LPN #154 identified Resident #31 was not in his room and the facility began searching for the resident. On 06/04/24 at 12:49 P.M., police located Resident #31 at a local shopping center parking lot. Resident #31 was transferred to the hospital for evaluation. Upon returning to the facility on [DATE] at approximately 3:50 P.M., Resident #31 was placed on one-on-one supervision. On 06/04/24, maintenance staff completed audits of all doors and windows for functionality and security. All resident windows were secured with special hardware to ensure they were not able to be opened greater than six inches. On 06/04/24, the DON assessed all residents for elopement risk and care plans were revised as indicated. There were no concerns identified regarding elopements. On 06/04/24, the Administrator educated all maintenance staff regarding door and window security. On 06/04/24, the DON/designee educated all current staff in person about policies and procedures related to elopement, missing residents, supervision of residents, and abuse/neglect. Assistant Director of Nursing (ADON) #85 and Human Resources (HR) #92 assisted in educating all remaining staff via telephone. The education was completed on 06/04/24. On 06/05/24 at 5:00 A.M. and again at 8:00 A.M., the Administrator/designee conducted elopement drills with staff scheduled to work on night shift on 06/04/24 and staff scheduled to work dayshift on 06/05/24. On 06/05/24, the facility-initiated audits of all windows to be performed by maintenance personnel. All windows on the B-Unit were audited five times a week for one week, and a minimum of five windows on the A-unit five times a week for one week. All variances will be corrected upon discovery and education/follow-up will be provided as deemed necessary. Further continued ongoing compliance will be further maintained through audits as dictated by the facility quality assurance committee. On 06/07/24, the facility-initiated audits of exit doors to be performed by maintenance personnel three times a week for one week. All variances will be corrected upon discovery and education/follow-up will be provided as deemed necessary. Further continued ongoing compliance will be further maintained through audits as dictated by the facility quality assurance committee. On 06/07/24, the facility held a Quality Assessment and Performance Improvement (QAPI) meeting with the Administrator, DON, Medical Director, and RRN #20 to review the elopement investigation and approve the plan of correction. All protocols were followed and there were no issues noted. On 06/11/24, the facility held a QAPI meeting with the Administrator, DON, Medical Director, ADON #85, ADON #94, and RRN #20. Elopement audits were reviewed, and there were no new issues identified. On 06/20/24 from 3:00 P.M. to 3:55 P.M., interviews with Scheduler #110, LPN #153, STNA #133, STNA #121, and Human Resources #93 confirmed they received education after Resident #31's elopement on 06/04/24 regarding policies for elopement, missing resident, supervision, and abuse. The staff were knowledgeable regarding the training. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Review of the medical record for Resident #31 revealed the resident was originally admitted to the facility on [DATE] and recently readmitted on [DATE]. Diagnoses included unspecified hypothyroidism, type II diabetes, unspecified schizophrenia, unspecified psychosis, unspecified extrapyramidal and movement disorder, and schizoaffective disorder bipolar type. Review of the care plan dated 01/12/24 revealed Resident #31 resided on a secured unit related to schizoaffective disorder and was at risk for elopement. Interventions included quarterly assessments related to secured unit placement, provide diversional activities, allow resident to express feelings related to being on a secured unit, and refer to psychiatric services as needed. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of eight out of 15 indicating the resident had moderate cognitive impairment. Resident #31 had self-directed behaviors, occasionally rejected care, and did not wander. Resident #31 was independent with activities of daily living (ADL's) and required staff supervision and setup assistance as needed. Review of the Admission Skilled Unit Assessment completed on 01/12/24 revealed Resident #31 had history of psychiatric hospitalization with recent medication adjustments to stabilize psychiatric conditions. Review of the medical record revealed Resident #31 was screened for elopement risk on 01/12/24, 04/13/24, and 05/13/24 and scored a low risk for elopement. Review of the Quarterly Secured Unit assessment dated [DATE] revealed Resident #31 had a history of psychiatric hospitalization and received psychiatric services. Resident #31 had auditory and visual hallucinations, and occasionally displayed aggressive and combative behaviors towards other residents and staff. Resident #31 also expressed the belief that staff was trying to poison him. Resident #31 was at risk for elopement and did not want to live on a secured unit but was considered unsafe to live alone. Review of progress note dated 06/04/24 at 8:04 A.M. revealed Resident #31 was last observed on the unit on 06/03/24 between 9:00 P.M. and 10:00 P.M. Resident #31 wore a black short-sleeved T-shirt, and black sweatpants. The lab technician went to Resident #31's room to draw labs on 06/04/24 at 4:00 A.M. Resident #31's window was open, and the window screen was missing. Resident #31 was not in his room. The nurse and State tested Nursing Assistant (STNA) searched the unit, perimeter, and areas surrounding the facility and did not locate Resident #31. The nurse called the DON, police, Resident #31's guardian, and the physician. All other residents were accounted for in the facility. The DON collected witness statements. Review of progress note dated 06/04/24 at 1:22 P.M. revealed Resident #31 was located, and the physician, guardian, and family were notified. (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 SRI titled Neglect/Mistreatment revealed on 06/04/24 at approximately 4:20 A.M. a lab technician went to draw labs on Resident #31, and the resident was unable to be located. Staff searched the facility and grounds but were unable to locate Resident #31. The physician, guardian, and local police were notified. Staff continued to search the community. Witness statements from staff revealed Resident #31 was at his baseline behavior and was last seen on 06/03/24 around 10:00 P.M. in the hallway wearing black pants, black shoes, and a black T-shirt. Police located Resident 31 on 06/04/24 at around 12:10 P.M. Staff responded to the location, and EMS were on scene transporting Resident #31 to the local hospital for evaluation where the resident was found to be without injury. Upon return to the facility, Resident #31 was assessed and was noted to be at baseline with delusions. Resident #31 was placed on one-on-one supervision. Upon interview, Resident #31 stated he had crawled out the window and was searching for his home. The facility assessed Resident #31 for elopement risk and updated his care plan. During an interview on 06/17/24 at 9:25 A.M., the Administrator stated Resident #31 went out his window in the middle of the night sometime on 06/03/24 into 06/04/24. The Administrator confirmed Resident #31 resided on the facilities secured behavioral unit. The Administrator stated prior to the elopement, all resident windows could be opened completely. The Administrator confirmed Resident #31 was discovered missing on 06/04/24 around 5:00 A.M. The Administrator confirmed Resident #31 was located on 06/04/24 in the afternoon in a local shopping center parking lot near the local Bureau of Motor Vehicles (BMV). Police found Resident #31 with a shopping cart. The Administrator stated Resident #31 was transferred to the hospital for evaluation before returning to the facility. During an interview on 06/17/24 at 9:49 A.M., RRN #20 stated the facility had no suspicions before Resident #31's elopement. RRN #20 stated Resident #31 had made statements infrequently about wanting to visit his mother in Columbus, Ohio but it was unsure if his mother was still living. RRN #20 confirmed Resident #31 had schizophrenia and exhibited typical behaviors. RRN #20 stated Resident #31 was a loner who stayed in his room mostly and had no prior exit-seeking behaviors. RRN #20 stated when Resident #31 returned to the facility, he was responding to internal stimuli and was fixated on wanting to go back to Columbus, Ohio and also stated someone was trying to kill him. Resident #31 made statements that his family was crazy, and they were doing crazy things to his mom. RRN #20 stated Resident #31 was placed on one-on-one supervision for agitation and exit seeking upon return to the facility on [DATE]. During an interview on 06/17/24 at 1:53 P.M., Maintenance Director #93 confirmed prior to 06/04/24 all resident windows including resident windows in the secured behavioral unit could be opened completely and a resident could exit from a window if they desired. During an interview on 06/18/24 at 3:18 P.M., RRN #20 stated the facility did not have a policy for supervision; however, staff are expected to observe and supervise every resident for safety at a minimum of once every two to three hours. RRN #20 confirmed per witness statements staff had last visualized Resident #31 on 06/03/24 at approximately 10:00 P.M. and no staff observed the resident again before he was discovered missing on 06/04/24 at around 4:00 A.M. Observations on 06/20/24 at 8:26 A.M. revealed Resident #31 approached the medication cart and was dancing and giggling while talking to LPN #155. Resident #31 was observed dancing and singing to himself. Attempts to interview Resident #31 revealed he was not interviewable. (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 the facility policy titled Elopement: Missing Resident Policy and Procedure dated 01/01/2016 revealed residents were assessed to identify risk for elopement, and care plans were implemented as indicated. If a resident was found to be missing, the facility would take prompt action to locate the resident and bring them back to safety. This deficiency represents non-compliance investigated under Complaint Numbers OH00154874 and OH00154600.		