STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365065	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Pavilion Care Center	2171 Harrison Avenue Cincinnati, OH 45211

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on staff interviews and record review, the facility failed to allow residents who were cognitively intact and were their own persons, the ability to independently sign out of the facility. This affected four Residents (#16, #69, #100 and #400) of the four residents reviewed for resident rights. The facility identified 63 Residents (#02, #05, #06, #09, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #22, #23, #24, #26, #27, #28, #29, #30, #31, #33, #35, #37, #38, #39, #40, #41, #42, #43, #45, #48, #49, #50, #52, #53, #54, #55, #56, #57, #58, #60, #61, #62, #63, #65, #66, #67, #68, #69, #70, #71, #72, #73, #75, #76, #78, #79, #80 and #81) as being their own person without a guardian at the facility and was able to sign themselves out of the facility if desired. The facility census was 78. Findings include: 1) Review of Resident #16's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included ataxia following other cerebrovascular disease, insomnia, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic obstructive pulmonary disease (COPD), unspecified focal traumatic brain injury with loss of consciousness and hypertension. Resident #16 was recorded as his own responsible party. Review of Resident #16's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, was independent with eating and required moderate assistance for all other activities of daily living (ADLs). 2) Review of Resident #69's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included hypertensive heart disease with heart failure, hepatic encephalopathy, unspecified cirrhosis of liver, type two diabetes mellitus with diabetic neuropathy, cellulitis of left lower limb, cellulitis of right lower limb, and peripheral vascular disease. Resident #69 was his own responsible party. Review of Resident #69's admission MDS assessment dated [DATE], revealed Resident #69 was cognitively intact, and was independent with eating, required set up assistance or supervision with other ADLs. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #69's behavior agreement dated 02/08/25, revealed the resident was not following the recommendations of the Centers for Disease Control and Prevention (CDC) and increased the health risk of others by leaving the facility unnecessarily and then returning. Resident #69 was educated on the behavioral agreement and verbalized understanding of the risk he possessed to himself, and the others. Resident #69 had been offered assistance with finding another facility that would meet his needs. Resident #69 was allowed to continue residency at the facility under the following conditions: Resident #69 would remain in the facility unless medically necessary, Resident #69 would abide by the recommendations of the facility that were present and any changes of recommendations that were implemented by the facility or CDC. Resident #69 was aware that not following the behavioral contract and leaving the facility unnecessarily may result in an against medical advice (AMA) discharge. The behavior agreement indicated that if Resident #69 failed to follow the conditions, this could result in an automatic AMA discharge. Resident #69 refused to sign the behavior agreement. 3) Review of Resident #100's closed medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included hypertensive heart disease without heart failure, abnormal results of thyroid function studies, lymphedema not elsewhere classified, insomnia, alcohol abuse, anemia, hyperlipidemia, alcoholic cirrhosis of liver with ascites and gastro esophageal reflux disease with esophagitis with bleeding. Resident #100 discharged from the facility on 02/08/25. Resident #100 was his own responsible party. Review of Resident #100's behavioral care plan dated 07/18/22, revealed the resident had a behavior problem as evidenced by a history of signing out of the facility and consuming alcohol in the community. Interventions included discussing the resident's behavior if reasonable, intervene as necessary to provide the rights and safety of others, monitor behavior episodes and attempt to determine the underlying cause and minimize the potential for the resident's disruptive behaviors by offering tasks to divert attention. Review of Resident #100's behavior agreement dated 11/14/24, revealed the resident was not following the recommendations of the CDC and the resident increased the health risk of others by unnecessarily leaving the facility and then returning. Resident #100 was educated and the resident verbalized understanding of the risks he possessed to himself, and others. Resident #100 had been offered assistance with finding another facility that would meet his needs. The facility agreed to allow Resident #100 to continue residency in the facility under the following conditions: Resident #100 would remain in the facility unless medically necessary, Resident #100 would abide by the recommendations of the facility that were present and any changes of recommendations that have been implemented by the facility or CDC, and Resident #100 was aware of not following the contract and leaving the facility unnecessarily, may result in an AMA discharge. The behavior agreement stated failure to follow the conditions could result in an automatic AMA discharge. Resident #100 signed the behavior agreement along with the Administrator on 11/14/24. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #100's 30-day discharge notice dated 01/13/25, revealed Resident #100 was given a 30-day discharge notice with a discharge date of [DATE]. Resident #100's discharge notice stated Resident #100 was being discharged because Resident #100's needs could not be met by the facility and the safety of other individuals was endangered. Resident #100 was given a behavior contract on 11/14/24 for going out of the facility and coming back drunk and disorderly. On 01/10/25, Resident #100 broke the behavior contract as the resident did not sign out of the facility and then returned with a beer for himself and others then refused to give the contraband to the nursing staff at first. The appeal information and contact information for the Ombudsman were listed on the notice. The notice was signed by Resident #100, the Administrator and Registered Nurse (RN) #437 on 01/13/25. Review of Resident #100's quarterly MDS assessment dated [DATE], revealed the resident was cognitively intact. Resident #100 was independent or required supervision with ADLS. Review of Resident #100's care conference dated 01/30/25, revealed Resident #100 attended in person. Resident #100 was leaving in his wheelchair in a negative two-degree weather to go to the store and he went down a hill in his wheelchair. Resident #100 was given a 30-day discharge notice and was in the process of looking for another facility. Review of Resident #100's progress note written by Licensed Practical Nurse (LPN) #434 dated 02/08/25 at 5:10 P.M., revealed Resident #100 left the facility around 2:00 P.M. and did not notify the nurse he was leaving. Resident #100 returned to the facility at 1:00 P.M. Resident #100 was made aware that he could not reenter the facility due to his behavior contract and Resident #100 refused to sign AMA papers. Review of Resident #100's progress note dated 02/08/25 at 5:31 P.M. revealed LPN #434 notified the physician of Resident #100's discharge. Review of Resident #100's incomplete discharge summary dated 02/08/25, revealed the resident broke his behavior contract agreement by going out of the facility without signing out. Resident #100 was on a 30- day discharge notice for the same behavior and Resident #100's family was coming to pick up his belongings. Review of Resident #100's physician order dated 02/08/25, revealed Resident #100 discharged from the facility AMA. Review of Resident #100's undated AMA form revealed Resident #100 refused to sign the AMA form. The form was signed by LPN #434 and RN #437. 4) Review of Resident #400's closed medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included major depressive disorder, acquired absence of right leg below the knee, acquired absence of left leg below the knee, schizoaffective disorder and constipation. Resident #400 discharged from the facility on 02/10/25. Resident #400 was his own responsible party. Review of Resident #400's medical record from 11/08/24 to 02/12/25 revealed no documentation a discharge notice was given to Resident #400. Review of Resident #400's admission MDS assessment dated [DATE] revealed Resident #400 was cognitively intact, was independent with eating, and required maximal and moderate assistance with ADLs. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #400's behavior agreement dated 01/10/25, revealed Resident #400 was not following the recommendations of the CDC and the facility regarding signing out of the facility with the nursing staff. Resident #400 had verbalized understanding of the risk he possessed to himself, and others and Resident #400 had been offered assistance with finding another facility that would meet his needs. The facility agreed to allow Resident #400 to continue residency with the facility under the following conditions: Resident #400 would remain in the facility unless medically necessary, Resident #400 would abide by the recommendations of the facility that were present and any changes of recommendations that have been implemented by the facility or CDC, and Resident #400 was made aware that not following the contract and leaving the facility unnecessarily may result in an AMA discharge. The behavior agreement stated failure to follow the conditions could result in an automatic AMA, 30-day or immediate discharge from the facility. Resident #400 signed the behavior agreement. Interview with Licensed Practical Nurse (LPN) #435 on 02/11/25 at 8:44 A.M. revealed the residents were not allowed to sign out of the facility alone. LPN #435 stated the residents could only sign out of the facility with family or supervision. LPN #435 stated Resident #100 violated his behavior contract which stated he would not leave the facility. LPN #435 reported Resident #100 was discharged from the facility AMA on 02/08/25 because he went out of the facility against his behavior contract on that date. Interview with Resident #16 on 02/11/25 at 8:52 A.M., revealed the resident had resided at the facility for over four years, and he had previously been allowed to sign himself out of the facility to go to the store alone. Resident #16 stated the facility no longer allowed him to sign out or leave the facility unless he was with family. Interview with Resident #69 on 02/11/25 at 12:47 P.M., revealed the Administrator presented him with a behavioral contract because he went out of the facility with his family. Resident #69 reported the behavior contract stated he would not leave the facility, and he refused to sign the behavioral contract. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator by telephone, and Regional Director of Operations (RDO) #600 and the DON in person on 02/11/25 at 2:14 P.M. revealed residents in the facility were not allowed to leave the facility without supervision. The Administrator reported the facility was located in an area with a large amount of violence and it was not safe for the residents to sign themselves out and sit in front of the facility. The Administrator stated Resident #69 was given a behavior agreement after he left the facility with family at 1:30 A.M. The DON stated Resident #69 told the nurse he was leaving the facility, but the nurse told him that he could not go out of the facility because they needed a physician order. The Administrator, DON and RDO #600 confirmed the behavior agreement provided to Resident #69 on 02/08/25 stated he would not leave the facility unless medically necessary. The Administrator stated Resident #100 was constantly leaving the facility and they discussed with Resident #100 that he could not sign out without supervision or without physician orders. The Administrator verified a behavior agreement was completed with Resident #100 on 11/14/24 which stated Resident #100 would not leave the facility unless medically necessary. The Administrator stated Resident #100 continued to go out of the facility without signing out and without supervision and the facility issued Resident #100 a 30-day discharge notice on 01/13/25 because Resident #100 went out during the cold weather and brought other residents alcohol and cigarettes. The Administrator stated Resident #100 went out of the facility on 02/08/25 without supervision and without signing out and he was discharged AMA on 02/08/25 for violating his behavior agreement. The Administrator stated the staff told Resident #100 that they would pack up his stuff and Resident #100's sister came and got his stuff. The Administrator reported Resident #100 remained in the lobby until he was picked up by family or a bus, she couldn't remember which one. The Administrator stated that Resident #100 wanted to remain in the facility after he left without signing out of the facility. The Administrator stated he broke the behavior agreement so that's him basically saying he was going AMA. The Administrator stated Resident #400 had a behavioral agreement that was put in place on 01/10/25 which stated Resident #400 would remain in the facility unless medically necessary. The Administrator stated Resident #400 was also smoking marijuana in the facility and he was discharged from the facility because he was smoking marijuana. The Administrator stated Resident #400 was given an immediate discharge notice, but she could not recall the date. The Administrator confirmed Resident #400 discharged from the facility on 02/10/25 to another long-term care facility. Telephone interview with Resident #100's sister on 02/11/25 at 2:53 P.M. revealed the DON informed her that Resident #100 was discharged from the facility because he was leaving the facility without supervision. Resident #100's sister stated the facility had Resident #100 sign a behavior agreement that he would not leave the facility, and he left the facility against the agreement. Resident #100's sister reported Resident #100 was currently at the homeless shelter, but she was not sure who picked Resident #100 up from the facility on 02/08/25 to take him to the homeless shelter. Attempted to call Resident #100 on 02/11/25 at 2:57 P.M. with no response. This deficiency represents non-compliance investigated under Complaint Number OH00162483 and OH00160783.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on staff interview, record review, and review of discharge notices, the facility failed to permit a resident to remain in the facility and not transfer or discharge from the facility without the proper documentation regarding the need for discharge from the facility or the physician. This affected one Resident (#400) of the three residents reviewed for transfers. The facility also failed to allow a resident to remain in the facility for the duration of their discharge notice. This affected one Resident (#100) out of three residents reviewed for transfer or discharge. The facility census was 78. Findings include: 1) Review of Resident #400's closed medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included major depressive disorder, acquired absence of right leg below the knee, acquired absence of left leg below the knee, schizoaffective disorder and constipation. Resident #400 discharged from the facility on 02/10/25. Resident #400's census information revealed Resident #400 was his own responsible party. Review of Resident #400's medical record from 11/08/24 to 02/12/25, revealed no documentation a discharge notice was given to Resident #400. Review of Resident #400's admission MDS assessment dated [DATE] revealed Resident #400 was cognitively intact, was independent with eating, and required maximal and moderate assistance with activities of daily living (ADL)s. Review of Resident #400's behavior agreement dated 01/10/25, revealed Resident #400 was not following the recommendations of the Centers for Disease Control (CDC) and the facility regarding signing out of the facility with the nursing staff. Resident #400 had verbalized understanding of the risk he possessed to himself, and others and Resident #400 had been offered assistance with finding another facility that would meet his needs. The facility agreed to allow Resident #400 to continue residency with the facility under the following conditions: Resident #400 would remain in the facility unless medically necessary, Resident #400 would abide by the recommendations of the facility that were present and any changes of recommendations that have been implemented by the facility or CDC, and Resident #400 was made aware that not following the contract and leaving the facility unnecessarily may result in an against medical advice (AMA) discharge. The behavior agreement stated failure to follow the conditions could result in an automatic AMA, 30-day or immediate discharge from the facility. Resident #400 signed the behavior agreement. Review of Resident #400's progress note dated 02/10/25 at 1:57 P.M., revealed Resident #400 was discharged from the facility. (continued on next page)

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #400's incomplete discharge summary dated 02/10/25, revealed Resident #400 discharged to another long-term care facility and Resident #400 was fine with the discharge. Information regarding Resident #400's admitted , date of discharge, reason for admission, reason for the discharge, treatment provided, progress in the facility, nutritional information, and therapy services were missing from the discharge summary. Interview with the Administrator by telephone and Regional Director of Operations (RDO) #600 and the Director of Nursing (DON) in person on 02/11/25 at 2:14 P.M., revealed residents in the facility were not allowed to leave the facility without supervision. The Administrator reported the facility was located in an area with a large amount of violence and it was not safe for residents to sign themselves out and sit in front of the facility. The Administrator stated Resident #400 had a behavior agreement that was put in place on 01/10/25 which stated Resident #400 would remain in the facility unless medically necessary. The Administrator stated Resident #400 was also smoking marijuana in the facility and he was discharged from the facility because he was smoking marijuana. The Administrator stated Resident #400 was given an immediate discharge notice, but she could not recall the date. The Administrator verified Resident #400 discharged from the facility on 02/10/25 to another long-term care facility. Interview with the DON on 02/11/25 at 2:45 P.M., verified the facility did not have a copy of a discharge notice given to Resident #400 and there was no documentation in Resident #400's chart that Resident #400 was provided with a discharge notice. The DON stated Resident #400 had a discharge summary dated 02/10/25 that reported Resident #400 was fine with the discharge. The DON verified the discharge summary did not include information regarding Resident #400's admitted , date of discharge, reason for admission, reason for discharge, treatment provided, progress in the facility, nutritional information, and therapy services. 2) Review of Resident #100's closed medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses including hypertensive heart disease without heart failure, abnormal results of thyroid function studies, lymphedema not elsewhere classified, insomnia, alcohol abuse, anemia, hyperlipidemia, alcoholic cirrhosis of liver with ascites and gastro esophageal reflux disease with esophagitis with bleeding. Resident #100 discharged from the facility on 02/08/25. Resident #100's census information revealed Resident #100 was his own responsible party. Review of Resident #100's quarterly MDS assessment dated [DATE], revealed the resident was cognitively intact. Resident #100 was independent or required supervision with ADLS. supervision with showering. Review of Resident #100's discharge care plan dated 08/08/21, revealed Resident #100 expressed the wish to discharge home. Resident #100 was currently homeless but wished to apply to Medicaid waiver programs once eligible. Interventions included notifying the physician of discharge plans and needs, making referrals to community agencies, encourage the resident to be involved in discharge planning, and discuss the discharge planning process with the resident as requested. Review of Resident #100's behavioral care plan dated 07/18/22, revealed the resident had a behavior problem as evidenced by a history of signing out of the facility and consuming alcohol in the community. (continued on next page)

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #100's behavior agreement dated 11/14/24, revealed the resident was not following the recommendations of the CDC and the resident increased the health risk of others by unnecessarily leaving the facility and then returning. Resident #100 was educated and the resident verbalized understanding of the risks he possessed to himself, and others. Resident #100 had been offered assistance with finding another facility that would meet his needs. The facility agreed to allow Resident #100 to continue residency in the facility under the following conditions: Resident #100 would remain in the facility unless medically necessary, Resident #100 would abide by the recommendations of the facility that were present and any changes of recommendations that have been implemented by the facility or CDC, and Resident #100 was aware of not following the contract and leaving the facility unnecessarily, may result in an AMA discharge. The behavior agreement stated failure to follow the conditions could result in an automatic AMA discharge. Resident #100 signed the behavior agreement along with the Administrator on 11/14/24. Review of Resident #100's 30-day discharge notice dated 01/13/25, revealed Resident #100 was given a 30-day discharge notice with a discharge date of [DATE]. Resident #100's discharge notice stated Resident #100 was being discharged because Resident #100's needs could not be met by the facility and the safety of other individuals was endangered. Resident #100 was given a behavior contract on 11/14/24 for going out of the facility and coming back drunk and disorderly. On 01/10/25, Resident #100 broke the behavior contract as the resident did not sign out of the facility and then returned with a beer for himself and others then refused to give the contraband to the nursing staff at first. The appeal information and contact information for the Ombudsman were listed on the notice. The notice was signed by Resident #100, the Administrator and Registered Nurse (RN) #437 on 01/13/25. Review of Resident #100's care conference dated 01/30/25, revealed Resident #100 attended in person. Resident #100 was leaving in his wheelchair in a negative two-degree weather to go to the store and he went down a hill in his wheelchair. Resident #100 was given a 30-day discharge notice and was in the process of looking for another facility. Review of Resident #100's progress note written by Licensed Practical Nurse (LPN) #434 dated 02/08/25 at 5:10 P.M., revealed Pt left from the facility around 1400 Pt did not notify nurse that he was leaving PT returned to facility at 1300. Made Pt aware that he could not re-enter to the facility due to behavior contract Pt refused to sign AMA papers. Review of Resident #100's progress note dated 02/08/25 at 5:31 P.M., revealed LPN #434 notified the physician of Resident #100's discharge. Review of Resident #100's physician order dated 02/08/25, revealed Resident #100 discharged from the facility AMA. (continued on next page)

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #100's incomplete discharge summary dated 02/08/25, revealed Section B (Social Services) indicated the resident understood the discharge due to having a Brief Interview Mental Status (BIMS) of 15, indicating cognitively intact, was on a 30-day discharge and behavioral contract. The resident was discharged with family and sister called to pick up his belongings. There was no documentation about a follow physician appointment including name, address, phone and appointment time, no documentation about community resources offered, and if any special treatments were required. The Service Discharge Summary indicated the resident broke his behavior agreement by going out of the facility without signing out. Resident #100 was on a 30-day discharge notice for the same behavior and Resident #100's family was coming to pick up his belongings. The discharge summary had no documentation in the recapitulation of residents stay, dietary/nutrition, activities, Rehabilitiation services, discharge instructions/follow-up precautions and the resident and/or the resident representative signature. Review of Resident #100's undated AMA form, revealed Resident #100 refused to sign the AMA form. The form was signed by LPN #434 and RN #437. Interview with LPN #435 on 02/11/25 at 8:44 A.M., revealed residents were not allowed to sign out of the facility alone. LPN #435 stated that residents could only sign out of the facility with family or supervision and Resident #100 violated his behavior agreement that stated he would not leave the facility. LPN #435 reported Resident #100 was discharged from the facility AMA on 02/08/25 because he went out of the facility against his behavior agreement on that date. Interview with the Administrator by telephone and Regional Director of Operations (RDO) #600 and the Director of Nursing (DON) in person on 02/11/25 at 2:14 P.M., revealed residents in the facility were not allowed to leave the facility without supervision. The Administrator reported the facility was located in an area with a large amount of violence and it was not safe for residents to sign themselves out and sit in front of the facility. The Administrator stated Resident #100 was constantly leaving the facility and they discussed with Resident #100 that he could not sign out without supervision or without physician orders. The Administrator verified a behavior agreement was completed with Resident #100 on 11/14/24 that stated Resident #100 would not leave the facility unless medically necessary. The Administrator stated Resident #100 continued to go out of the facility without signing out and without supervision and the facility issued Resident #100 a 30-day discharge notice on 01/13/25 because Resident #100 went out during the cold weather and brought other residents alcohol and cigarettes. The Administrator stated Resident #100 went out of the facility on 02/08/25 without supervision and without signing out and he was discharged AMA on 02/08/25 for violating his behavior agreement. When Resident #100 returned to the facility, the Administrator stated staff told Resident #100 that they would pack up his stuff and was to remain in the lobby until he was picked up by family or a bus. The Administrator stated she was not sure how Resident #100 left the facility. The Administrator reported Resident #100's sister came and got his stuff. The Administrator stated that Resident #100 wanted to remain in the facility after he left the facility without signing out of the facility. The Administrator stated he broke the behavior agreement so that's him basically saying he was going AMA. (continued on next page)

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview with Resident #100's sister on 02/11/25 at 2:53 P.M., revealed the DON informed her that Resident #100 was discharged from the facility because he was leaving the facility without supervision. Resident #100's sister stated the facility had Resident #100 sign a behavior agreement that he would not leave the facility, and he left the facility against the agreement. Resident #100's sister reported Resident #100 was currently at the homeless shelter, but she was not sure who picked Resident #100 up from the facility on 02/08/25 to take him to the homeless shelter. Attempted to call Resident #100 on 02/11/25 at 2:57 P.M. with no response. Review of an electronic mail (email) note dated 02/12/25 at 1:35 P.M., from the Surveyor to the Administrator, DON and RDO #600, revealed the Surveyor asked the facility to clarify the times from the progress noted dated 02/08/25 at 5:10 P.M. when Resident #100 was recorded as leaving the facility at 2:00 P.M. and then returning at 1:00 P.M. Review of an email note dated 02/12/25 at 1:38 P.M., from the Administrator, revealed we are told he left multiple times that day. He didn't sign out for any of them so I really can't answer that sorry. Review of the policy titled Facility-Initiated Transfer or discharge date d October 2022 revealed residents have the right to remain in the facility once admitted in the facility. The residents and their representatives are given a 30 day advance written notice of an impending transfer or discharge from the facility. This deficiency represents non-compliance investigated under Complaint Number OH00162483 and OH00160783.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365065	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on staff interview and record review, the facility failed to ensure a resident's discharge summary included a recapitulation of the resident's stay. This affected one Resident (#400) out of three residents reviewed for transfer or discharge summaries. The facility census was 78. Findings include: Review of Resident #400's closed medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included major depressive disorder, acquired absence of right leg below the knee, acquired absence of left leg below the knee, schizoaffective disorder and constipation. Resident #400 discharged from the facility on 02/10/25. Resident #400's census information revealed Resident #400 was his own responsible party. Review of Resident #400's medical record from 11/08/24 to 02/12/25, revealed no documentation a discharge notice was given to Resident #400. Review of Resident #400's admission MDS assessment dated [DATE], revealed Resident #400 was cognitively intact, was independent with eating, and required maximal and moderate assistance with activities of daily living (ADL)s. Review of Resident #400's behavior agreement dated 01/10/25, revealed Resident #400 was not following the recommendations of the Centers for Disease Control (CDC) and the facility regarding signing out of the facility with the nursing staff. Resident #400 had verbalized understanding of the risk he possessed to himself, and others and Resident #400 had been offered assistance with finding another facility that would meet his needs. The facility agreed to allow Resident #400 to continue residency with the facility under the following conditions: Resident #400 would remain in the facility unless medically necessary, Resident #400 would abide by the recommendations of the facility that were present and any changes of recommendations that have been implemented by the facility or CDC, and Resident #400 was made aware that not following the contract and leaving the facility unnecessarily may result in an against medical advice (AMA) discharge. The behavior agreement stated failure to follow the conditions could result in an automatic AMA, 30-day or immediate discharge from the facility. Resident #400 signed the behavior agreement. Review of Resident #400's incomplete discharge summary dated 02/10/25, revealed Resident #400 discharged to another long-term care facility and Resident #400 was fine with the discharge. Information regarding Resident #400's admitted , date of discharge, reason for admission, reason for the discharge, treatment provided, progress in the facility, nutritional information, and therapy services were missing from the discharge summary. Review of Resident #400's progress note dated 02/10/25 at 1:57 P.M., revealed Resident #400 was discharged from the facility. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator by telephone and Regional Director of Operations (RDO) #600 and the Director of Nursing (DON) in person on 02/11/25 at 2:14 P.M., revealed residents in the facility were not allowed to leave the facility without supervision. The Administrator reported the facility was located in an area with a large amount of violence and it was not safe for residents to sign themselves out and sit in front of the facility. The Administrator stated Resident #400 had a behavior agreement that was put in place on 01/10/25 which stated Resident #400 would remain in the facility unless medically necessary. The Administrator stated Resident #400 was also smoking marijuana in the facility and he was discharged from the facility because he was smoking marijuana. The Administrator stated Resident #400 was given an immediate discharge notice, but she could not recall the date. The Administrator verified Resident #400 discharged from the facility on 02/10/25 to another long-term care facility. Interview with the DON on 02/11/25 at 2:45 P.M., verified the facility did not have a copy of a discharge notice given to Resident #400 and there was no documentation in Resident #400's chart that Resident #400 was provided with a discharge notice. The DON stated Resident #400 had a discharge summary dated 02/10/25 that reported Resident #400 was fine with the discharge. The DON verified the discharge summary did not include information regarding Resident #400's admitted , date of discharge, reason for admission, reason for discharge, treatment provided, progress in the facility, nutritional information, and therapy services. Review of the facility's undated discharge summary and plan policy revealed the discharge summary will include a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge. The discharge summary shall include a description of the resident's current diagnoses, medical history, course of illness, treatment, and therapy since entering the facility, current laboratory, radiology, consultation and diagnostic test results, physical and mental functional status, ability to perform activities of daily living, and nutritional status.