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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health Care	7600 S Ridge Rd Madison, OH 44057

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 - Minimal harm or potential for actual harm 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** 42733 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on interview, record review, local police report review, and policy and procedure review the facility failed to ensure appropriate supervision to prevent a resident from leaving the facility unattended without staff knowledge. This affected one (Resident #82) of three residents reviewed for elopement. The facility census was 95. Findings include: Review of Resident #82's medical records revealed an admitted [DATE]. Diagnoses included traumatic brain injury, cognitive communication deficit, impulse disorder and falls. Review of Resident #82's care plan dated 01/01/24 revealed Resident #82 required assistance with activities of daily living (ADL) related to cognitive impairments and traumatic brain injury and fluctuations could occur. Interventions included extensive assistance with some tasks including dressing, toileting and personal hygiene. Review of elopement assessment dated [DATE] revealed Resident #82 was at risk for elopement and had expressed desire to leave in the past. Review of Resident #82's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #82 had impaired cognition. Resident #82 had lower extremity impairment and used a walker and wheelchair for ambulation. Review of the progress note dated 01/24/24 timed 7:45 A.M. authored by Licensed Practical Nurse (LPN) #307 revealed a State tested Nursing Assistant (STNA) approached the nurses station with Resident #82's nasogastric (NG) tube, (tube inserted into the nose, down the throat and into the stomach for means of nutrition) in her hand and stated Resident #82 pulled the NG tube out. LPN #307 notified the physician and received orders to send Resident #82 to the hospital. Transportation was scheduled to arrive at 9:30 P.M. and Resident #82 was aware. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 01/24/24 timed 9:20 P.M. authored by Registered Nurse (RN) #341 revealed Resident #82 was last seen by staff at 9:00 P.M. when he was requesting to go outside to smoke. Staff educated Resident #82 he was to be picked up and transferred to an area hospital for replacement of his NG tube within the next thirty minutes. At approximately 9:20 P.M. a woman entered the facility and yelled for staff. The woman informed staff she was driving down the road in front of the facility and had observed a resident wearing a gown in a wheelchair going down the road in front of the facility. Staff initiated elopement procedures and emergency medical services (911) was called. During the 911 call, RN #341 was informed by police dispatch, the police were already in route to a house adjacent to the facility because the homeowners had called to report a man in a gown and wheelchair was at their doorway. Staff located Resident #82 at the residence around 9:25 P.M. and he was immediately returned to the facility and was assessed for injuries with none noted. Upon return to the facility a private ambulance company arrived to transport Resident #82 to the area hospital as previously scheduled for placement of a new NG tube. The Director of Nursing (DON) and Administrator were notified. Review of the progress note dated 01/25/24 timed 6:20 A.M. authored by RN #341 revealed Resident #82 returned from the hospital and was placed on 1:1 supervision. Review of the police report dated 01/24/24 timed 9:22 P.M. revealed an arrival time of 9:28 P.M. The report indicated a homeowner called to report a man wearing a gown from a nursing home knocking on her back door. At 9:29 P.M. nursing home staff was at the scene and took Resident #82 back to the facility at 9:33 P. M. Observation on 07/25/24 at 8:17 A.M. revealed Resident #82 in bed with his call light activated. An attempt to interview Resident #82, at time of observation, was unsuccessful; Resident #82 responded to all questions by laughing. At time of observation State tested Nursing Assistant (STNA) #271 entered and began assisting Resident #82 with care. STNA #271 stated Resident #82 required extensive assistance with care. Interview on 07/25/24 at 2:05 P.M. with the Administrator and Regional Administrator revealed they were aware Resident #82 had left the facility sometime in January 2024. The Administrator stated Resident #82 was his own responsible person and alert and oriented although his mentation fluctuated at times. The Administrator explained the police were called and Resident #82 was located at a home across the street from the facility. Resident #82 was immediately returned to the facility and was assessed for injuries with none noted. The facility initiated an investigation immediately and staff were educated on elopement policies and procedures. Resident #82 was returned to the secured unit, where he had been residing prior to his hospitalization on [DATE] and had not exhibited any exit seeking behavior. The Administrator stated the facility considered the event to be an unauthorized leave of absence (LOA). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/29/24 at 6:31 A.M. with RN #341 revealed Resident #82 returned from the hospital on 01/24/24 sometime between 6:30 P.M. and 7:00 P.M. RN #341 began her shift at 7:00 P.M. The previous nurse told RN #341 Resident #82 had pulled out his NG tube earlier in the day and he was to be sent to the hospital at approximately 9:30 P.M. to have the NG replaced. Resident #82 had asked RN #341 if he could go outside and smoke sometime before 9:00 P.M. and RN #341 told Resident #82 he was going to be taken to the hospital soon and therefore he could not go out to smoke. RN #341 last saw Resident #82 around 9:00 P.M. and at approximately 9:20 P.M. a woman entered the facility yelling for staff. RN #341 immediately responded to the woman who stated she had seen a resident outside in a gown and a wheelchair on the road in front of the facility. RN #341 immediately initiated a Dr. Walker, which was code for an elopement and the staff began a head count. RN #341 called 911 and while she was on the phone the dispatcher told her a call had come in from a homeowner indicating a man in a gown and wheelchair was at their door. Staff immediately left the facility and went to the home located across the street from the facility and identified Resident #82. Resident #82 could not provide RN #341 with any information as to why he had left the facility and apologized for leaving. RN #341 stated Resident #82 was returned to the facility by staff and she assessed him for injuries with none noted. RN #341 contacted the DON, physician and the Administrator to inform them of the situation. RN #341 described Resident #82 as alert and oriented with fluctuations due to his traumatic brain injury. Resident #82 was transported to the hospital to have his NG tube replaced and upon his return he was placed on a 1:1 supervision by staff. RN #341 was not aware of any further elopement attempts. Review of facility policy Elopements and Wandering Residents revised 10/01/22 revealed facility was to establish and utilize a systemic approach to monitoring and managing residents at risk for elopement including identifying and assessment of risk, implementing interventions to reduce hazards and risks and monitoring for effectiveness and modifying interventions when necessary. The deficient practice was corrected on 01/25/24 when the facility implemented the following corrective actions. On 01/24/24 a head count was completed and all residents were accounted for. On 01/24/24 statements were obtained from staff members related to the elopement. On 01/24/24 an incident report was completed and elopement risk care plans for all residents were reviewed and updated as indicated. On 01/24/24 elopement drills were initiated on each shift and staff from each shift participated by 01/25/24. On 01/24/24 the Regional Director of Clinical Services educated the Administrator and DON on elopement and abuse policies and procedures. On 01/25/24 the DON, Unit Manager and Administrator educated all staff on placement of residents at risk for elopement and wandering. The education was completed on 01/25/24 at 5:00 P.M. Any staff who had not received the education did not return to work prior to being educated. On 01/25/24 all admissions/readmissions from the previous 30 days were reviewed by the DON, Unit Manager and Administrator with no exit seeking behaviors noted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/25/24 the DON, Unit Manger and Administrator reviewed progress notes from the prior 72-hours for exit seeking behaviors with no exit seeking behaviors noted. On 01/25/24 the DON and Unit Manager completed secured unit audits for all current residents. No concerns were noted. On 01/25/24 the facility implemented a new policy that doors would be locked at 4:30 P.M. daily and unlocked at 6:45 A.M. daily On 01/25/24 a Quality Assurance and Performance Improvement (QAPI) meeting was held to discuss elopement and corrective action. The meeting was completed at 5:00 P.M. Ongoing QAPI review was held for four weeks to ensure admission paperwork was reviewed and residents were placed on secured unit if needed, wandering/elopement admission paperwork was completed on admission and residents at risk for elopement had appropriate interventions in place. The DON, Unit Manager and Administrator completed elopement drills twice weekly for three weeks This deficiency represents non-compliance investigated under Complaint Number OH00155614.