STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365320	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Copley	2631 Copley Road Akron, OH 44321

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** 43063 Based on observation, record review and interviews, the facility failed to provide adequate supervision to prevent exit seeking behavior and elopement for Resident #40 and a fall for Resident #11. This affected two (Residents #11 and #40) of two residents reviewed for accident hazards. The facility census was 51. Findings include: 1. Review of the medical record for Resident #40 revealed an admitted [DATE] with diagnosis including late onset Alzheimer's Disease, dementia, anxiety and depression. Her medical record contained a photograph so that she was identifiable to staff. Review of the Admission Elopement assessment dated [DATE] revealed Resident #40 was mobile and had unsafe wandering prior to coming to the facility. Review of the Elopement assessment dated [DATE] revealed Resident #40 was at risk for elopement due to being cognitively impaired, making poor decisions, exit seeking and having a history of an actual elopement or unsafe wandering. Review of the physician's orders dated 03/04/24 revealed Resident #40 had a wander guard (a device that an at-risk resident wears which alerts caregivers when the resident has wandered from the protected and secured zone) to her right ankle. The staff were to check placement and function every shift. Review of the Treatment Administration Record (TAR) for March 2024 and April 2024 for Resident #40 revealed staff were checking placement of her wander guard and it was in place on her right ankle. Review of Resident #40's care plan dated 03/04/24 revealed she was an elopement risk and wanderer related to dementia, being disoriented to place, history of attempts to leave the facility unattended and impaired safety awareness. The care plan stated she wandered aimlessly. Interventions included checking the wander guard placement every shift, identifying patterns of wandering and intervene as appropriate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note dated 03/04/24 at 4:09 P.M. revealed while Resident #40 was at home, her family had become aware that she had symptoms of dementia as she had gotten out of her home and fell and broke her wrist. It was noted on 03/06/24, 03/23/24, 03/24/24 and 03/25/24 that Resident #40 was exit seeking and wandering, however, the facility staff were able to redirect her and keep her from exiting the building. Review of the admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #40 had impaired cognition. She had wandered one to three days on this assessment and had delusions. Review of the nursing progress note on 03/26/24 at 2:52 P.M. revealed that approximately 1:30 P.M. Resident #40 pushed another resident out the front door of the facility. An STNA noted the residents outside the front door and both residents were brought back into the facility. An additional nursing progress note on 04/14/24 at 6:05 P.M. revealed Resident #40 had her wander guard on and alarmed the front door of the facility attempting to exit the building. However, a nurse had intervened before she was able to leave. She was observed to be pacing in the hallways and pushing on the doors to leave the facility. Review of the facility elopement investigation for 03/26/24 at 1:30 P.M. for Resident #40 revealed she had escorted another resident outside by pushing her in her wheelchair. State tested Nurse Aide (STNA) #209's witness statement dated 03/26/24 revealed at 1:30 P.M. she was going to her car to get her lunch when she saw two residents (Residents #11 and #40) outside the facility doors. She stated one resident (Resident #11) was out of her wheelchair and on her knees. She stated she got assistance from another nurse and was able to bring both residents back in the building. Resident #40 was placed on 15 minutes checks from 03/26/24 through 03/28/24. Review of the facility elopement investigation for Resident #40 on 04/09/24 revealed she had gone to the front of the facility and was attempting to push open the doors to leave. Resident #40 then went to the back of the facility to the door where the generator was located. She pushed on the door, and it alarmed and opened after 15 seconds. The facility staff heard the alarm, called a code [NAME] (elopement code) and went to the door that alarmed as well as around the front of the building where Resident #40 was located in the parking lot. Resident #40 was redirected and brought back into the building. She was placed on 1:1 supervision at that time until 04/10/24 and then 15 minutes checks were initiated. Interview on 04/15/24 at 7:23 A.M. with Resident #40 revealed she was confused and was unable to understand the questions this surveyor asked. She was observed to have a wander guard to her right ankle. Interview on 04/15/24 at 10:27 A.M. with Licensed Practical Nurse (LPN) #204 revealed Resident #40 had been ambulating independently on 04/09/24 and seen by an aide who thought the resident was going to her room. She stated one minute later, the generator door alarm sounded, and the aide called a code brown and then went to the generator door. LPN #204 stated staff went to the parking lot where Resident #40 was located and redirected her inside. She stated Resident #40 exited on 04/09/24 at 3:52 P.M. and the staff were able to redirect her though it did take seven minutes due to the resident not wishing to return to the building. (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 04/15/24 at 10:40 A.M. with the Maintenance Director #207 revealed on 04/09/24 he had heard the code brown and he went out the front of the facility and observed Resident #40 in the parking lot. He stated she was only in the parking lot 30 seconds before he reached her. Interview on 04/15/24 at 11:16 A.M. with the Director of Nursing (DON) revealed on 03/26/24 Receptionist #206 was at the front desk, had put the code in and opened the door for Resident #11 and Resident #40 for them to leave the facility. The DON stated Receptionist #206 did not know that Resident #40 was a resident at the facility and was an elopement risk. He stated she was educated and 15-minute checks on Resident #40 were initiated. Interview on 04/15/24 at 11:29 A.M. with STNA #209 revealed she was going to lunch on 03/26/24 at 1:30 P. M. when she observed Residents #11 and #40 outside of the facility. She stated both residents were outside by the facility doors. She updated the nurse and went to assist both residents. STNA #209 stated she was also working on 04/09/24 when Resident #40 went out the generator door and staff called a code brown and went immediately to both the generator door and front doors where Resident #40 was located in the parking lot. Interview on 04/15/24 at 11:40 A.M. with Receptionist #206 revealed she had been at the front entrance on 03/26/24 and saw Resident #40 pushing Resident #11 in her wheelchair and believed that Resident #40 was a family member and not a resident. She stated Resident #40 was new to the facility and she did not recognize her. She stated she placed the code in so that the doors would unlock and both residents would be able to exit the building. Receptionist #206 stated an STNA came to the front to leave for lunch and noted both residents outside. She stated the aide was able to redirect them back into the building. Interview and observation on 04/15/24 at 12:05 P.M. with the Maintenance Director #207 revealed a video on his phone dated 03/26/24 at 1:32 P.M. of Resident #40 pushing Resident #11 in her wheelchair. Receptionist #206 placed the door code and allowed both residents to exit the facility. Receptionist #206 then was observed walking away from the front doors at 1:33 P.M. At 1:34 P.M. STNA #205 was seen to be walking in the common area and over to the main doors when she witnessed both residents outside the door. She then called for assistance and went outside with the residents. He was unable to provide a copy of the video file. Interview on 04/16/24 at 8:33 A.M. with the Administrator revealed Resident #40 attempted to exit the building for a third time on 04/14/24 at 5:59 P.M. but the nurse on duty intervened and was able to redirect her. Interview and observation on 04/16/24 at 9:18 A.M. with Maintenance Director #207 revealed Resident #40 was seen on 04/14/24 at 5:58 P.M. pushing on the main entrance doors waiting for the 15 seconds for the door to open. At 5:59 the door open and Resident #40 was seen exiting through the first set of doors, however, the nurse on duty was seen running to the resident before the second set of doors were opened. He was unable to provide a copy of the video file. Review of the facility policy titled, Elopements and Wandering Residents, last reviewed/revised on 02/02/21, revealed the facility would ensure residents who exhibit wandering behavior or are a risk for elopement receive adequate supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including Huntington's Disease (disorder that causes nerve cells in parts of the brain to gradually break down and die), schizoaffective disorder, dementia and depression. Review of the elopement assessment dated [DATE] for Resident #11 revealed resident was at risk for elopement. She was cognitively impaired with poor decision-making skills. Resident #11 had a history of elopement or unsafe wandering. Resident #11 had no other elopement assessments in her chart from 06/06/22 until 04/10/24. Review of Resident #11's physician's orders revealed an order dated 12/27/23 for a wander guard to be on the left ankle. Staff were to check placement and function every shift. Review of the TAR for March 2023 and April 2023 for Resident #11 revealed staff ensured the wander guard was on her left ankle and functioning. Review of the care plan dated 03/04/24 and last updated on 04/10/24 revealed Resident #11 was an elopement risk related to dementia, disoriented to place, history of attempts to leave the facility unattended and impaired safety awareness. It was noted that she wandered aimlessly. Interventions included checking for wander guard placement each shift, to identify pattern of wandering and to intervene as appropriate. Review of the nursing progress note dated 03/26/24 at 1:45 P.M. revealed Resident #11 was pushed outside the door in her wheelchair by another resident. Review of the facility elopement investigation for 03/26/24 for Residents #11 and #40 at 1:30 P.M. revealed Resident #40 escorted Resident #11 outside by pushing her in her wheelchair. STNA #209's witness statement dated 03/26/24 revealed at 1:30 P.M. she was going to her car to get her lunch when she saw two residents (Residents #11 and #40) outside the facility doors. She stated one resident (Resident #11) was out of her wheelchair and on her knees. She stated she got assistance from another nurse and was able to bring both residents back into the building. Interview on 04/15/24 at 11:16 A.M. with the DON revealed on 03/26/24 Receptionist #206 was at the front desk, had put the code in and opened the door for Resident #11 and Resident #40 for them to leave the facility. The DON stated Receptionist #206 did not know that Resident #40 was a resident at the facility and believed she was a family member of Resident #11. Interview on 04/15/24 at 11:29 A.M. with STNA #209 revealed she was going to lunch on 03/26/24 at 1:30 P. M. when she observed Residents #11 and #40 outside of the facility. She stated both residents were outside by the facility doors. She updated the nurse and went to assist both residents. Interview on 04/15/24 at 11:40 A.M. with Receptionist #206 revealed she had been at the front entrance on 03/26/24 and saw Resident #40 pushing Resident #11 in her wheelchair and believed that Resident #40 was a family member and not a resident. She stated Resident #40 was new to the facility and she did not recognize her. She stated she placed the code in so that the doors would unlock and both residents were able to exit the building. Receptionist #206 stated an STNA came to the front to leave for lunch and noted both residents outside. She stated the aide was able to redirect them back into the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 04/15/24 at 12:05 P.M. with the Maintenance Director #207 revealed a video on his phone dated 03/26/24 at 1:32 P.M. of Resident #40 pushing Resident #11 in her wheelchair. Receptionist #206 placed the door code and allowed both residents to exit the facility. Receptionist #206 then was observed walking away from the front doors at 1:33 P.M. At 1:34 P.M. STNA #205 was seen to be walking in the common area and over to the main doors when she witnessed both residents outside the door. She then called for assistance and went outside with the residents. He was unable to provide a copy of the video file. Review of the facility policy titled, Elopements and Wandering Residents, last reviewed/revised on 02/02/21, revealed the facility would ensure residents who exhibit wandering behavior or are a risk for elopement receive adequate supervision. This deficiency represents non-compliance investigated under Complaint Number OH00152322.