

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Green Hills Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6557 US 68 South West Liberty, OH 43357	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review, staff interview and policy review, the facility failed to ensure a resident representative was notified of a resident elopement timely. This affected one (#46) resident out of the three residents reviewed for notification of changes. The facility census was 73.</p> <p>Findings include:</p> <p>Review of the medical record for the Resident #46 revealed an admitted [DATE] with medical diagnoses of cerebral infarction, dementia, chronic obstructive pulmonary disease, diabetes mellitus, and Depression.</p> <p>Review of the medical record for Resident #46 revealed a quarterly Minimum Data Set (MDS) assessment, dated 04/03/24, which indicated Resident #46 had moderate cognitive impairment and required supervision to partial/moderate staff assistance for wheelchair mobility, was dependent for toilet hygiene and bathing, and required substantial staff assistance for transfers and bed mobility. The MDS indicated Resident #46 had a wander/elopement alarm in place daily. The MDS did not indicate Resident #46 wandered during the assessment time frame.</p> <p>Review of the medical record for Resident #46 revealed an elopement risk assessment dated [DATE], which indicated Resident #46 was at risk for elopement due to history of elopement, wandering, and resident expressed desire to return home.</p> <p>Review of the medical record for Resident #46 revealed a plan of care dated 07/24/23 which stated Resident #46 was at risk for elopement/wandering behavior due to dementia. The interventions included wander guard as ordered.</p> <p>Review of medical record for Resident #46 revealed a physician order dated 10/12/23 for wander guard (device to prevent elopement) to be placed and function checked every shift.</p> <p>(continued on next page)</p>

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: 365362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Green Hills Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6557 US 68 South West Liberty, OH 43357	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record for Resident #46 revealed an incident note dated 05/26/24 at 11:46 P.M. which stated Resident #46 was outside of the facility during shift unattended. Returned to facility by a visitor. Roam alert in place on wheelchair. Assessment for skin and injury. None noted at this time. Resident known to roam around the facility freely in wheelchair. Staff were not alerted by alarms. Roam alert checked for safety red light on. Physician on call sent message through tiger text. Power of Attorney was notified. Resident was returned to room and slept throughout night without further incident. Fifteen-minute checks initiated.</p> <p>Interview on 05/30/24 at 10:26 A.M. with Administrator confirmed Resident #46 had an elopement from the facility on 05/26/24. Administrator confirmed Resident #46 had a wander guard device attached to her wheelchair. Administrator stated staff responded to the door near Foundation Hall alarming around 7:58 P.M. on 05/26/24. Administrator stated the facility staff looked around the hallways and didn't see any residents and cleared the alarm at 8:04 P.M. Administrator stated on 05/26/24 at 8:52 P.M. a visitor brought Resident #46 back into the facility and the visitor stated Resident #46 was sitting in the parking lot. Administrator stated nursing staff immediately assessed the resident for any injuries and none were noted. Administrator stated she was notified of the elopement on 05/26/24, and an investigation was initiated. Administrator confirmed Resident #46's family was not notified of the elopement until 05/27/24 at 5:15 A.M.</p> <p>Review of the facility policy titled, Notification of Changes, revised 11/18/21, revealed the staff would notify the resident and/or resident representative and his/her physician or delegate of changes in the residents' condition or status in order to obtain orders for appropriate treatment and monitoring and promote resident's rights to make choices about treatment and care preferences. The policy stated the nurse would notify the resident and/or representative and physician of an accident involving the resident which resulted in injury or has the potential for requiring physician interventions. The policy stated the family was to document the notification in the resident's medical record.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154269.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Green Hills Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6557 US 68 South West Liberty, OH 43357	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review, review of a facility self-reported incident (SRI), staff interviews and policy review, the facility failed to provide adequate interventions and/or supervision to ensure a resident who was assessed as being at risk for elopements did not elope from the facility. This affected one (#46) resident out of three residents reviewed for elopement. The facility census was 73.</p> <p>Finding include:</p> <p>Review of the medical record for the Resident #46 revealed an admitted [DATE] with medical diagnoses of cerebral infarction, dementia, chronic obstructive pulmonary disease, diabetes mellitus, and Depression.</p> <p>Review of the medical record for Resident #46 revealed a quarterly Minimum Data Set (MDS) assessment, dated 04/03/24, which indicated Resident #46 had moderate cognitive impairment and required supervision to partial/moderate staff assistance for wheelchair mobility, was dependent for toilet hygiene and bathing, and required substantial staff assistance for transfers and bed mobility. The MDS indicated Resident #46 had a wander/elopement alarm in place daily. The MDS did not indicate Resident #46 wandered during the assessment time frame.</p> <p>Review of the medical record for Resident #46 revealed an elopement risk assessment dated [DATE], which indicated Resident #46 was at risk for elopement due to history of elopement, wandering, and resident expressed desire to return home.</p> <p>Review of the medical record for Resident #46 revealed a plan of care dated 07/24/23 which stated Resident #46 was at risk for elopement/wandering behavior due to dementia. The interventions included wander guard as ordered.</p> <p>Review of medical record for Resident #46 revealed a physician order dated 10/12/23 for wander guard (device to prevent elopement) to be placed and function checked every shift.</p> <p>Review of the medical record for Resident #46 revealed an incident note dated 05/26/24 at 11:46 P.M. which stated Resident #46 was outside of the facility during shift unattended. Returned to facility by a visitor. Roam alert in place on wheelchair. Assessment for skin and injury. None noted at this time. Resident known to roam around the facility freely in wheelchair. Staff not alerted by alarms. Roam alert checked for safety red light on. Physician on call sent message through tiger text. Power of Attorney was notified. Resident was returned to room and slept throughout night without further incident. Fifteen-minute checks initiated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Green Hills Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6557 US 68 South West Liberty, OH 43357	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/30/24 at 10:26 A.M. with Administrator confirmed Resident #46 had an elopement from the facility on 05/26/24. Administrator confirmed Resident #46 had a wander guard device attached to her wheelchair. Administrator stated staff responded to the door near Foundation Hall alarming around 7:58 P.M. on 05/26/24. Administrator stated the facility staff looked around the hallways and didn't see any residents and cleared the alarm at 8:04 P.M. Administrator stated on 05/26/24 at 8:52 P.M. a visitor brought Resident #46 back into the facility and the visitor stated Resident #46 was sitting in the parking lot. Administrator stated nursing staff immediately assessed the resident for any injuries and none were noted. Administrator stated she was notified of the elopement on 05/26/24, and an investigation was initiated. Administrator confirmed Resident #46's family was not notified of the elopement until 05/27/24 at 5:15 A.M.</p> <p>Interview on 05/30/24 at 11:00 A.M. with Director of Nursing (DON) stated she was notified on 05/26/24 around 10:00 P.M. that Resident #46 had eloped from the facility and was returned to the building by a visitor. DON stated an investigation was completed and determined Resident #46 wheeled herself past the front lobby to the doors that lead to Foundation Hall. DON stated the doors in the front lobby lock when a resident with a wander guard is near, so Resident #46 was not able to exit through those doors. DON stated Resident #46 was able to push open the locked doors (the doors will unlock after being pushed for 15 seconds) to enter Foundation Hall area and the door alarm sounded. DON stated Resident #46 made her way down the hallway to the sliding doors near Foundation Hall entrance/exit. DON stated the sliding doors near Foundation Hall did not have the ability to lock or alarm when a resident with a wander guard was near. DON stated staff responded to the door alarm but did not see any residents in the hallway, so the alarm was cleared, and staff did not complete a resident head count to ensure a resident had not eloped. DON stated Resident #46 was found in the parking lot outside of Foundation Hall doors by a visitor and had been outside approximately 45-50 minutes. DON confirmed Resident #46 did not sustain any injuries from the incident. DON stated a company was at the facility today to provide an estimate for installation of alarms and locks to the sliding doors near Foundation Hall.</p> <p>Review of the SRI dated 05/26/24 revealed staff interviews were conducted to determine how Resident #46 eloped from the facility. Resident #46 was put on fifteen-minute checks on 05/26/24 and 05/27/24, and the staff was educated on elopement and notification of changes on 05/27/24 and 05/28/24. Review of the SRI revealed the facility had not completed the investigation, training, and audits for the elopement.</p> <p>Review of facility policy titled Elopement, revised 12/19/23, revealed the facility was to safely and timely redirect residents to safe environment.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154269.</p>		