

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Heath		STREET ADDRESS, CITY, STATE, ZIP CODE 717 South 30th Street Heath, OH 43056	

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** 43064</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on interview, observation medical record review, review of facility policy, and review of facility investigation, the facility failed to ensure Resident #127 did not elope from the facility for an extended period of time. This affected one resident (#127) of three residents reviewed for elopement. The facility census was 122.</p> <p>Findings include:</p> <p>Review of Resident #127's medical record revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, cachexia, panic disorder, depression, dementia, and mild cognitive impairment.</p> <p>Review of Resident #127's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition.</p> <p>Review of Resident #127's plan of care initiated 06/11/24 revealed the resident was at risk for exit seeking and elopement related to impaired cognition, enjoying being outside and going to local stores, being observed outside saying she was going for a stroll, being independently mobile in wheelchair, and having a wanderguard. Interventions included applying the wanderguard as ordered and checking placement, function, and expiration date according to policy, redirecting away from exit doors as needed, distracting when wandering into inappropriate areas, identifying patterns of wandering, providing structured activities, toileting, and walking inside and outside with supervision as needed.</p> <p>Review of Resident #127's elopement risk assessment dated [DATE] revealed the resident was at risk for elopement.</p> <p>Review of Resident #127's physician order dated 06/11/24 to 05/09/25 revealed an order to check wanderguard placement every shift.</p> <p>Review of Resident #127's physician order dated 01/10/25 to 05/09/25 revealed an order to check the wanderguard function every night 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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #127's physician order dated 09/18/24 to 05/08/25 revealed an order to maintain wanderguard to wheelchair and check placement every shift.</p> <p>Review of Resident#127's Treatment Administration Record (TAR) for May 2025 revealed the nursing staff had been indicating they had checked placement and function of night shift from 05/01/25 to 05/07/25. The day shift had not marked that the wanderguard was in place to the wheelchair on 05/08/25.</p> <p>Review of Resident #127's progress note dated 05/08/25 revealed at approximately 2:05 P.M. the facility received a call from Heath Police Dispatch stating the resident was at rural king. Her wanderguard was not in place. Staff picked up the resident via their transport bus. The resident reported a lady took her to the store by pushing her in her wheelchair from the building, dropped her off the store, and she had been there for two days. The resident had a diagnosis of dementia. She had a head-to-toe assessment with no concerns noted. Her face was flushed, and she was provided with a cool rag and ice water. She was placed on one-on-one supervision and the on-call provider, Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrator, and guardian were notified.</p> <p>Review of the facilities Self-Reported incident dated 05/08/25 revealed an allegation of neglect when the facility was notified at 2:16 P.M. that Resident #127 was at a local store by police dispatch. Facility transported the resident back to the building escorted by police. A head-to-toe assessment was done, and no injury was noted.</p> <p>Review of the Missing Resident Investigation form dated 05/08/25 revealed a call was received and the facility was notified that Resident #127 was at a local store. The resident was last seen at 9:00 A.M. and was wearing a dark T-shirt and pants in a black wheelchair.</p> <p>Review of the incident and accident investigation form dated 05/08/25 revealed police dispatch called the building and notified the Business office manager at 2:16 P.M. that the resident was at a local store. The facility transported the resident back to the facility. Following an assessment no injury was noted, and the physician and guardian were notified.</p> <p>Review of the interview summary dated 05/08/25 revealed Resident #127 indicated a lady took her to the store by pushing her in her wheelchair and she had been there for two days. Certified Nursing Assistant (CNA) #120 indicated they were assigned to Resident #127's hallway and last spoke with the resident before breakfast. CNA #125 was assigned to Resident #127's hallway and last saw the resident after breakfast. CNA #127 was assigned to the adjacent hallway to Resident #127 and stated she saw the resident before breakfast when the resident was by the dining room. Medication Technician #113 stated she saw the resident after her morning medication administration around 9:00 A.M. Licensed Practical Nurse (LPN) Supervisor #106 indicated she saw the resident by her room after breakfast.</p> <p>Review of the quality assurance interview summary dated 05/08/25 revealed LPN Supervisor #106 revealed she called the store and spoke with the manager who said the resident made a purchase around 11:30 A.M. The manager was asked to check the cameras and stated the resident entered the store at 9:48 A.M. The manager also stated the resident was in and out of the store multiple times and was sitting by the front door when she was outside of the store.</p> <p>Review of Google Maps on 05/13/25 revealed the facility was 0.5 miles and an 11-minute walk from Rural King.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 05/13/25 revealed the facility was located across from a mall. The mall had a road with a 15 mile per hour speed limit surrounding it. The facility was off this road, as was rural king.</p> <p>Interview on 05/13/25 at 10:00 A.M. with the DON revealed the resident returned to the facility at 2:16 P.M. The facility did not have cameras near the front door. To know how long she was gone they had gone with the last time she had been seen which was 9:00 A.M. and the cameras from Rural King.</p> <p>Interview on 05/13/25 at 10:35 A.M. with the Administrator revealed the facility received a call from Rural King a bit before 10:50 A.M. indicating there was a lady outside of their store with a pink basket attached to their wheelchair. She spoke to activities personnel and the receptionist, and they were unaware of anyone with a pink basket on their wheelchair. She went to Rural King and drove around the store two to three times and did not see anyone. She reported the area had a lot of people who ride around in wheelchairs, so she did not think anything of it and did not initiate a headcount.</p> <p>Interview on 05/13/25 at 11:06 A.M. with Medication Technician #113 revealed on 05/08/25 she saw Resident #127 around 9:00 A.M. coming out of her room. She reported she did not require any medications until later in the afternoon, so she had not checked her wanderguard placement yet that day. She reported she noted the resident had not been in her room for lunch, but she had assumed that she was in the dining room and did not check on her.</p> <p>Interview on 05/13/25 at 11:15 A.M. and 1:18 P.M. with Regional Nurse #110 revealed Resident #127 had a history of cutting wanderguard off when they were on her. They switched the wanderguard to her wheelchair and it had been effective until 05/08/25. They were unable to locate the device itself but found the band.</p> <p>Interview on 05/13/25 at 11:24 A.M. with CNA #103 revealed Resident #127 normally spent a lot of her time in different areas of the facility or in activities. She had a history of removing her wanderguard, but it had been a while since that had happened. She reported they were supposed to check on residents every two hours, but she had been busy and had not done so on 05/08/25. She reported if staff had not seen residents in a while they would go check their usual spots and notify staff on their way. Reported she did take an untouched lunch tray from the resident's room but that had been normal for her.</p> <p>Interview on 05/13/25 at 2:00 P.M. with the DON and Regional Nurse #110 revealed they had interviewed the receptionist, and they had not seen the resident leave the building. They reported there had been no evidence anyone pushed the resident to the facility, they believed she went on her own. Her statement was not accurate as she had also reported she had stayed in a tent in the camping section for two days. They reported they had not been able to identify a root cause as it seemed to have come out of nowhere. They reported it may have been because it had been raining for days and it was finally nice outside.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/13/25 at 3:05 P.M. with LPN Supervisor # 106 revealed she assessed the resident following her return to the facility and had no concerns. She reported she spoke to Rural King and according to their cameras the resident repeated a cycle. She would come in the store, then sit right outside the front door, and then come back in and repeat it. LPN Supervisor #106 reported the resident had not had any exit seeking behaviors in a while. She stated the resident was normally out of her room and out in the facility, in activities, in the dining room, or in other resident rooms. She reported the staff likely just got used to her being in one of her preferred locations. LPN Supervisor #106 reported the resident had returned to the facility at 2:16 P.M. and the cops had notified them of her absence around five to 10 minutes prior.</p> <p>Review of the facility policy 'Elopement policy' revised 04/26/22, revealed rounds of all residents were to be made at the beginning of the shift, at mealtimes, and at the end of the shift at a minimum by all direct care staff and licensed nurses. If a resident was missing the facility was to check and see if the guest signed out, designate a search coordinator, and initiate a missing resident form. The nurse was to notify other units of the missing resident, and all staff were to thoroughly search the building room by room.</p> <p>The deficient practice was corrected on 05/10/24 when the facility implemented the following corrective actions:</p> <ul style="list-style-type: none"> - On 05/08/25 after 2:16 P.M. a headcount of residents was performed. - On 05/08/25 after Resident #127 returned a new wanderguard was applied and she was placed on one-on-one supervision until her discharge on 05/09/25. - On 05/08/25 all staff were educated on laying eyes on residents every two hours, at the beginning of their shift, at meals, and at the end of their shift. - On 05/08/25 the DON and Administrator were educated by Regional Nurse #110 on performing headcounts for missing residents. - On 05/08/25 all staff were educated on the elopement policy - On 05/08/25 all residents were reevaluated for elopement risk - On 05/08/25 a Quality Assurance and Performance Improvement (QAPI) meeting was held with the medical director to discuss the elopement. - On 05/08/25 the facility initiated an audit to ensure Wanderguards were in place as ordered, the audit was to take place three times a week for four weeks. - On 05/09/25 at 6:03 A.M. and 5:00 P.M. and on 05/10/25 at 12:25 P.M. the facility held elopement drills <p>This deficiency represents noncompliance investigated under OH00165564.</p>		