STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365562	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madeira Healthcare Center	6940 Stiegler Lane Cincinnati, OH 45243

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 - Immediate jeopardy to resident health or safety 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** 37447 Based on observation, medical record review, staff interviews, review of a police report, and review of the facility policy, the facility failed to provide adequate supervision and implement timely interventions for exit-seeking behaviors for Resident #37, who was cognitively impaired, had a history of wandering and exit seeking behavior and who resided in a secured unit, to prevent his elopement from the facility without staff knowledge. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries, and/or death on [DATE] when Resident #37 left the secured unit, got in a car in the parking lot which had the keys inside and drove approximately 8.2 miles away from the facility. Resident #37 was missing from the facility for approximately two hours before staff were notified the resident had been located by the police and would be returned to the facility. This affected one (Resident #37) of three residents reviewed for elopement risk. The facility identified 21 residents (#25, #26, #27, #28, #29, #30, #32, #33, #35, #36, #37 #39, #40, #41, #42, #44, #46, #47, #48, #49 and #51) on the secured unit who were at risk for elopement. Additionally, the facility identified nine residents (#01, #02, #05, #08, #10, #15, #17, #19, #21) residing in the unsecured area of the facility who were at risk for elopement. The total facility census was 93 residents. On [DATE] at 3:25 P.M., the Administrator, the Director of Nursing (DON), and Divisional Director of Clinical Operations (DDCO) #200 were notified Immediate Jeopardy began on [DATE] at 6:00 P.M. when Resident #37 eloped from the facility without staff knowledge. On [DATE] at approximately 7:30 P.M., Certified Nurse Aide (CNA) #166 discovered Resident #37 was not present on the secured unit when completing her rounds and reported the missing resident to Licensed Practical Nurse (LPN) #181. Staff completed a search of the unit and checked the logs to ensure the resident had not been signed out. As the staff were beginning to expand the search for Resident #37, they received a call from the police notifying them the resident had been located and would be returned to the facility. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at approximately 5:45 P.M., Resident #37 was observed on the secure unit as his dinner tray was retrieved. On [DATE] at approximately 6:00 P.M., a visitor who was visiting her father reported her car had been stolen from the front parking lot of the nursing home. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 7:30 P.M., CNA #166 was completing her rounds, was not able to find Resident #37, notified LPN #181 and a search was conducted of the secured unit. A head count revealed 93 residents were present out of 94 with Resident #37 unable to be located. On [DATE] at approximately 8:00 P.M., LPN #181 was notified the police had located Resident #37 and would return him to the facility. On [DATE] at approximately 8:10 P.M., the nurses on each unit conducted a head count of all residents in the facility. All residents except for Resident #37 were in the facility. Staff checked the doors on the memory care unit and verified the doors were securely locked and the keypads were in working order. Staff checked all windows and found them all intact with no broken windows. On [DATE] at 8:10 P.M., Clinical Manager (CM) #146 notified Resident #37's family of the situation. Immediately after, the physician was notified with no new orders obtained. On [DATE] at 8:15 P.M., the DON provided verbal education on elopement to all staff working in the facility via telephone. On [DATE] at 8:25 P.M., Resident #37 returned to the facility and was placed immediately on one-on-one supervision. LPN #181 completed a physical assessment of Resident #37 with no adverse findings. The nurse notified Resident #37's family and physician of the assessment with no new orders recommended by the physician. On [DATE] at 9:00 P.M., the DON began reassessing residents for wandering/elopement risk. The facility identified 21 residents (#25, #26, #27, #28, #29, #30, #32, #33, #35, #36, #37 #39, #40, #41, #42, #44, #46, #47, #48, #49 and #51) on the secured unit who were at risk for elopement. Additionally, the facility identified nine residents (#01, #02, #05, #08, #10, #15, #17, #19, #21) residing in the unsecured area of the facility who were at risk for elopement. On [DATE] at 7:00 A.M., Maintenance Director #106 completed an audit/evaluation of all egress doors in the building with no adverse findings. The code to the stairwell exiting to the front parking lot from the secured memory care unit was changed. On [DATE] at 8:00 A.M., the DON and the Administrator began educating all staff regarding elopement policies, procedures and prevention. On [DATE] at 8:05 A.M., Director of Social Services (DSS) #114 completed a new Brief Interview of Mental Status (BIMS) evaluation for Resident #37. The resident scored two out of 15 possible points which indicated severe cognitive impairment. On [DATE] at 10:00 A.M., the Interdisciplinary Team (IDT) met and conducted a Quality Assurance and Performance Improvement (QAPI) review with Medical Director (MD) #205, Nurse Practitioner (NP) #112, and Psychiatric NP #216 present. The team reviewed Resident #37's care plan, orders and medical history and determined the resident should remain on one-on-one supervision with no new orders recommended. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:30 A.M., Clinical Manager (CM) #125 completed a Wanderguard audit with no adverse findings. The facility identified three residents (#01, #17 and #21) residing on the unsecured area of the facility with orders for Wanderguards. On [DATE] at 11:00 A.M., the Administrator audited the elopement binder with preliminary findings from the wandering/elopement risk assessments and determined no changes were needed. On [DATE] at 1:00 P.M., the DON and Unit Manager (UM) #190 completed wandering and elopement risk assessments. They held a meeting with Minimum Data Set Nurse (MDS Nurse) #107 regarding care planning. The IDT reviewed care plans for all like residents and agreed upon interventions. On [DATE] at 2:45 P.M., the Administrator posted signs on the entry doors indicating visitors should not leave cars running unattended in parking lot. On [DATE] at 3:45 P.M., MDS Nurse #107 completed a review and updated all of the care plans for residents identified to be at risk for elopement. On [DATE] at 4:00 P.M., the Administrator reviewed the elopement binders again to verify all resident information was updated and current. On [DATE] at 4:50 P.M., the facility conducted an elopement drill during mealtime. No concerns were observed during or after the completion of the drill. On [DATE] at 7:15 P.M., the Administrator and the DON completed all staff re-education on elopement policies, procedures and prevention for all staff in facility with signatures obtained. The facility does not use agency staff and there were no staff on leave at the time of the incident involving Resident #37. Beginning [DATE], to monitor for ongoing compliance, the DON or ED will conduct elopement drills twice weekly on random shifts for four weeks, and then monthly. On [DATE] at 9:30 A.M., the DON and the Administrator reported to the QAPI committee findings related to compliance. The QAPI committee consisted of the Administrator the DON, Registered Dietitian (RD) #220, DSS #114, MDS Nurse #107, Therapy Director (TD) #224, MD #205, NP #215, and Psych NP #216. Beginning [DATE], the Administrator, the DON and department leaders will complete random audits of at least five staff per day to determine comprehension of elopement policies, procedures and prevention techniques. Beginning [DATE], Maintenance Director #106 and/or designee will complete daily audits of the secured doors in the facility to ensure proper functioning and security. Daily audits will continue for at least 90 days and then be referred to the facility QAPI team to review for further monitoring recommendations. On [DATE] at 10:00 A.M., the IDT met to review Resident #37's need for ongoing one-on-one observation with MD #205 present. The IDT agreed to continue one-on-one observation for the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on [DATE] between the hours of 11:16 A.M. and 11:42 A.M. with Registered Nurse (RN) #148 and CNAs #147 and #169 and on [DATE] between the hours of 9:40 A.M. and 1:00 P.M. with LPN #181 and CNA #166 confirmed they were educated and verbalized knowledge of the facility's elopement policies and procedures and guidelines for monitoring residents who have been placed on one-on-one supervision. On [DATE] at 4:15 P.M., Maintenance Director #106 changed the remaining two door codes to the stairwells and the elevator code for the secured unit. The facility will change the door codes monthly moving forward. Resident #37 was placed on immediate one-on-one observation and will be reviewed by the facility IDT/QAPI team weekly to determine appropriate interventions. On [DATE] the surveyor completed review of the medical records for Residents #41 and #47 identified as elopement risks and revealed no concerns related to actual elopement from the facility, elopement risk assessments were current and accurate, and care plans were initiated and updated with appropriate interventions to prevent elopement. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility had not changed the door codes on all of the doors and is still in the process of implementing their corrective action plan and monitoring to ensure ongoing compliance. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including dementia, insomnia, hypertension, personal history of traumatic brain injury, congestive heart failure, anxiety disorder, and malignant neoplasm of prostate. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #37 dated [DATE] revealed the resident had severe cognitive impairment and was independently mobile without an assistive device. Review of the wandering observation tool for Resident #37 dated [DATE] revealed the resident had a history of wandering and the resident's family reported he might try to leave. Further review of the tool revealed Resident #37 was not accepting of his current living arrangements and expressed a desire to leave the facility. Resident #37 had no history of elopement but wandered without a sense of purpose and had the additional risk factor of dementia and poor safety awareness and was determined to be at risk of elopement. Review of the care plan for Resident #27 dated [DATE] revealed the resident wandered the unit looking for an exit to get home, had agitation, was restless and exit-seeking and was at risk for elopement and noted to exit seek by pushing on doors and trying to get onto the elevator. Interventions included the following: one-on-one observation, assess and meet needs, assist to call family when exit seeking or if the resident is not easily redirected, educate the resident and representative on the need for secured unit, involve the resident in listening to music, attending activities and getting a snack, increased supervision when ambulating in the hallways, and place identifying information in the elopement book. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 3:15 P.M. with the Administrator and the DON confirmed Resident #37 lived on the secured unit and had been living at home with his wife, went to the hospital and was admitted from the hospital to the facility's secured unit which had three stairwell doors and one elevator which required codes to get out. Further interview confirmed Resident #37 eloped from the facility without staff knowledge on [DATE] and was returned hours later by police. The facility was unable to determine how the resident exited the facility, but they suspected he might have gone down the stairwell door to the left of the nurses' station. They did not think he had exited the unit via the elevator because he would have had to walk past the reception desk which was attended by staff to go out the front door. They stated they did not think the resident was cognitively capable of memorizing the code and surmised the resident pushed buttons and somehow entered the correct code which they characterized as being an easy code (1245). Further interview confirmed an aide discovered Resident #37 was missing from the unit on [DATE] at approximately 7:30 P.M. Staff began to search for Resident #37 without success and the staff were preparing to expand their search at 8:00 P.M. when the facility was notified the police had located the resident and would bring him back to the facility. The Administrator and DON reported they thought Resident #37 had left around 6:00 P.M. as an aide had last seen the resident around 5:45 P.M. as she was picking up his dinner tray. At 6:00 P.M., a family member of another resident reported they had their car stolen from the facility ' s front parking lot. Police found Resident #37 in the visitor's car which had been reported stolen and the resident was approximately 8.2 miles from the facility on a busy road. Observation on [DATE] at 9:45 A.M. revealed two of the stairwell doors opened using the same code,1245, which had been the code at the time of Resident #37's elopement. Further observation revealed the door at the bottom of the stairwell opened to the outside and allowed egress with no additional code required or an alarm to the door. Interview on [DATE] at 10:38 A.M. with Maintenance Director #106 confirmed he was notified of Resident #37's [DATE] elopement on the morning of [DATE]. Maintenance Director #106 confirmed the elevator and three stairwells to the unit all had codes to prevent residents from exiting, but on [DATE] he only changed the code to one of the stairwells and had left the elevator code and two of the stairwell codes unchanged. Interviews on [DATE] between the hours or 11:16 A.M. and 11:42 A.M. with Registered Nurse (RN)#148 and CNAs #147 and #169 confirmed Resident #37 had not seemed agitated or actively exit-seeking prior to leaving the building on [DATE] but had been displaying his usual level of wandering. They reported last seeing him around 5:45 P.M. when gathering dinner trays. Interview on [DATE] at 9:40 A.M. with LPN #181 confirmed she was notified by CNA #166 at around 7:30 P. M. that Resident #37 was not present on the unit. They searched the unit and as CNA #166 was coming back from checking if Resident #37 had been signed out, they received notification that the police had located the resident and were bringing him back to the facility. LPN #181 stated she assessed Resident #37, and he had no injuries. Interview on [DATE] at 12:10 P.M. with the Administrator confirmed following Resident #37 ' s elopement on [DATE] it was her understanding and intent that Maintenance Director #106 would change the codes to all three stairwells and the elevator on the secured unit as the facility was unsure how Resident #37 had been able to exit the facility without staff knowledge or supervision on [DATE]. The Administrator confirmed awareness that Maintenance Director #106 had only changed the code on [DATE] to the stairwell to the left of the nurses' station. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 1:00 P.M. with CNA #166 confirmed she was doing rounds at approximately 7:15 P. M. on [DATE] when she noted Resident #37 was not present. As she was coming back upstairs from checking the front desk sign out log, another staff reported the police had located Resident #37 and would return him to the facility. She stated when Resident #37 returned, he was assessed with no injury and was laughing and stated the police had caught him stealing his father's car. Observations on [DATE] and [DATE] revealed Resident #37 was in his room and was on droplet isolation due to COVID -19 and also remained on one-on-one supervision with no wandering or exit seeking behavior exhibited. Review of a police report from the city in which the facility was situated dated [DATE] revealed an unlocked vehicle with the keys inside parked in front of the facility on [DATE] was reported stolen. The owner of the vehicle had last seen the car parked in front of the facility on [DATE] at 5:20 P.M. and at 6:05 P.M. the car was gone. Local police found the vehicle at an address which was 8.2 miles away. The vehicle was equipped with a device which allowed police to turn off the vehicle remotely rendering it undrivable and thus preventing a possible crash. The device also enabled police to locate the vehicle and Resident #37 to bring him back to the facility. Review of the facility policy titled Elopement Prevention and Management, undated, revealed elopement was defined as a resident leaving the premises or safe area without authorization and necessary supervision putting them at risk. The procedure entailed identifying residents who were at risk for elopement and what factors might contribute to their elopement. The facility would develop and document individualized interventions to manage resident risk factors and modify interventions as needed. In the event a resident eloped, the facility would announce a resident was missing, form a search team and search all areas of the facility, then the grounds and broaden the search until the resident was found. The facility would notify law enforcement as needed to assist with the search. This deficiency represents noncompliance investigated under Complaint Number OH00159871.