STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365606	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Als Woodstock Inc	1649 Park Rd Woodstock, OH 43084

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** 49039 Based on observations, staff interviews, review of the medical record, review of the police report, review of the hospital documentation, and review of the facility's wandering and exit-seeking policy and procedure, the facility failed to provide a safe environment and adequate supervision to prevent Resident #8 from exiting the facility without staff knowledge. This affected one (Resident #8) of three residents reviewed for elopement. The facility identified six residents (Resident #8, #19, #20, #23, #25, and #33) at risk for elopement. The facility census was 39. Findings include: Review of Resident #8's medical record revealed he was admitted to the facility on [DATE] with diagnoses including pulmonary nodule, metastatic squamous cell carcinoma, and emphysema. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #8 had severe cognitive impairment, required contact guard assistance from staff with ambulation, exhibited wandering behaviors, and required an elopement alarm. Review of Resident #8's care plan dated 12/02/23 revealed he was at risk of elopement with a wanderguard placed on his left ankle. Interventions included educating family on elopement risks and interventions, utilizing wander guard for safety, and employing distractions to help decrease wandering. Review of the physician orders for Resident #8 revealed an order dated 05/16/24 for WanderGuard (Secure Care device) placement on the left ankle due to increased wandering. Review of Resident #8's elopement assessment dated [DATE] revealed he had a history of wandering and attempting to leave the facility unattended, and he had voiced the desire to go home. Review of the facility incident report revealed on 06/22/24 at 7:30 A.M., Resident #8 had an event of wandering/elopement. Resident #8 was unable to be located within the facility. On 06/22/24 at 7:45 A.M., nursing staff implemented an internal and external search for this resident. The Director of Nursing (DON) was notified immediately; the DON notified the Administrator. Staff were delegated to continue the search and immediately notify the police department and family. When Resident #8 was found, his mental state was at baseline; he denied having pain and had no visible injuries. (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 timeline of events undated revealed on 06/22/24 at 7:45 A.M., Resident #8 was identified as missing. The internal and external search began at 7:45 A.M. Staff members conducting the search were Licensed Practical Nurse (LPN) #109, LPN #151, and LPN #152, State tested Nursing Assistant (STNA) #102 and STNA #152. Non-direct care staff present were Housekeeping Aide (HA) #141, HA #143, Dietary Aide (DA) #154, and #155. All staff members participating in the search did not stop until Resident #8 was found. Resident #8 was found approximately 250 feet from the facility's front door, behind a tree line, at 10:13 A.M. Resident #8 was assessed for injuries and transported to the hospital for further evaluation at 10:30 A.M. Review of the police report dated 06/22/24 revealed the police were called at 8:16 A.M. and arrived at 8:55 A. M. for a report of a missing [AGE] year-old male with dementia. It was possible he left when another patient was transported earlier that morning. Resident #8 was located at approximately 10:12 A.M. Review of the hospital after-visit summary completed on 06/22/24 revealed Resident #8 did not sustain any injuries. Review of LPN #110's statement dated 06/22/24 revealed she was the night shift nurse. LPN #110's most recent sighting of Resident #8 was on 06/22/24 at 5:45 A.M. when he was seen wandering in the middle hallway. Review of LPN #109's statement dated 06/22/24 revealed she had last seen Resident #8 at shift change around 6:00 A.M. At approximately 7:45 A.M., STNA #102 asked LPN #109 if she knew where Resident #8 was. LPN #109 denied knowing and directed STNA #102 to check the dining room, where she was unable to locate him. LPN #109 initiated a whole-house search within the nursing department. After an initial search was conducted, LPN #109 initiated a ground search with all available staff. At this time, they were unable to locate Resident #8. On 06/22/24 at approximately 8:10 A.M., LPN #109 notified the DON and called the sheriff's office. Review of STNA #102's statement dated 06/22/24 revealed she had begun hourly rounds on her assignment between 6:30 A.M. and 6:45 A.M. At this time, she was unable to locate Resident #8. STNA #102 walked to the kitchen to look for Resident #8 in the dining room. STNA #102 asked Dietary Aide (DA) #154 and #155 if they had seen Resident #8; both dietary aides denied. STNA #102 notified the nurse. Review of DA #155's statement dated 06/22/24 revealed he had entered the facility at 6:00 A.M. On 06/22/24 during breakfast preparation, STNA #102 asked him if he had seen Resident #8 for breakfast. DA #155 assisted STNA #102 with the search immediately, driving around the neighborhood. Review of DA #154's statement dated 06/22/24 revealed upon entering the facility on 06/22/24 at 5:50 A.M., the back door was closed. At approximately 7:50 A.M., STNA #102 asked DA #155 and #154 if they had seen Resident #8; both denied. DA #155 assisted with the search while DA #154 assisted the remaining residents in the dining room. Review of LPN #151's statement dated 06/22/24 revealed they had assisted in the internal and external search for Resident #8. (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 Registered Nurse (RN) #152's statement dated 06/22/24 revealed she was notified when Resident #8 went missing; at that time, she stopped medication administration to assist with the search. RN #152 attempted to contact the family several times to ensure the resident was not on a leave of absence. RN #152 completed notification to the sheriff. Review of HA #141's statement, undated, revealed he and HA #143 looked for Resident #8 for two and a half hours. HA #141 and #143 went door to door before local authorities arrived. Review of HA #143's statement revealed she arrived at 7:55 A.M., where HA #141 had notified her that Resident #8 was missing. HA #141 and #143 began the search. Interview conducted on 06/27/24 at 10:18 A.M. with the DON confirmed emergency medical technicians (EMT) transported a resident out of the facility due to a fall between 7:30 and 7:45 A.M. During the resident's transfer, the EMTs left the door open, giving Resident #8 the opportunity to elope from the facility undetected. Interview conducted on 06/27/24 at 10:20 A.M. with Maintenance Supervisor #145 verified all doors were checked after the elopement and were functioning properly. He contacted the company in charge of the monitoring system to come to the facility to check the system. Following inspection, the company indicated all exit door alarms were functioning as expected. Observation on 06/27/24 at 11:20 A.M. revealed the facility's wanderguard system was functioning properly. The system worked by locking the doors when a resident with a wanderguard ankle bracelet attempted to open the door. Upon exiting the building, a large blacktop parking lot was found, approximately 200 yards away from a dense tree line. Beyond the tree line, at approximately 250 yards from the front entrance, was where Resident #8 was found unharmed. Observation on 06/27/24 at 3:25 P.M. of Resident #8 revealed he was lying in bed with a wanderguard present. Resident #8 was aware of himself but confused about time, place, and situation. Resident #8 was unable to provide meaningful information when interviewed. Interview conducted on 06/27/24 at 5:07 P.M. with STNA #102 confirmed she was the last staff member to see Resident #8 shortly after 6:00 A.M. on 06/22/24. STNA #102 notified the nurse immediately when Resident #8 could not be located. Interview conducted on 06/27/24 at 5:44 P.M. with LPN #152 denied seeing Resident #8 on the morning of the elopement. LPN #152 confirmed the WanderGuard system did not work properly because the EMTs left the door open, allowing Resident #8 the opportunity to elope. LPN #152 denied seeing Resident #8 walk past the front entrance when she was sitting at the desk Interview conducted on 06/27/24 at 6:19 P.M. with LPN #109 denied seeing Resident #8 on the morning of the elopement. LPN #109 confirmed the WanderGuard system did not alarm when Resident #8 left 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	Review of the facility's Wandering and Elopement policy dated 08/2021 revealed the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If a resident is identified at risk for wandering, elopement, or other safety issues, the resident's orders will include strategies and interventions to maintain the resident's safety. This was an incidental finding discovered the course of the complaint investigation.