STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365612	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on observation, medical record review, electronic mail (email) communication review, interviews, and review of the facility policy, the facility failed to reasonably accommodate the request of Resident #72's family/responsible party to install an electronic monitoring device (camera of choice) in Resident #72's room. This affected one resident (#72) of five residents reviewed for unnecessary medication use. The facility census was 85. Findings include: Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses that included dementia, hypertension, cardiac arrhythmia, anxiety, and depression. Review of the demographics sheet for Resident #72 revealed Resident Representative (RR) #500 was power of attorney (POA) and health care decision maker for Resident #72. Review of POA documents for Resident #72 revealed RR #500 was designated as POA on 11/20/15. Review of the care plan dated 02/09/24 revealed Resident #72 had cognitive loss/dementia with trouble sleeping or sleeping too much. Interventions include to observe/report any changes in mental status or behavior to physician and keep RR informed of Resident #72's status. A care plan for psychotropic medications for agitation and restlessness dated 02/21/24 revealed interventions included to encourage resident/family to ask questions about medication and encourage Resident #72 to voice any concerns with encounters. Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #72 was cognitively impaired and had behaviors. The behaviors interfered with care and activities, intruded on others, disrupted care or living environment, and Resident #72 wandered into others' space. A social service note dated 04/12/24 at 2:25 P.M. revealed Social Service met with the Administrator and RR #500 on this date. RR #500 requested a camera in Resident #72's room to monitor how well Resident #72 was sleeping. The Administrator reviewed the corporate policy with RR #500 about a camera being placed in Resident #72's room. Observation on 04/15/24 at 10:57 A.M. revealed Resident #72 was in a double occupancy room but did not have a roommate. No camera was observed in the resident's room. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/15/24 at 1:02 P.M. with the Administrator revealed RR #500 voiced concerns Resident #72 was being chemically restrained. RR #500 had visited on 04/08/24 and had difficulty waking Resident #72. Interview on 04/16/24 at 10:26 A.M. with the Ombudsman revealed they were only aware of one camera being installed in any of the facilities owned by the corporation that owned Summit Acres. The corporation only allowed their specific cameras and only permitted the cameras to be installed by a company the facility chose. The Ombudsman stated it appeared the corporation put many obstacles in place to deter families from installing cameras in any of their facilities. Interview on 04/17/24 at 7:33 A.M. with RR #500 revealed they were concerned about Resident #72 being overmedicated and sleeping too much. RR #500 had asked about a camera being put in Resident #72's room so they could monitor how much Resident #72 was sleeping. RR #500 stated the administrator said it would cost around $800 for a camera to be installed in Resident #72's room. RR #500 stated they had to purchase a specific camera and had to have it installed by someone the facility had chosen. RR #500 stated they understood that there were certain guidelines for cameras to be placed in a resident's room but felt that the cost was absorbate. RR #500 stated they had decided to not pursue the installation of a camera due to the cost. Interview on 04/17/24 at 1:14 P.M. with Regional Nurse Consultant #151 revealed the corporation picked a particular camera due to it met all the requirements in the facility policy. A typed statement by the Administrator dated 04/17/24 revealed they discussed with RR #500 the cost of purchasing a camera and the cost of installation for a camera in Resident #72's room. RR #500 was provided the approved camera type to be ordered by the facility information technology (IT) department. The Administrator explained to RR #500 the estimated cost would be $700.00 to $900.00. RR #500 expressed concerns over the cost and stated RR #500 would be in touch with an attorney and would let the Administrator know if RR #500 wanted to proceed with a camera being placed in Resident #72's room. On 04/22/24 at 2:33 P.M. a call was placed by this surveyor to the company used by the corporation for camera installation. The ABC representative stated a salesperson could come to the facility and provide a quote for the installation. The representative stated a quote could not be given without a salesperson assessing what the installation would entail. Email correspondence on 04/22/24 at 2:54 P.M. with the Administrator verified an estimate for Resident #72 had not been done by ABC. The Administrator indicated RR #500 stated they were going to check with other family (sisters) and an attorney due to the cost of a camera and installation. RR #500 had not indicated if they wanted to proceed with installing a camera in Resident #72's room. The Administrator indicated if RR #500 wanted to proceed with the installation of a camera, the administrator would contact the corporate IT department and they would contact ABC. An additional email from Administrator on 04/22/24 at 2:59 P.M. revealed the cost of the camera was between $50 and $55. The installation would be between $700 and $900 based on a camera being installed in a sister facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/22/24 at 3:40 P.M. with the Administrator revealed the facility corporation was located in [NAME], Ohio. The facility corporation used ABC, also located in [NAME], Ohio, for installation of cameras in all their buildings throughout Ohio. The Administrator indicated he was not aware there was mark up on the costs and stated the facility did not make money off the installation of cameras. Interview on 04/22/24 at 4:32 P.M. with the Administrator verified residents and guests were permitted to use internet service throughout the facility. Review of the facility Electronic Monitoring in Resident Rooms policy and procedure dated November 2022 revealed an electronic monitoring device was a surveillance instrument with a fixed position video camera or an audio recording device, or a combination of the two, that was installed in a resident's room and broadcasts or records activities or sounds occurring n the room. The facility had an approved device that Authorized Persons may use. An authorized person who wished to conduct electronic monitoring must complete a Facility's standard Authorization for Electronic Monitoring in Resident Room. The facility would verify whether the form had been signed by an Authorized Person. The facility had an approved device that meets all the criteria of the law and can be installed at the request of an Authorized Person. Only authorized facility personnel were permitted to install electronic monitoring devices in resident rooms. The Authorized Person was responsible for all costs of the electronic monitoring device, including installation, maintenance, and removal of the device. The facility would be responsible only for the cost of procuring electricity to the electronic monitoring device.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 33019 Based on observation, interview, and policy review, the facility failed to ensure Resident #16's medical record was maintained in a secure and confidential manner. This affected one (Resident #16) of one resident reviewed for confidentiality of medical records. The facility census was 85. Findings include: Observation on 04/17/24 at 10:05 A.M. revealed a computer monitor, located on the top of a medication cart, displaying Resident #16's confidential health information. There was no staff member utilizing the medication cart at the time of the observation. During interview on 04/17/24 at 10:13 A.M., Regional Director of Nursing (DON) #151 confirmed the computer monitor was displaying confidential medical records and should not be. Regional DON #151 locked the screen to ensure privacy. Review of the facility's policy titled, Medical Record Policy and Procedure, dated 08/16/10, revealed it is the facility's policy to utilize an electronic medical records system. The facility maintains resident and facility privacy and promotes the protection of clinical information within and above the Health Insurance Portability and Accountability Act (HIPAA) program requirements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, facility investigation review, interview and policy review the facility failed to ensure a thorough investigation was completed regarding a resident elopement. This affected one resident (Resident #74) of two residents reviewed for accidents. The facility census was 85. Findings include: Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anxiety, and depression. Resident #74 was admitted to the facility Speret Hall, a secure unit that required a code to enter and exit the unit. Clinical admission documentation dated 02/28/24 at 3:25 P.M. authored by Licensed Practical Nurse (LPN)/Program Director (PD) #128 revealed Resident #74 had short and long-term memory impairment and no mobility limitations. Resident #74's gait and balance were normal. The assessment revealed Resident #74 was not at risk for falls but was at high risk for elopement. An elopement risk observation form dated 02/28/24 authored by LPN/PD #128 revealed Resident #74 was able to ambulate, had a diagnosis of dementia, noted to be staying near windows or exit doors, was searching, and made verbal statements of needing to leave. The elopement risk observation form revealed Resident #74 was at high risk for elopement. Review of Secure Unit Pre-Admission assessment dated [DATE] revealed Resident #74 had cognitive impairment and exhibited poor safety awareness within the past three months. Resident #74 had resided in a private home and had wandered off and was unable to find his way back home. The history of mood/behavior revealed Resident #74 was easily confused and was recently at the emergency room after wandering out of his apartment. The pre-admission assessment revealed Resident #74 was compatible with admission criteria for secured unit. Review of a nursing note dated 03/14/24 at 5:50 P.M. authored by LPN/PD #128 revealed LPN/PD#128 was called to the lobby to get Resident #74. When LPN/PD #128 asked how Resident #74 got to the front lobby, LPN/PD #128 was told Resident #74 was mistaken as a visitor and allowed to exit Speret Hall and the facility. Staff were educated not to let anyone out of Speret Hall without asking. LPN/PD#128 noticed Resident #74 had a skin tear to the right wrist that measured one centimeter (cm) long, 0.5 cm wide, and 0.1 cm deep. It was also noted Resident #74 had a bruise to the right elbow and left hand near the thumb. Another resident reported Resident #74 fell outside on the sidewalk. (The progress note did not identify who the other resident was). Review of the incident and accident log revealed on 03/14/24 at 5:50 P.M. Resident #74 eloped from the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility safety event report-fall with injury event dated 03/14/24 at 7:40 P.M. authored by LPN/PD #128 revealed an (unidentified) visitor found Resident #74 on the ground on the ramp in front of the facility (however, this visitor was not identified by the facility or interviewed as part of the facility investigation to determine the time the resident was located, the location of the resident or any additional information pertinent to the investigation). State tested Nursing Assistant (STNA) #82 assisted Resident #74 to stand (later interview with STNA #82 and Resident #6, who witnessed the fall, said Resident #74 was already standing or stood up by himself and brought Resident #74 into the facility. A skin tear was noted on Resident #74's right wrist that measured one cm long, 0.5 cm wide and less than 0.1 cm deep. Resident #74 also had a bruise to the right elbow and near the left thumb. Interventions put in place included frequent checks for 24 hours. The incident was documented as occurring on the sidewalk. Fall interventions included staff education about residents on the secure unit. Further review of the safety event report-fall with injury event revealed no information related to Resident #6's interview/statement (Resident #6 witnessed the Resident's fall on 03/14/24). A written statement dated 03/14/24 (no time) by LPN/PD #128, revealed at 5:30 P.M. Resident #74 was observed sitting at the table in the day area eating dinner. LPN/PD #128 gave Resident #74 medication at this time. After Resident #74 finished dinner, Resident #74 went down the hallway and then back to the day area to the exit door and tried to open the door. LPN/PD #128 redirected Resident #74 and told Resident #74 he had an apartment down the hall. Resident #74 went down the hall like he was going to his room. Cook #99 came down the hall with a bowl of food and LPN/PD #128 was administering medication to another resident. The statement indicated at 5:50 P.M. LPN/PD #128 was called to the front lobby to get Resident #74. A written statement dated 03/14/24 (no time) by Cook #99 revealed on 03/14/24 at approximately 5:50 P.M. Cook #99 walked past a room on Speret Hall and saw a man leaning over a bed and it looked like the man was talking to someone. Cook #99 assumed the man was a visitor. When Cook #99 got closer to the door (coded exit door leading off of Speret Hall onto Unit 2) the man (Resident #74) said there we go. Cook #99 put the code in to unlock the door while Resident #74 was standing at the doorway to a resident room. When Cook #99 opened the door, Resident #74 zoomed out (of the secured unit). Cook #99 asked Resident #74 if he was allowed out and Resident #74 said yes. Cook #99 wrote if I had closed the door, it would have hit Resident #74. Cook #99 thought Resident #74 was a visitor. A written statement dated 03/14/24 (no time) by LPN #106 revealed on 03/14/24 at approximately 5:50 P.M. Resident #74 stated he needed to come through the door as he exited the door from Speret (secure) Hall. Cook #99 was coming off Speret Hall at the same time. Resident #74 seemed like a visitor, walking full stride with a steady gait and at a fast pace. The statement revealed LPN #106 had not seen or dealt with Resident #74 before. A written statement dated 03/14/24 (no time) by State tested Nursing Assistant (STNA) #82 revealed STNA #82 was sitting at the assisted living desk (the unit located near the main entrance) when a woman walked into the building and was talking to Receptionist #400. STNA #82 overheard the woman say there was possibly a resident outside. STNA #82 walked over to the door and saw Resident #74 outside. STNA #82 walked outside to see if it was one of the residents from the facility. Resident #74 was bleeding from his right arm and had told the unidentified lady that he needed a ride to Cambridge. STNA #82 asked Resident #74 if he would walk back into the building to have his arm checked out. STNA #82 asked STNA #90 if Resident #74 was one of the residents on Speret Hall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written statement dated 03/14/24 (no time) by STNA #90 revealed STNA #90 went to the kitchen to get a cup of juice for LPN/PD #128. STNA #82 asked STNA #90 what unit they were working on and asked if any residents were missing from Speret Hall. STNA #90 stated they were working on Speret Hall, and no residents were missing. STNA #82 said the man (that was outside) stated his name was (not his name). STNA #90 then walked closer to see the man STNA #82 was talking about. STNA #90 stated it was Resident #74. STNA #82 said someone found Resident #74 in the road. STNA #90 asked how Resident #74 got off the unit. STNA #82 stated a girl from the kitchen thought Resident #74 was a visitor and allowed Resident #74 to leave Speret Hall. Receptionist #400 called LPN/PD #128 to come get Resident #74. LPN/PD #128 made phone calls to the Director of Nursing and Administrator and asked staff to do a head count. A written statement dated 03/14/24 (no time) by Receptionist #400 revealed a man (Resident #74) walked from Unit 2 onto the smoker's patio. Resident #74 entered the front lobby from the smoking patio. Resident #74 then walked to the main entrance door and stood inside for a minute. Receptionist #400 thought Resident #74 had paused to look at the cats on the smoking patio. Resident #74 then started walking to the main entrance door without any questions or hesitation. Resident #74 looked like other visitors, so Receptionist #400 did not question Resident #74 and had no way of knowing Resident #74 was a resident. After Resident #74 exited the building, a visitor then came inside and said there was an older man outside asking for a ride to Cambridge. The visitor stated the man (Resident #74) did not seem familiar with where he was. STNA #82 came to the receptionist desk and spoke to the woman and then went outside to talk to Resident #74. STNA #82 brought Resident #74 back in and Receptionist #400 called LPN/PD #128. A written statement dated 03/14/24 (no time) that was signed by Resident #6 revealed Resident #6 observed a man (Resident #74) fall onto the concrete at the bottom of the ramp. Resident #74 was able to get up unassisted. The statement was received from the resident by LPN #106. The facility investigation of an elopement dated 03/14/24 revealed Resident #74 exited the secure unit onto Unit 2. Resident #74 went through the Unit 2 smoking patio door then walked through the smoking patio area and through the door into the front lobby. Resident #74 then exited the facility out the front lobby door. A new dietary aide (Cook) #99 thought Resident #74 was a visitor and allowed Resident #74 to exit Speret Hall. Resident #74 walked past LPN #106 on Unit 2. LPN #106 also thought Resident #74 was a visitor. Resident #74 then entered the lobby and exited out the lobby door where Resident #74 was seen by Receptionist #400 who also thought Resident #74 was a visitor. Resident #74 was last seen by Cook #99 at 5:50 P.M. Resident #74 left the unit at approximately 5:50 P.M. Director of Nursing (DON) received a call from LPN #128 at 6:12 P.M. It was believed Resident #74 was out of the facility for no longer than 15-20 minutes. Resident #74 got 77 feet away from the facility (this cannot be confirmed through staff statements or interviews because no staff could report the resident's exact location when discovered by the unidentified female individual as she was not interviewed for this information). Resident #74 was wearing blue jeans, a long sleeve plaid shirt, and shoes. The earliest Resident #74 exited the facility was at 5:50 P.M. The DON was called at 6:12 P.M. and the LHNA was called at 6:15 P.M. The temperature at 6:00 P.M. was 70 degrees Fahrenheit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility removal plan for the Immediate Jeopary issued for the elopement revealed on 03/15/24 at 9:00 A.M. the LNHA and DON reviewed the statements from Cook #99, LPN #106 and Receptionist #400 and determined the root cause of the elopement was the fact that three staff members did not know Resident #74 was a facility resident and not a visitor. Cook #99 allowed the resident to exit the secured unit without verifying if the individual was a resident or visitor. LPN #106 allowed the resident to exit Unit 2 (the unit outside of the secured unit) thinking Resident #74 was a visitor and Receptionist #400 allowed the resident to exit the facility without verifying whether he was a resident or a visitor. Interview on 04/17/24 at 2:49 P.M. with LNHA revealed a dietary staff member (Cook#99) was going down the hall and Resident #74 followed the staff member out the door from Speret Hall. Cook #99 thought Resident #74 was a visitor. Resident #74 went through a door on Unit 2 to the smoking patio and then through another door to the main lobby. Resident #74 told Receptionist #400 he was ready to go home. Receptionist #400 unlocked the front door to let Resident #74 out of the facility. A visitor talked to Resident #74 outside and thought Resident #74 seemed confused and notified Receptionist #400 there was a possible resident outside. Resident #74 had a skin tear and some bruises from a fall that occurred outside the facility. The LNHA revealed he was notified of the elopement at 6:15 P.M. by LPN/PD #128. The LNHA verified Resident #74's information had not been placed in the elopement binders located at the nurse's station and receptionist desk. The LNHA also verified the doors to the smoking patio were to alarm when opened on Unit 2 and the main lobby. However, the doors were not alarmed at the time Resident #74 went out the door to the smoking area. LNHA also verified the time of elopement and time Resident #74 was found were both listed as 5:50 P.M. on some information. During the interview, the LNHA could not verify how long Resident #74 was off the secure unit, how long Resident #74 was outside of the facility, exactly where Resident #74 was found or had been, and/or who the visitor was that reported finding Resident #74 outside of the facility. The LNHA also verified he was unaware of the resident's location when the resident was discovered by the unidentified female. He verified this information should have been clarified during the investigation and that the inconsistencies were not identified until this interview. Interview on 04/18/24 at 3:03 P.M. with Cook #99 revealed upon hire Cook #99 had been educated about not letting residents off Speret Hall. Cook #99 stated Resident #74 was walking without difficulty and was nicely dressed and had his shirt tucked in. Cook #99 thought Resident #74 was a visitor and asked Resident #74 if they were permitted off the unit. Resident #74 stated he was permitted to leave. Cook #99 stated LPN #106 was asked if she recognized Resident #74. LPN #106 stated she did not know Resident #74. Interview on 04/22/24 at 10:20 A.M. with STNA #90 revealed Resident #74 always wandered. STNA #90 stated she was working Speret Hall and was not aware Resident #74 had left the unit until STNA #82 asked if anyone was missing from Speret Hall. STNA #90 saw Resident #74 standing at the front desk. LPN/PD #128 was notified and assisted Resident #74 back to Speret Hall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/22/24 at 10:27 A.M. with Responsible Party #250 of Resident #74 revealed she was notified a new kitchen staff member had let Resident #74 off the secure unit and Resident #74 had fallen outside the facility. Resident #74's Responsible Party #250 was not sure where Resident #74 fell but stated it was possibly on the smoking patio. LPN/PD #128 called Resident #74's daughter and stated Resident #74 was found on State Route (SR) 78 (a two-lane road with no sidewalks and speed limits of 55 miles per hour), trying to hitchhike to Cambridge (a town approximately 20 miles from the facility). A lady stopped on SR 78 and brought Resident #74 to the facility to see if Resident #74 resided there. The daughter stated Resident #74 was admitted to the facility because he kept wandering away from home and trying to hitch hike. Interview on 04/22/24 at 10:34 A.M. with LPN/PD #128 revealed Cook #99 let Resident #74 off Speret Hall. LPN #106 was working on Unit 2 and was not aware Resident #74 was from Speret Hall. LPN #106 did not stop Resident #74 from leaving Speret Hall or Unit 2. LPN/PD #128 was not aware Resident #74 was missing until Receptionist #400 called stating Resident #74 was in the main lobby. LPN/PD #128 stated Resident #74 was not found near SR 78 but found on the road in front of the facility, near the parking lot and the ramp from the main entrance. Further interview revealed Receptionist #400 reported to her the resident was on the roadway, in front of the facility. The LPN also stated she was unsure why the resident's information was not in the elopement binder but LPN/PD #128 usually verbally informed medical records when a resident was identified at risk for elopement because the medical records staff (LPN #116) was usually working. LPN/PD #128 verified she did not know who located the resident while he was outside of the facility. Interview on 04/22/24 at 10:51 A.M. with Resident #6 revealed he saw Resident #74 fall on the ramp in front of the facility. Resident #74 got up unassisted. Resident #6 stated he reported to LPN/Supervisor #106 someone had fallen outside. Resident #6 provided no additional information related to the incident. Interview on 04/22/24 at 12:44 P.M. with STNA #82 revealed she did not witness Resident #74 exit the facility. A female entered the facility and reported she was driving up the hill to the facility and saw a man walking past the independent living apartments. (The apartments are attached to the right side of the skilled facility located at the end where the road goes down a steep hill to SR 78.) STNA #82 went outside and found Resident #74 at the bottom of the ramp leading from the front door of the facility. STNA #82 stated she did not recognize Resident #74 but brought Resident #74 back into the facility. Interview on 04/22/24 at 12:49 P.M. with Receptionist #400 revealed she thought Resident #74 was a visitor and let Resident #74 exit the facility. Receptionist #400 stated Resident #74 was outside the facility for approximately 10 to 15 minutes. Receptionist #400 stated the female visitor who reported Resident #74 was outside was someone who frequented the facility, but Receptionist #400 did not know the visitor's name or who they were visiting. (Receptionist #400 also shared she would recognize the unidentified female if she saw her face but resigned her position at the facility after the incident occurred). Receptionist #400 stated it was reported Resident #74 was located at the bottom of the ramp leading from the main entrance when the female entered the facility. Receptionist #400 verified residents at risk for elopement was discussed upon hire but did not feel the education was thorough enough. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an email correspondence with LNHA on 04/23/24 at 4:21 P.M. revealed neither the LNHA nor DON went to the facility after being notified Resident #74 had eloped from the facility. The LNHA revealed LPN/PD #128, who was the coordinator for Speret Hall, was at the facility when the event occurred. Interview on 04/23/24 at 4:30 P.M. LPN/PD #128 revealed she was called to the front desk to get Resident #74. LPN/PD #128 stated she only spoke to Receptionist #400 when she went to the lobby and did not get the whole story about where Resident #74 was found and who found Resident #74. LPN/PD #128 stated she was only told Resident #74 was out in front of the facility. LPN/PD had a head count done to ensure all residents were still at the facility and had neurological checks started for Resident #74 since it appeared Resident #74 had an unwitnessed fall. Review of an email correspondence with Regional Nurse #151 on 04/23/24 at 5:02 P.M. regarding clarification of the intervention of frequent checks of Resident #74 for the next 24 hours indicated on the safety event report-fall with injury event form dated 03/14/24 at 7:40 P.M. safety checks for Resident #74 were done with neurological checks. The neurological checks were started on 03/14/24 at 6:00 P.M. and were done every 15 minutes for two hours. The neurological checks were then done every 30 minutes for two hours, then every hour for four hours, and then every eight hours until 03/17/24 at 5:15 P.M. During the annual and extended survey, multiple attempts were made to reach LPN #106. Voicemail messages were left, and no return call was provided. During the annual and extended survey, multiple attempts were made to reach Medical Director (MD) #200. Voicemail messages were left, and no return call was provided. Review of the facility Abuse, Mistreatment, Neglect, Misappropriation of Resident Property and Exploitation Policy dated 2016 revealed Neglect was the failure of the facility, its employees or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress.The person investigating the incident should generally take the following actions: interview the resident, the accused, and all witnesses. Witnesses generally include anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and alleged victim the day of the incident. If there are no direct witnesses, then the interviews may be expanded. For example, to cover all employees on the unit, or, as appropriate, the shift. Obtain written statements from the resident, if possible, the accused and each witness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of shower schedules, observation, resident interview, staff interview, and policy review, the facility failed to ensure residents, who were dependent on staff for personal care, were provided the assistance they required for showers and nail care. This affected three (Resident #26, #41, and #236) of five residents received for activities of daily living (ADL). Findings include: 1. Review of Resident #26's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses include the need for assistance with personal care, weakness, reduced mobility, abnormalities of gait and mobility, cerebral palsy, and adult-onset diabetes mellitus. Review of Resident #26's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had clear speech and adequate hearing. She was able to make herself understood and was usually able to understand others. She was cognitively intact and was not known to display any behaviors. Review of Resident #26's care plans revealed she required therapy services related to a decline in her prior level of mobility and ADL's. Her goal was to improve in ADL. The interventions included providing encouragement as needed to participate with ADL's and to provide assistance as needed with ADL. Review of the shower scheduled for Resident #26's unit revealed she was scheduled to receive showers every Sunday and Wednesday. The showers were to be completed on the 6:00 A.M. to 2:00 P.M. shift. Review of Resident #26's shower documentation revealed her last documented bathing activity occurred on 04/17/24. The resident was documented as having been given a complete bed bath. The resident was indicated to have had her fingernails cleaned/ trimmed as indicated by the aide circling a Y for yes on the form. On 04/15/24 at 11:07 A.M., an observation of Resident #26 noted her to have fingernails that extended past the end of her digit by about a half an inch. An interview with the resident revealed she preferred to keep her nails trimmed short and they were longer than she wanted them to be. 04/17/24 at 8:25 A.M., the resident was observed lying in bed with the head of the bed (HOB) up. Her breakfast tray was on her bedside table in front of her. The resident was sleeping and not eating the meal that was in front of her. She aroused when spoken to and was encouraged to eat her eggs before they got cold. Further observation of Resident #26 on 04/18/24 at 11:13 A.M. noted the resident to still have long fingernails that were in need of being trimmed. The fingernails were clean under the nails, but continued to extend a half an inch longer than the end of her fingers on both hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 11:15 A.M., an interview with State tested Nursing Assistant (STNA) #140 revealed Resident #26 was dependent on staff for her ADL's. She verified the resident's fingernails were long and in need of being trimmed. She stated she would have to check with the nurse to see if the resident was a diabetic. They had someone come in to trim them, if the resident was in fact a diabetic. She would let the nurse know, if the resident was a diabetic, so the resident could be put on that list. On 04/18/24 at 11:19 A.M., an interview with RN #146 revealed the nurses trimmed fingernails of those residents who were diabetic. She stated the facility had someone who did the toenails for diabetic residents, but the nurses took care of the fingernails when they needed trimmed. She indicated she would add the resident to her list and would trim her fingernails for her later that shift. A review of the facility's policy on the Care of Fingernails/ Toenails undated revealed it was the facility's policy to keep nails trimmed. Nail care was to include the cleaning and trimming of the nails as needed. 2. Review of Resident #236's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) affecting her left non-dominant side, muscle weakness, abnormalities of gait and mobility, morbid obesity, reduced mobility, arthritis, and age related debility. Review of Resident #236's admission MDS dated [DATE] revealed the resident did not have any communication issues and her cognition was moderately impaired. She was not known to display any behaviors nor was she known to reject care. She was dependent on staff for showers/ bathing. Review of Resident #236's care plans revealed she needed therapy services related to a decline in her ADL's. Her interventions included allowing as much independence with ADL as possible while still maintaining safety, providing encouragement as needed to participate with ADL daily and offer praise for resident efforts, and to provide assistance as needed with ADL. Review of the shower schedule for Resident #236's unit revealed the resident was scheduled to receive showers every Tuesday and Thursday. The showers were to be completed on the 2:00 P.M. to 10:00 P.M. shift. Review of Resident #236's shower documentation revealed the resident was provided a shower on 04/09/24. A bed bath had been given to the resident on 04/03/24. No other bathing activities had been documented as having been completed. The resident was not documented as having been provided a shower or any other type of bathing activity on 03/28/24, 04/02/24, 04/04/24, or 04/11/24, which were all her scheduled shower days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/24 at 3:45 P.M., an interview with ADON #132 revealed the STNA's documented showers on the paper shower sheets (bathing/ skin tool) kept in binders at the nurses' stations. She was told they would keep three months worth in the binder. Any bathing activity that had been provided and not found in the binder may have been pulled and given to medical records. She went to medical records to see if they had any additional documentation to show showers or other types of a bathing activity had been provided to the resident since her admission to the facility on [DATE]. She confirmed the only documented shower given to the resident was on 04/09/24 with the only other bathing activity being a bed bath given on 04/03/24. No additional bathing activity documentation had been found in medical records. On 04/16/24 at 3:50 P.M., an interview with Resident #236 confirmed she had only been given one shower since she had been admitted to the facility. She reported she received two other bed baths during her time in the facility and they were provided to her upon her request. She asked for a bed bath on the evening of 03/26/24 when she was admitted to the facility. She requested another bathing activity on 04/03/24 when it was documented as having been provided to her. She denied that she requested any specific type of bathing activity on that day and just wanted bathed. The facility's administrator denied they had a facility policy specific to bathing activities. 34298 3. Review of the medical record revealed Resident #41 was admitted on [DATE] with diagnoses that included acute respiratory failure, dementia, schizophrenia, psychosis, and major depressive disorder. The quarterly MDS dated [DATE] revealed Resident #41 had cognitive impairment. Review of the bathing schedule revealed Resident #41 was to be bathed on Sundays and Thursdays between 2:00 P.M. and 10:00 P.M. Review of the bathing documentation revealed Resident #41 was bathed and had finger nails cleaned and trimmed as necessary on 03/17/24, 03/21/24, 03/24/24, 03/28/24, 03/31/24, 04/07/24, 04/11/24, and 04/14/24. Observation on 04/15/24 at 10:17 A.M. revealed Resident #41 had long jagged fingernails with a dark substance under some of the fingernails. Observation and interview on 04/17/24 at 8:53 A.M. revealed Resident #41 had long jagged fingernails with a dark substance under some of the fingernails. Medical Records #116 verified Resident #41 had long jagged fingernails with a dark substance under some of the fingernails. Medical Records #116 asked Resident #41 if Medical Records #116 could clean and cut Resident #41's fingernails. Resident #41 replied yes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of audiology visit reports, resident interview, and staff interview, the facility failed to ensure a resident was seen by an audiologist as requested by the resident and/ or her resident representative. This affected one (Resident #26) of two residents reviewed for ancillary services. The facility census was 85. Findings include: Review of Resident #26's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included cerebral palsy and adult- onset diabetes mellitus. Her payer status was private insurance when she was first admitted and was Medicaid (MCD) effective 12/22/23. Review of Resident #26's ancillary service consent form through 360 Care revealed the resident's niece signed the bottom of the consent form under where residents without MCD had the option to consent or decline those services. The consent form was signed on 09/29/23, but the boxes were not checked to indicate whether the niece wanted the resident to receive those services or not. Review of Resident #26's quarterly Minimum Data Set (MDS) assessment revealed the resident had adequate hearing without the use of a hearing aid and clear speech. She was able to make herself understood and was usually able to understand others. She was cognitively intact and no behaviors were indicated to have occurred. Review of Resident #26's care plans revealed she had an impaired ability to express and comprehend verbal communication. The care plan was not marked to reflect what her impaired ability was related to including being hard of hearing. Interventions included approaching the resident slowly and talk while facing the resident. They were to obtain audiologist consults as needed/ordered. Review of Resident #26's progress notes revealed a nurse's note dated 10/22/23 that indicated the resident's family expressed concerns about the resident's hearing. The family member reported the resident could hear fine until she came off of the ventilator while at hospital and now, she could not hear. The family reported they wanted the resident seen by an audiologist as soon as possible. Medical was indicated to have been notified for a referral to audiologist. Further review of Resident #26's medical record revealed it was absent for any evidence of the resident being seen by an audiologist. There had not been any further progress notes that addressed her hearing complaint or evidence she was seen by an audiologist. The medical record was also absent for an audiology consult report to show she had been seen by an audiologist. Review of an audiology visit lists by the facility's contracted audiologist's revealed visits were made to the facility on [DATE] and again on 03/13/24. Resident #26 was not one of the 31 residents seen on both those dates. The next scheduled audiology visit was to be held on 07/29/24. A list of residents to be seen on that day had not been generated yet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/24 at 11:06 A.M., an interview with Resident #26 revealed she does having hearing problems and wanted a hearing test. She stated she had Medicaid now but had not been seen. She would like to be seen to see if she needed hearing aids On 04/18/24 at 3:15 P.M., an interview with Licensed Social Worker (LSW) #97 revealed she could not find any evidence of Resident #26 being seen by an audiologist, after her family had requested that she be seen as soon as possible on 10/22/23. She indicated the resident had been in and out of the hospital several times after she first came to the facility. She confirmed the resident was in the facility when the audiologist was there on 12/19/23 and again on 03/13/24 but the resident was not seen. She would place the resident on the visit list for 07/29/24. She later returned and indicated they made an appointment for the resident to be seen the following day with an outside audiologist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on observation, record review, interview, and policy review, the facility failed to ensure residents received routine, preventative foot care. This affected one resident (#2) of two residents reviewed for ancillary services. The facility census was 85. Findings include: Medical record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, heart disease, vascular disease, diabetes mellitus, morbid obesity, and weakness. Review of the care plan, initiated on 05/06/21, revealed the resident had an alteration in blood glucose related to the diagnosis of insulin dependent diabetes mellitus with an intervention to observe the feet for potential ulcer formation. Further review of the care plan, initiated on 04/10/24, revealed the resident had an infection of the right great toe. Further review of the medical record revealed Resident #2's last podiatry examination was on 09/14/23. Review of the podiatry progress note dated 09/14/23 revealed Resident #2 received treatment for thick/mycotic (brittle and possibly affected by a fungus) nails. The nails were trimmed, and all remaining non-mycotic or dystrophic nails were trimmed to prevent pain, ingrown nails, or trauma. Review of podiatry Not Seen Visit Report, dated 01/18/24 and 04/05/24, revealed both appointments were canceled due to time constraints. Review of the Minimum Data Set (MDS) quarterly assessment, dated 03/20/24, revealed a Brief Interview for Mental Status (BIM) score of 13, which indicated Resident #2 was cognitively intact. The MDS further revealed Resident #2 was dependent on staff for assistance with dressing, toileting, showering/bathing. The resident required substantial/maximal assistance for personal hygiene. Review of a nursing progress note dated 04/09/24 at 12:53 P.M. revealed the resident complained that his right, great toe was painful, red, and irritated. An antibiotic, Keflex 500 milligrams (mg) was ordered, every eight hours for ten days, for an infected right, great toe. Review of the Medication Administration Record, dated April 2024, reflected the order for Keflex 500 mg, one tablet, every eight hours for ten days, for infection of right, great toe initiated on 04/09/24. During an interview on 04/17/24 at 3:00 P.M., Resident #2 stated he had asked staff repeatedly to clip his toenails and was told he would have to wait until podiatry comes in. Resident #2 stated his right toe was very painful and infected. Observation on 04/17/24 at 3:02 P.M. revealed the resident's toenails were thick and overgrown. Each toenail protruded beyond the end of the toe, approximately 1.5 centimeters (cm). Observation of the right, great toe revealed redness and swelling of the tissue adjoining the nail. There was no drainage observed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/24 at 3:11 P.M. Regional Director of Nursing (DON) #375 confirmed Resident #2 had not received podiatry services since 09/14/23. Regional DON #375 stated the podiatrist was scheduled to come in tomorrow and she would make sure the resident was seen due to his infection. During an interview on 04/19/24 at 8:54 A.M., RN #87 stated he and Social Services Director (SSD) #88 schedule the podiatry appointment. RN #87 confirmed Resident #2 should have been seen as recommended by the physician, and his last podiatry appointment was on 09/14/23. RN #87 stated Resident #2's last two appointments were canceled due to physician time constraints. RN #87 stated although the resident does have a history of refusing care at times, there was no documentation in the medical record indicating the resident refused podiatry services. During an interview on 04/18/24 at 11:05 A.M., Physician #432 stated that she has provided podiatry services at the facility since January 2024 and had not examined or treated Resident #2 prior to today. Physician #432 confirmed the resident should be examined every nine to ten weeks due to his diagnosis of diabetes mellitus. Physician #432 confirmed Resident #2 had an ingrown toenail and infection of the right, great toe and stated the cause was most likely due to having untrimmed toenails. Physician #432 stated some negative outcomes of untrimmed toenails were infection and ingrown toenails. Review of the facility's policy titled, Ancillary Services, dated July 2017, revealed the Social Services Department would ensure any resident's need for any ancillary service was met to maintain a full continuum of medical care and services and would assist and/or oversee the process of referral. The Social Services Coordinator and/or facility staff designee would schedule resident initial and routine ancillary services visits, as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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** 34298 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, review of the facility incident and accident log and corresponding investigation, review of the Facility Assessment, review of the Elopement Risk Assessment Policy and Procedure and staff, family and resident interviews, the facility failed to provide adequate supervision to Resident #74, who was actively exit seeking, cognitively impaired (with a Brief Interview Memory Score of six indicating severe cognitive impairment), identified as an elopement risk and resided on the secured unit, to prevent the resident from exiting the secured unit and the facility unsupervised. This resulted in Immediate Jeopardy and the potential for serious, life-threatening harm, injuries and/or death on [DATE] at approximately 5:50 P.M. when Resident #74 was granted access through the secured unit door by Cook #99 (who was unaware if the individual was a resident or visitor), passed by Licensed Practical Nurse #106 (who was unsure if the individual was a resident or visitor) and was then granted access through the secured facility main entrance by Receptionist #400 who had no knowledge if the individual was a resident or visitor. At the time of the investigation, it was unknown who located the resident, the time the resident was located and the actual whereabouts of the resident due to the lack of a thorough investigation by the facility but it was believed the resident was either located by an (unidentified) female visitor/individual on or near a road in front of the facility or at the State Route located approximately 100 yards from the facility, at the bottom of a wooded, downhill, paved road. The resident was noted with a skin tear and bruising thought to have occurred during a fall, on the facility main entrance/ exit ramp. This affected one resident (#74) of two residents reviewed for accidents and/or supervision. The facility identified 21 residents at risk for elopement (Resident #1, #7, #11, #22, #29, #30, #42, #46, #47, #48, #56, #60, #68, #70, #72, #74, #76, #138, #180, #181, and Resident #184). The facility census was 85. On [DATE] at 4:38 P.M., the Licensed Nursing Home Administrator (LNHA), Regional Nurse Consultant (RNC) #151 and Regional Nurse Consultant #375 were notified Immediate Jeopardy began on [DATE] at approximately 5:50 P.M. when the facility failed to follow proper protocols permitting Resident 74 to exit the secured unit and secured facility main entrance with assistance of staff (Cook #99, LPN #106 and Receptionist #400). Staff working on the secured care unit on [DATE] were unaware the resident, who was identified at risk for elopement, was cognitively impaired and had actively been exit seeking since admission to the facility, had exited the facility. At around 6:12 P.M. an unidentified female/visitor observed Resident #74 unsupervised, outside of the facility with the exact location unknown. The unidentified female notified Receptionist #400 an individual who she thought may be a resident, was outside of the facility, without staff knowledge. The Immediate Jeopardy was removed and subsequently corrected on [DATE] when the facility implemented the following corrective actions: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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	On [DATE] at 6:12 P.M., Resident #74 was returned to his room and assessed by Licensed Practical Nurse (LPN)/Program Director (PD) #128 (the director of the secured unit, also known as Speret Hall). A head-to-toe skin assessment, vital signs, range of motion, and neurological checks were completed. An Elopement Observation form was completed, and frequent checks for the next 24 hours were initiated. Certified Nurse Practitioner (CNP) #200 was notified at approximately 6:20 PM. Resident #74's Responsible Party (RP) #250 was notified at 6:49 P.M. and 6:58 P.M. regarding the resident's elopement. This was completed by LPN/PD #128. On [DATE] at 6:12 P.M. the Director of Nursing (DON) was notified of the elopement and the Licensed Nursing Home Administrator (LNHA) was notified at 6:15 P.M. An investigation was initiated. During the investigation, the LNHA and DON attempted to determine who the individual was who alerted the receptionist of Resident #74 being outside during the staff interviews with LPN #106, LPN/PD #128, Receptionist #400, and State tested Nursing Assistant (STNA)# 82. No one was able to identify the unknown female. On [DATE] (no identified time) the DON instructed LPN/PD #128 to obtain statements from the three staff directly involved with Resident #74's elopement, LPN #106, Receptionist #400 and Cook #99 before the end of their shift on [DATE]. On [DATE] at 7:00 P.M. a facility head count was completed by Registered Nurse (RN) #146 and #84, LPN #106, LPN/PD #128 and all 76 residents were verified to be in the facility. On [DATE] at 9:00 A.M. the LNHA and DON reviewed the statements from Cook #99, LPN #106 and Receptionist #400 and determined the root cause of the elopement was the fact that three staff members did not know Resident #74 was a facility resident and not a visitor. Cook #99 allowed the resident to exit the secured unit without verifying if the individual was a resident or visitor. LPN #106 allowed the resident to exit Unit 2 (the unit outside of the secured unit) thinking Resident #74 was a visitor and Receptionist #400 allowed the resident to exit the facility without verifying whether he was a resident or a visitor. On [DATE] at approximately 10:00 A.M. the LNHA and DON provided LPN #106, Receptionist #400 and Cook #99 with one-to-one education regarding the Elopement Policy, and to ensure they distinguished the actual identity of the person as a resident or visitor prior to allowing the individual to exit the secured unit or facility. On [DATE] at 10:00 A.M. the LNHA, DON, and Staff Coordinator (SC) #100 began mandatory in-services for all staff via OnShift Alert (Scheduling software that the facility utilizes to communicate with all staff members. Staff received their schedules and notifications through this software), 1:1 verbal education and handouts related to a new entry and exit process for Speret Hall (when management becomes aware that visitors know the codes to either enter or exit Speret Hall, the LNHA or DON will have Maintenance Coordinator #110 change the codes to keep the unit as safe as possible), visitor badge process (visitor badges will be provided or encouraged to Speret Hall visitors by the receptionist upon arrival for visitation), and the Elopement Policy. Education continued through [DATE] with a plan for any staff educated as of this time to be addressed. On [DATE] at 12:00 P.M. Maintenance Coordinator #110 completed an audit of all facility magnetic door locks (15 locks) to ensure they were functioning appropriately. Observational audits of door locks continued four times weekly for four weeks and as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER: Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 44565 Sunset Road Caldwell, OH 43724	

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	On [DATE] at 3:20 P.M. Maintenance Coordinator #110 completed an elopement drill. A plan was also implemented to conducted one drill per shift, weekly, for four weeks and as needed was completed. On [DATE] at 3:47 P.M. elopement risk assessments (observations) were completed for all 76 residents currently in the facility by the DON, RN #84 and RN #146 and LPN/PD #128. Changes in elopement risk scores were addressed through initiation of care plans and/or adding photos and information to the elopement binder. The facility identified 21 residents at risk for elopement (Resident #1, #7, #11, #22, #29, #30, #42, #46, #47, #48, #56, #60, #68, #70, #72, #74, #76, #138, #180, #181, and Resident #184). On [DATE] at 4:15 P.M. LPN #116 reviewed and updated four elopement binders to include photographs and the resident identification information form. Information for Resident #74 and all residents who were at moderate to high risk for elopement. One binder was located at Home B Nurses station, one at Unit 2 Nurses station, one at Speret Hall nurses' station and one at the reception desk. The Elopement scores were also discussed during the Clinical Meeting for any new admissions, readmissions and when a Minimum Data Set (MDS) is completed. The DON, Assistant Director of Nursing (ADON) #72, ADON #132 or MDS Nurse #87 were responsible for auditing the Elopement score. The Elopement binders would be updated by LPN #116, or the DON, Assistant Director of Nursing (ADON) #72, ADON #132 or MDS Nurse #87 with any change in a resident's Elopement Risk score. The Clinical Meeting is held Monday through Friday at 9:00 A.M. On [DATE] at 5:00 P.M. the facility implemented a plan all newly admitted residents' photos would be posted at the receptionist desk for one week and completed by Lead Receptionist #81. The lead receptionist/designee was responsible for posting the pictures of the new admissions at the front desk. The Designee could be any staff member working as the receptionist for that day. The LNHA and DON were responsible to verify this was being completed and have verified all new admission photos have been posted since implementation. On [DATE] at 4:00 P.M. 76 resident care plans were reviewed by MDS Nurse #87 to ensure care plans were accurate for residents at risk for elopement. A care plan for Resident #74 was created this date. On [DATE] the LNHA sent a letter via the United States Postal Service to responsible parties/families of residents residing on Speret Hall, providing education on the facility visitor badge protocol. On [DATE] at 9:30 A.M. an AD HOC Quality Assurance/Performance Improvement meeting was held with Medical Director #600, LNHA, DON, MDS Nurse #87, LPN #116, Dietary Coordinator #68, Intake Coordinator #61, Environmental Services Coordinator #123, and Lead Receptionist #81 to review the incident investigation and prevention plan. The LNHA would then refer adverse audit findings to the QAPI committee for review as needed and at monthly scheduled meetings. On [DATE], the LNHA and DON began audits to ensure visitor badges were in place or encouraged, three times weekly for four weeks and as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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	On [DATE] (no time identified), audits were implemented to ensure the doors to the smoking patio were secured with the alarm turned on three times a week for four weeks and as needed. (The door alarm to the smoking patio on Unit 2 was turned off at the time of the elopement). The LNHA, DON and/or Lead Receptionist #81 were responsible for completing the audits. On [DATE], the LNHA and/or DON initiated audits to validate the Speret Hall residents had their identifier wrist band on, or the Refused Wristband care plan was in place. The audits were completed once per week for four weeks and as needed. As of [DATE], 98 of 106 employees had received facility education. The remaining eight employees were identified as Cook #142, Housekeeping #139, STNA #56, #57, #66, #82 and #96 and LPN #63. STNA #57 and STNA #66 were currently on leave and would be educated upon return to work. The remaining six staff (Cook #142, Housekeeping #139, STNA #56, #82 and #96; LPN #63) work as needed and were removed from the scheduled effective [DATE] due to not receiving the education despite communication the education was required for continued employment. If the staff were not educated by [DATE], their employment with the facility would be terminated due to lack of participation. Findings include: Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anxiety, and depression. Resident #74 was admitted to the facility Speret Hall, a secure unit that required a code to enter and exit the unit. Clinical admission documentation dated [DATE] at 3:25 P.M. authored by Licensed Practical Nurse (LPN)/Program Director (PD) #128 revealed Resident #74 had short and long-term memory impairment and no mobility limitations. Resident #74's gait and balance were normal. The assessment revealed Resident #74 was not at risk for falls but was at high risk for elopement. An elopement risk observation form dated [DATE] authored by LPN/PD #128 revealed Resident #74 was able to ambulate, had a diagnosis of dementia, noted to be staying near windows or exit doors, was searching, and made verbal statements of needing to leave. The elopement risk observation form revealed Resident #74 was at high risk for elopement. Review of Secure Unit Pre-Admission assessment dated [DATE] revealed Resident #74 had cognitive impairment and exhibited poor safety awareness within the past three months. Resident #74 had resided in a private home and had wandered off and was unable to find his way back home. The history of mood/behavior revealed Resident #74 was easily confused and was recently at the emergency room after wandering out of his apartment. The pre-admission assessment revealed Resident #74 was compatible with admission criteria for secured unit. Further review of the medical record revealed Resident #74 did not have a care plan for his identified high risk for elopement identified on admission to the facility. Review of a nursing note dated [DATE] at 3:30 P.M. authored by Registered Nurse (RN) #450 revealed Resident #74 walked up and down the hallway. Resident #74 did go to the front and back door and tried to open the doors. No intervention was documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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	Review of a nursing note dated [DATE] at 2:57 P.M. authored by LPN/PD #128 revealed Resident #74 had been trying to get out the door nearest the end of the building. No intervention was documented. Review of a nursing note dated [DATE] at 10:37 A.M. authored by LPN/Supervisor #130 revealed Resident #74 continued to walk throughout the unit wandering from room to room and to the exit doors and asking to go home to Cambridge. No intervention was documented. Review of a nursing note dated [DATE] at 6:39 P.M. authored by LPN/PD #128 revealed Resident #74 continued to walk up and down the hall and asked if the doors could be opened. No intervention was documented. Review of a nursing note dated [DATE] at 3:11 P.M. authored by LPN/PD #128 revealed Resident #74 had been wandering around and asked three times if he could get out. Redirection helped for short periods of time. Review of a nursing note dated [DATE] at 5:54 P.M. authored by LPN/PD #128 revealed Resident #74 had tried to exit the building. The note indicated Resident #74 would be redirected to his apartment but would return to the day area. Resident #74's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 had severe cognitive impairment and wandering behavior that was not at significant risk for getting to a potentially dangerous place. Review of a nursing note dated [DATE] at 2:17 P.M. authored by LPN/PD #128 revealed Resident #74 had been walking up and down the hall. Resident #74 continued to go to the door and try to open the door. No intervention was documented. Review of a nursing note dated [DATE] at 1:18 P.M. authored by LPN/PD #128 revealed Resident #74 had been on the unit for two weeks. Resident #74 continued to go to the outside doors. Resident #74 tried to open the doors and would ask staff to let him out. Staff redirected the resident without problems. Review of a nursing note dated [DATE] at 5:50 P.M. authored by LPN/PD #128 revealed LPN/PD#128 was called to the lobby to get Resident #74. When LPN/PD #128 asked how Resident #74 got to the front lobby, LPN/PD #128 was told Resident #74 was mistaken as a visitor and allowed to exit Speret Hall and the facility. Staff were educated not to let anyone out of Speret Hall without asking. LPN/PD#128 noticed Resident #74 had a skin tear to the right wrist that measured one centimeter (cm) long, 0.5 cm wide, and 0.1 cm deep. It was also noted Resident #74 had a bruise to the right elbow and left hand near the thumb. Another resident reported Resident #74 fell outside on the sidewalk. (The progress note did not identify who the other resident was). Review of the incident and accident log revealed on [DATE] at 5:50 P.M. Resident #74 eloped from the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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	Review of the facility safety event report-fall with injury event dated [DATE] at 7:40 P.M. authored by LPN/PD #128 revealed an (unidentified) visitor found Resident #74 on the ground on the ramp in front of the facility (however, this visitor was not identified by the facility or interviewed as part of the facility investigation to determine the time the resident was located, the location of the resident or any additional information pertinent to the investigation). State tested Nursing Assistant (STNA) #82 assisted Resident #74 to stand (later interview with STNA #82 and Resident #6, who witnessed the fall, said Resident #74 was already standing or stood up by himself and brought Resident #74 into the facility. A skin tear was noted on Resident #74's right wrist that measured one cm long, 0.5 cm wide and less than 0.1 cm deep. Resident #74 also had a bruise to the right elbow and near the left thumb. Interventions put in place included frequent checks for 24 hours. The incident was documented as occurring on the sidewalk. Fall interventions included staff education about residents on the secure unit. Further review of the safety event report-fall with injury event revealed no information related to Resident #6's interview/statement (Resident #6 witnessed the Resident's fall on [DATE]). An elopement risk observation form dated [DATE] at 8:04 P.M. authored by LPN/PD #128 revealed Resident #74 was at high risk for elopement. A written statement dated [DATE] (no time) by LPN/PD #128, revealed at 5:30 P.M. Resident #74 was observed sitting at the table in the day area eating dinner. LPN/PD #128 gave Resident #74 medication at this time. After Resident #74 finished dinner, Resident #74 went down the hallway and then back to the day area to the exit door and tried to open the door. LPN/PD #128 redirected Resident #74 and told Resident #74 he had an apartment down the hall. Resident #74 went down the hall like he was going to his room. Cook #99 came down the hall with a bowl of food and LPN/PD #128 was administering medication to another resident. The statement indicated at 5:50 P.M. LPN/PD #128 was called to the front lobby to get Resident #74. A written statement dated [DATE] (no time) by Cook #99 revealed on [DATE] at approximately 5:50 P.M. Cook #99 walked past a room on Speret Hall and saw a man leaning over a bed and it looked like the man was talking to someone. Cook #99 assumed the man was a visitor. When Cook #99 got closer to the door (coded exit door leading off of Speret Hall onto Unit 2) the man (Resident #74) said there we go. Cook #99 put the code in to unlock the door while Resident #74 was standing at the doorway to a resident room. When Cook #99 opened the door, Resident #74 zoomed out (of the secured unit). Cook #99 asked Resident #74 if he was allowed out and Resident #74 said yes. Cook #99 wrote if I had closed the door, it would have hit Resident #74. Cook #99 thought Resident #74 was a visitor. A written statement dated [DATE] (no time) by LPN #106 revealed on [DATE] at approximately 5:50 P.M. Resident #74 stated he needed to come through the door as he exited the door from Speret (secure) Hall. Cook #99 was coming off Speret Hall at the same time. Resident #74 seemed like a visitor, walking full stride with a steady gait and at a fast pace. The statement revealed LPN #106 had not seen or dealt with Resident #74 before. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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	A written statement dated [DATE] (no time) by State tested Nursing Assistant (STNA) #82 revealed STNA #82 was sitting at the assisted living desk (the unit located near the main entrance) when a woman walked into the building and was talking to Receptionist #400. STNA #82 overheard the woman say there was possibly a resident outside. STNA #82 walked over to the door and saw Resident #74 outside. STNA #82 walked outside to see if it was one of the residents from the facility. Resident #74 was bleeding from his right arm and had told the unidentified lady that he needed a ride to Cambridge. STNA #82 asked Resident #74 if he would walk back into the building to have his arm checked out. STNA #82 asked STNA #90 if Resident #74 was one of the residents on Speret Hall. A written statement dated [DATE] (no time) by STNA #90 revealed STNA #90 went to the kitchen to get a cup of juice for LPN/PD #128. STNA #82 asked STNA #90 what unit they were working on and asked if any residents were missing from Speret Hall. STNA #90 stated they were working on Speret Hall, and no residents were missing. STNA #82 said the man (that was outside) stated his name was (not his name). STNA #90 then walked closer to see the man STNA #82 was talking about. STNA #90 stated it was Resident #74. STNA #82 said someone found Resident #74 in the road. STNA #90 asked how Resident #74 got off the unit. STNA #82 stated a girl from the kitchen thought Resident #74 was a visitor and allowed Resident #74 to leave Speret Hall. Receptionist #400 called LPN/PD #128 to come get Resident #74. LPN/PD #128 made phone calls to the Director of Nursing and Administrator and asked staff to do a head count. A written statement dated [DATE] (no time) by Receptionist #400 revealed a man (Resident #74) walked from Unit 2 onto the smoker's patio. Resident #74 entered the front lobby from the smoking patio. Resident #74 then walked to the main entrance door and stood inside for a minute. Receptionist #400 thought Resident #74 had paused to look at the cats on the smoking patio. Resident #74 then started walking to the main entrance door without any questions or hesitation. Resident #74 looked like other visitors, so Receptionist #400 did not question Resident #74 and had no way of knowing Resident #74 was a resident. After Resident #74 exited the building, a visitor then came inside and said there was an older man outside asking for a ride to Cambridge. The visitor stated the man (Resident #74) did not seem familiar with where he was. STNA #82 came to the receptionist desk and spoke to the woman and then went outside to talk to Resident #74. STNA #82 brought Resident #74 back in and Receptionist #400 called LPN/PD #128. A written statement dated [DATE] (no time) that was signed by Resident #6 revealed Resident #6 observed a man (Resident #74) fall onto the concrete at the bottom of the ramp. Resident #74 was able to get up unassisted. The statement was received from the resident by LPN #106. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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	The facility investigation of an elopement dated [DATE] revealed Resident #74 exited the secure unit onto Unit 2. Resident #74 went through the Unit 2 smoking patio door then walked through the smoking patio area and through the door into the front lobby. Resident #74 then exited the facility out the front lobby door. A new dietary aide (Cook) #99 thought Resident #74 was a visitor and allowed Resident #74 to exit Speret Hall. Resident #74 walked past LPN #106 on Unit 2. LPN #106 also thought Resident #74 was a visitor. Resident #74 then entered the lobby and exited out the lobby door where Resident #74 was seen by Receptionist #400 who also thought Resident #74 was a visitor. Resident #74 was last seen by Cook #99 at 5:50 P.M. Resident #74 left the unit at approximately 5:50 P.M. Director of Nursing (DON) received a call from LPN #128 at 6:12 P.M. It was believed Resident #74 was out of the facility for no longer than ,d+[DATE] minutes. Resident #74 got 77 feet away from the facility (this cannot be confirmed through staff statements or interviews because no staff could report the resident's exact location when discovered by the unidentified female individual as she was not interviewed for this information). Resident #74 was wearing blue jeans, a long sleeve plaid shirt, and shoes. The earliest Resident #74 exited the facility was at 5:50 P.M. The DON was called at 6:12 P.M. and the LHNA was called at 6:15 P.M. The temperature at 6:00 P.M. was 70 degrees Fahrenheit. A plan of care dated [DATE] (not initiated until four days after the elopement) revealed Resident #74 was at risk of eloping related to the resident's ability to self-propel (resident ambulated independently), Alzheimer's/dementia, history of alcoholism, express delusions, express hallucinations, near windows/exit, searching, verbal statements about leaving, and a history of elopement. Interventions included to check Resident #74 frequently and re-direct from exit doors as needed, inform facility staff including the interdisciplinary team and receptionist of the potential for elopement, complete the resident identification sheet due to risk factors, staff to report immediately to the nurses any statements by the resident of needing to leave, encourage activity involvement, attempt to determine what Resident #74 wanted or was searching for and try to convince Resident #74 that there is no need to look outside, notify family of the potential for elopement and encourage their help keeping Resident #74 safe, redirect to outside only with one-on-one staff supervision and instruction of the nurse, and educate/encourage family/friends to inform staff prior to Resident #74 leaving the facility with them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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	Interview on [DATE] at 2:49 P.M. with LNHA revealed a dietary staff member (Cook#99) was going down the hall and Resident #74 followed the staff member out the door from Speret Hall. Cook #99 thought Resident #74 was a visitor. Resident #74 went through a door on Unit 2 to the smoking patio and then through another door to the main lobby. Resident #74 told Receptionist #400 he was ready to go home. Receptionist #400 unlocked the front door to let Resident #74 out of the facility. A visitor talked to Resident #74 outside and thought Resident #74 seemed confused and notified Receptionist #400 there was a possible resident outside. Resident #74 had a skin tear and some bruises from a fall that occurred outside the facility. The LNHA revealed he was notified of the elopement at 6:15 P.M. by LPN/PD #128. The LNHA verified Resident #74's information had not been placed in the elopement binders located at the nurse's station and receptionist desk. The LNHA also verified the doors to the smoking patio were to alarm when opened on Unit 2 and the main lobby. However, the doors were not alarmed at the time Resident #74 went out the door to the smoking area. LNHA also verified the time of elopement and time Resident #74 was found were both listed as 5:50 P.M. on some information. During the interview, the LNHA could not verify how long Resident #74 was off the secure unit, how long Resident #74 was outside of the facility, exactly where Resident #74 was found or had been, and/or who the visitor was that reported finding Resident #74 outside of the facility. The LNHA also verified he was unaware of the resident's location when the resident was discovered by the unidentified female. He verified this information should have been clarified during the investigation and that the inconsistencies were not identified until this interview. Interview on [DATE] at 3:03 P.M. with Cook #99 revealed upon hire Cook #99 had been educated about not letting residents off Speret Hall. Cook #99 stated Resident #74 was walking without difficulty and was nicely dressed and had his shirt tucked in. Cook #99 thought Resident #74 was a visitor and asked Resident #74 if they were permitted off the unit. Resident #74 stated he was permitted to leave. Cook #99 stated LPN #106 was asked if she recognized Resident #74. LPN #106 stated she did not know Resident #74. Interview on [DATE] at 3:30 P.M. with Regional Nurse #151 verified the elopement care plan was initiated after Resident #74 eloped from the facility despite the resident being identified as an elopement risk on admission and displaying frequent exit seeking behaviors prior to his elopement. Interview on [DATE] at 10:20 A.M. with STNA #90 revealed Resident #74 always wandered. STNA #90 stated she was working Speret Hall and was not aware Resident #74 had left the unit until STNA #82 asked if anyone was missing from Speret Hall. STNA #90 saw Resident #74 standing at the front desk. LPN/PD #128 was notified and assisted Resident #74 back to Speret Hall. Interview on [DATE] at 10:27 A.M. with Responsible Party #250 of Resident #74 revealed she was notified a new kitchen staff member had let Resident #74 off the secure unit and Resident #74 had fallen outside the facility. Resident #74's Responsible Party #250 was not sure where Resident #74 fell but stated it was possibly on the smoking patio. LPN/PD #128 called Resident #74's daughter and stated Resident #74 was found on State Route (SR) 78 (a two-lane road with no sidewalks and speed limits of 55 miles per hour mph), trying to hitchhike to Cambridge (a town approximately 20 miles from the facility). A lady stopped on SR 78 and brought Resident #74 to the facility to see if Resident #74 resided there. The daughter stated Resident #74 was admitted to the facility because he kept wandering away from home and trying to hitch hike. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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	Interview on [DATE] at 10:34 A.M. with LPN/PD #128 revealed Cook #99 let Resident #74 off Speret Hall. LPN #106 was working on Unit 2 and was not aware Resident #74 was from Speret Hall. LPN #106 did not stop Resident #74 from leaving Speret Hall or Unit 2. LPN/PD #128 was not aware Resident #74 was missing until Receptionist #400 called stating Resident #74 was in the main lobby. LPN/PD #128 stated Resident #74 was not found near SR 78 but found on the road in front of the facility, near the parking lot and the ramp from the main entrance. Further interview revealed Receptionist #400 reported to her the resident was on the roadway, in front of the facility. The LPN also stated she was unsure why the resident's information was not in the elopement binder but LPN/PD #128 usually verbally informed medical records when a resident was identified at risk for elopement because the medical records staff (LPN #116) was usually working. LPN/PD #128 verified she did not know who located the resident while he was outside of the facility. Interview on [DATE] at 10:51 A.M. with Resident #6 revealed he saw Resident #74 fall on the ramp in front of the facility. Resident #74 got up unassisted. Resident #6 stated he reported to LPN/Supervisor #106 someone had fallen outside. Resident #6 provided no additional information related to the incident. Interview on [DATE] at 11:00 A.M. LPN/Medical Records #116 revealed the nurses would notify Medical Records #116 if a resident was an elopement risk. Medical Records #116 would then take the resident's picture, complete the Resident Identification Form, and place the information in the elopement binder. Medical Records #116 did not know why Resident #74 did not have information in the elopement binder. Medical Records #116 verified she was not aware Resident #74 was at high risk for elopement and Resident #74's information was not in the elopement binder at the time Resident #74 had exited the facility without staff knowledge. Interview on [DATE] at 12:44 P.M. with STNA #82 revealed she did not witness Resident #74 exit the facility. A female entered the facility and reported she was driving up the hill to the facility and saw a man walking past the independent living apartments. (The apartments are attached to the right side of the skilled facility located at the end where the road goes down a steep hill to SR 78.) STNA #82 went outside and found Resident #74 at the bottom of the ramp leading from the front door of the facility. STNA #82 stated she did not recognize Resident #74 but brought Resident #74 back into the facility. Interview on [DATE] at 12:49 P.M. with Receptionist #400 revealed she thought Resident #74 was a visitor and let Resident #74 exit the facility. Receptionist #400 stated Resident #74 was outside the facility for approximately 10 to 15 minutes. Receptionist #400 stated the female visitor who reported Resident #74 was outside was someon [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on observation, record review, resident and staff interviews, review of the facility policy, and review of manufacture instructions, the facility failed to ensure Resident #8's continuous positive airway pressure (CPAP) mask was properly cleaned. This affected one (Resident #8) out of three residents reviewed for respiratory care. The facility census was 85. Findings include: Review of the medical record revealed Resident #8 was admitted on [DATE] with diagnoses that included acute respiratory failure, diabetes mellitus, chronic obstructive pulmonary disease (COPD) with exacerbation, emphysema, sleep apnea, and anxiety disorder. Review of a plan of care dated 12/28/21 revealed Resident #8 had the potential for impaired gas exchange related to diagnoses of sleep apnea and the use of CPAP (a form of positive airway pressure that is continuously applied to the upper airway collapse, as occurs in sleep apnea and is highly effective in treating sleep apnea) equipment. Interventions for cleaning CPAP equipment included filters to be cleaned monthly. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #8 was cognitively intact. Interview on 04/15/24 at 9:56 A.M. with Resident #8 revealed their CPAP mask was dirty and not cleaned. Observation of the CPAP mask revealed dried substances on the inside of the mask where Resident #8's nose and mouth would be when Resident #8 was wearing the mask. Interview on 04/17/24 at 9:18 A.M. with Licensed Practical Nurse (LPN) #106 revealed CPAP equipment was to be cleaned by the night shift nurses. On 04/17/24 at 9:23 A.M. LPN #106 verified Resident #8's CPAP mask had dried substance on the inside of the mask. Interview on 04/17/24 at 12:12 P.M. Regional Nurse #375 verified there was not any documentation of CPAP mask being cleaned as recommended by the manufacture. Review of the medication administration records and treatment administration records for March and April 2024 for Resident #8 revealed the only documentation regarding usage or care for the CPAP equipment was Resident #8 to have full face mask on at bedtime. Review of the CPAP support policy and procedure (no date) revealed it was the facility's policy to improve arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. The procedures included to review and follow the manufacturer instructions for machine setup and oxygen delivery. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacture instructions, provided by the facility, revealed daily and after each use, the mask should be disassembled and the frame, elbow, and cushion should be rinsed under running water and cleaned with a soft brush until dirt is removed. The components should soak in warm water with a mild liquid detergent for up to ten minutes and then shaken vigorously in the water for at least one minute. The moving parts of the elbow, around the vent holes, the frame where the arms connect and inside and outside of the frame where the elbow connects, should be brushed. The components should be rinsed under running water. The components should be air dried and the arms of the frame squeezed to ensure that excess water was removed. Weekly care instructions included to disassemble the mask, handwash the headgear in warm water with mild liquid detergent, rinse under running water, squeeze the headgear to remove excess water, and leave the headgear to air dry.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, pharmacy review, and interview the facility failed to ensure physician orders were implemented after a pharmacy recommendation and failed to provide rationale for extending as needed psychotropic medication beyond 14 days. This affected one resident (Resident #62) of five residents reviewed for unnecessary medications. The facility census was 85. Findings include: a. Review of the medical record revealed Resident #62 was admitted on [DATE] with diagnoses that included dementia, alcohol abuse, and anxiety disorder. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #62 had severely impaired cognition and behaviors (verbal/disruptive sounds) towards others. Review of the monthly pharmacy recommendation dated 08/04/23 revealed a recommendation for Resident #62 to have a gradual dose reduction. The physician wrote an order (no date) on the pharmacy recommendation for Zyprexa (antipsychotic) 2.5 milligram (mg) twice a day to be decreased to 2.5 mg once a day for 14 days and then discontinued. Further review of the medical record revealed the resident was currently receiving the medication, Zyprexa. On 04/18/24 at 1:38 P.M. Regional Nurse #375 verified the physician order for Resident #62's Zyprexa to be decreased and discontinued was not implemented. b. Review of the medical record revealed Resident #62 was admitted on [DATE] with diagnoses that included dementia, alcohol abuse, and anxiety disorder. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #62 had severely impaired cognition and behaviors (verbal/disruptive sounds) towards others. A pharmacy note to the physician dated 04/04/24 revealed Resident #62 was currently receiving Xanax (psychotropic) 0.25 mg every six hours as needed. The duration of treatment with such medications on an as needed basis should be limited to 14 days. However, a new order may be written to extend the duration beyond 14 days if the prescriber believes it is appropriate. If it is to be extended, document the rationale for the extended time period in the medical record and indicate a specific duration. The physician marked the form as disagree and extend for 90 days. On 04/18/24 at 1:38 P.M. Regional Nurse Consultant #375 verified the physician did not document a rationale for the extended time period of the as needed Xanax.