STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365695	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Doylestown Health Care Center	95 Black Drive Doylestown, OH 44230

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on staff interview, medical record review, emergency department encounter report review, and facility policy and procedure review, the facility failed to ensure adequate supervision to prevent Resident #168, who was a high-risk for elopement, from exiting a fifteen second delayed and alarmed egress door resulting in a fall with injury. This affected one resident (Resident #168) of three residents reviewed for elopement. The facility census was 68. Actual harm occurred on 03/23/24 around 4:20 P.M. when Resident #168, who was severely cognitively impaired, exited the facility through a fifteen second delayed and alarmed egress door in a wheelchair. Resident #168 fell forward on a ramp leading to the parking lot and was found face down leaning to her left side with obvious facial injuries that were bleeding. Resident #168's wheelchair was behind her and her shoes had come off during the fall. Resident #168 sustained a six-centimeter laceration in the center of the scalp requiring sutures to close and acute bilateral nasal bone fractures. Findings include: Review of the closed medical record for Resident #168 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to intracerebral hemorrhage, hemiplegia and hemiparesis, type one diabetes mellitus, dysphagia, stage III chronic kidney disease, major depressive disorder, and depression. Review of Resident #168's quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed a Brief Interview of Mental Status score of seven which indicated severe cognitive impairment. The assessment also indicated Resident #168 required supervision for wheeling wheelchair 50 feet, maximum assistance for toileting, bathing and transfers, and for wheeling wheelchair 150 feet. Review of Resident #168's elopement risk evaluation dated 02/05/24 revealed a score of one indicating the resident was not at risk of elopement. No additional elopement risk evaluations were completed. Review of the nursing progress note dated 02/25/24 timed at 1:33 P.M. revealed Resident #168 was exit-seeking and pushing on doors. Resident #168 was redirected; a wanderguard (a bracelet worn by the resident that sets of an alarm and locks armed doors), was placed on her ankle and the physician was notified. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of nursing progress note dated 02/26/24 timed at 2:45 P.M. revealed Resident #168 was observed by a therapist at Exit door 12 holding it open. Resident #168 did not go outside and was redirected to the activities room. Review of nursing progress note dated 03/02/24 timed at 11:27 A.M. revealed Resident #168 continued exit seeking. Review of the nursing progress note dated 03/18/24 timed at 5:29 P.M. revealed Resident #168 was exit-seeking and appeared to be getting worse. Review of the nursing progress note dated 03/18/24 timed at 6:20 P.M. revealed Resident #168 was exit-seeking, one-on-one was unsuccessful and family came to sit with Resident #168. Review of the nursing progress note dated 03/19/24 timed at 5:00 P.M. revealed Resident #168 was pushing on Exit door 8 causing the alarm to sound. Resident #168 had a wanderguard attached to her ankle, but it did not trigger the door alarm. The wanderguard was replaced with a functioning wanderguard. Review of Resident #168's care plan with a revision date of 03/20/24 revealed Resident #168 was an elopement risk related to wandering, disoriented thinking, impaired safety awareness and confusion. Interventions dated 02/28/24 included assess for fall risk, wanderguard, distract the resident with activities, food, TV, and staff interaction. An intervention dated 03/20/24 indicated replacement of wanderguard. Resident #168 was noted to have an activities of daily living deficit related to right hemiplegia, limited mobility and stroke and required staff assistance for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. Review of the nursing progress note dated 03/21/24 timed at 5:14 P.M. revealed Resident #168 was exit-seeking, stating she wanted out of the facility and redirection after each attempt was completed. Review of the nursing progress note dated 03/23/24 timed at 5:00 P.M. revealed Registered Nurse (RN) #13 was approaching the [NAME] unit lounge when she heard a door alarm. RN #13 immediately responded to Exit door 12 and observed Resident #168 outside on the ramp; Resident #168 had fallen forward out of her wheelchair. RN #13 alerted staff to get immediate assistance and went out to assess Resident #168. Resident #168 was laying on her belly leaning to her left side with obvious facial injuries that were bleeding. Resident #168's wheelchair was behind her, and her shoes had come off her feet during the fall. Another nurse called emergency medical services (911) at 4:25 P.M. Resident #168 was alert and able to speak and stated she wanted to get up. Resident #168 was moving her head and denied any neck pain. No inward or outward rotation to the bilateral lower extremities were noted. Laundry staff brought out towels to put pressure on her head wound. Three nurses and one State tested Nursing Assistant (STNA) assisted Resident #168 back into her wheelchair. Resident #168 was noted to have a head laceration about three centimeters long and one quarter inch wide at the center, and her nose was bleeding. Resident #168 was brought back into the building and pressure was applied to her forehead laceration and blood was cleaned off her face. Emergency medical services (EMS) arrived at 4:30 P.M. and Resident #168 was transported to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Emergency Department Encounter dated 03/23/24 timed at 5:10 P.M. revealed Resident #168 arrived at the hospital with a six-centimeter laceration in the center of the scalp down to the [NAME] with no skull visible and acute bilateral nasal bone fractures. The laceration required simple interrupted sutures at the level of the epidermis. Interview on 04/15/24 at 1:35 P.M. with RN #13 revealed she found Resident #168 when she was transporting another resident to the activity lounge around 4:20 P.M. on 03/23/24 and heard the door alarm. RN #13 ran to Exit door 12 and saw Resident #168 through the window and observed she had fallen out of her wheelchair onto the cement. Resident #168 was observed about four feet from the door lying on her stomach leaning to the left trying to get back up. RN #13 yelled for assistance. Two other nurses reported to the scene, and they began to assess Resident #168. Resident #168 was noted to have a laceration on her forehead and was bleeding from her nose. Licensed Practical Nurse (LPN) #9 called for EMS and then came back to assist. Three nurses and an aide assisted Resident #168 back into her wheelchair and used towels to apply pressure to her wounds. EMS arrived within five to ten minutes of being called and she left for the hospital. Phone interview on 04/15/24 at 3:57 P.M. with LPN #8 revealed when she got report at 3:00 P.M. on 03/23/24 she was told that Resident #168 was exit seeking and they had placed her at the nurse's station. LPN #8 had just seen Resident #168 and taken her blood sugar at the nurse's station and then walked to the end of the hall to start passing medications and before being able to start passing medications was paged to Exit door 12. When LPN #8 arrived, Resident #168 was sitting up on the ground at the top of the ramp. LPN #8 assisted the other nurses and aide to get Resident #168 back up into her wheelchair. Resident #168 stated she was trying to leave. They obtained vitals and then called the doctor and waited for EMS to arrive. EMS arrived in less than ten minutes, and she left for the hospital. Interview on 04/16/24 at 8:20 A.M. with LPN #9 revealed she was working on the [NAME] unit on 03/23/24. LPN #9 stated earlier on 03/23/24 she heard the alarm for Exit door 3 going off and found Resident #168 at the door and had the door open, but staff brought her back to the nurse's station before she got outside. Staff were watching her at the nurse's station. About 4:20 P.M. on 03/23/24, LPN #9 was passing medications down by Exit door 3 and was alerted by another staff Resident #168 had gotten outside and fallen out of her wheelchair. LPN #9 ran to Exit door 12 to assist and then ran back inside to call 911 and then proceeded to get her equipment to take vitals. LPN #9 did an assessment on Resident #168 and then she along with three other staff lifted Resident #168 back into her wheelchair and brought her inside until the ambulance arrived. Interview on 04/16/24 at 10:40 A.M. with the Director of Nursing (DON) revealed Resident #168 was cut from skilled services on 02/14/24 and moved to a semi-private room on 02/15/24. On 02/23/24 Resident #168 was noted to be picking at her skin and having mental changes and a urine sample revealed a urinary tract infection (UTI) which was treated with an antibiotic. On 02/25/24, Resident #168 was observed by staff at Exit door 12 with the door open. Staff redirected her. On 02/28/24, Resident #168 continued to be exit-seeking and a wanderguard was applied. On 03/18/24 Resident #168 was again exit-seeking and staff provided one-on- one supervision and then called family who came and sat with her. On 03/19/24 Resident #168 was pushing on exit doors and her wanderguard did not activate properly. Resident #168's wanderguard was replaced. A urine sample was obtained on 03/21/24 and was negative for a UTI. The DON confirmed the current elopement assessment was dated 02/05/24 and an elopement assessment was to be completed following each attempt to elope and had not been completed following attempts on 02/25/24, 02/28/24, 03/18/24, 03/19/24, and 03/21/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 04/16/24 at 11:22 A.M. with Corporate Quality Assurance Nurse #16 confirmed Resident #168's care plan was not updated following exiting attempts on 03/18/24, 03/19/24, and 03/21/24. Interview on 04/16/24 at 11:45 A.M. with Maintenance Director #17 confirmed Exits 3, 4, 5 and 12 were not wanderguard armed; they were 15 second delayed alarmed egress doors. The doors alarmed and released when the bar at the center of the door was pushed and held for 15 seconds. Review of the facility policy Wandering/Elopement, dated December 2015 revealed the resident would be screened during preadmission, an assessment would be completed upon admission, quarterly and with a change in condition and with any attempt to leave the facility unplanned or unsupervised. When identified as a wanderer, the facility would identify the need for regular monitoring of the resident's whereabouts each shift and would include the frequency of monitoring. Additional interventions could include a wanderguard or placement on a secured unit if applicable. The care plan would be updated. This deficiency represents non-compliance under Control Number OH00152564.