STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365714	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Leonard Hcc	8100 Clyo Road Centerville, OH 45458

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a facility (self-reported incident), observations, staff interview and facility policy review, the facility failed to provide adequate interventions and/or supervision to ensure a resident who was assessed as being at risk for elopements did not elope from the facility. This affected one (#205) out of three residents reviewed for elopement risk. The facility census was 116. Findings include: Review of Resident #205's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses include Alzheimer's disease, dementia and traumatic brain injury. Review of the Minimum Data Set (MDS) 3. 0 assessment dated [DATE] revealed Resident #205 was severely cognitively impaired, required moderate assistance with dressing, toileting and bathing. Review of Resident #205's care plan dated 06/29/25 revealed the resident was at risk for falls, self-care performance deficit and elopement. Interventions included Resident #205 to be one on one with someone. Review of Resident #205's nursing progress notes dated 06/26/25 identified as a late entry, revealed the resident was placed on a one-on-one on 06/25/25 due to wandering. A wander guard was in place. An aide left Resident #205 to answer a call light and resident left front door with emergency medical services (EMS). Review of a facility SRI dated 06/26/25 revealed for neglect revealed Resident #205 was found outside the facility on the facility grounds by an independent living resident. On 06/25/25 at approximately 7:15 P.M. Resident #205 was assumed to be missing. A headcount was done immediately which confirmed that Resident #205 was not in the facility. Staff initiated a search of the premises. The nurse on duty concluded that Resident #205 was following someone out the main entrance, the Wanderguard system did not sound an alarm. The resident was last seen at 7:00 P.M. in the common area on by Certified Nursing Assistant (CNA) #12. CNA #12 went into another resident's room to provide resident care and when she came back to the common area at 7:15 P.M., Resident #205 was no longer there. Security was notified. At 7:25 P.M., an anonymous caller reported to security that Resident #205 was seen standing in the backyard of one of the Independent Living Cottages. Security personnel was immediately dispatched and successfully returned the resident to the facility. The nurse on duty completed a head-to-toe assessment; the resident was free of injury. The facility conducted an investigation and determined the allegation to be substantiated. Observation on 09/17/25 at 1:41 P.M. revealed when the code to exit door is placed in or when button to unlock front door by receptionist desk, this stops the wander guards from alarming for 60 seconds. Interview on 09/17/25 at 10:48 A.M. with Administrator verified Resident #205 eloped the facility on 06/26/25 approximately 7:15 P.M. Resident #205 was a one on one with Certified Nursing Assistant (CNA) #400. CNA #400 left Resident #205 and answered another resident's light. When CNA #400 returned, Resident #205 was no longer in the common area and a search was started The Administrator stated the facility determined the ambulance was transferring another resident out of facility at the time of Resident #205's elopement. The Administrator stated an anonymous caller on 06/26/25 at 7:24 P. M. reported Resident #205 was found in independent living yard. The Administrator confirmed Resident #205 was assessed and was not injured. Interview on 09/17/25 at 10:48 A.M. with Director of Nursing (DON) verified the facilities security system is currently being changed from x-mark to secure care. New wiring is currently being placed in the facility. The DON stated a secure care will not allow a wandergaurd to pass doorways at anytime without alarming. The DON confirmed with the current system, if a staff or visitor presses the button at the receptionist desk this silences the alarm. Review of facility policy, Elopement and Wandering Residents, dated 05/22/25 revealed residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. This deficiency represents non-compliance investigated under Complaint Number 1323869 (OH00167528).