STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365718	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Streetsboro	1645 Maplewood Dr Streetsboro, OH 44241

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38523 Based on medical record review, review of the Certification and Licensure System (CALS), staff interview and review of facility policy, the facility failed to report incidents of elopement to the State Agency. This affected two residents (#03 and #18) of four residents reviewed for neglect. The facility census was 71. Findings include: Review of the medical record for Resident #03 revealed an admitted d of 11/21/23. Diagnoses included dementia, mild intellectual disabilities, impulse disorder, Alzheimer's disease with late onset, wandering in diseases classified elsewhere and unspecified psychosis not due to a substance or known physiological condition. Resident #03 had a legal guardian and resided on the secured memory care unit of the facility. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/25/24, revealed Resident #03 had a Brief Interview for Mental Status (BIMS) score of 09, indicating he had moderate cognitive impairment. The assessment identified the resident to have behaviors of wandering and he was independent for ambulation. Review of a nursing note dated 11/02/24 at 3:58 P.M., and completed by Licensed Practical Nurse (LPN) #144, revealed a call was received from the police department at 2:10 P.M. stating a resident (identified to be Resident #03) was on a street 0.7 miles away from the facility. The resident was crying and lost, taken to the police station and then brought back to the facility around 2:30 P.M. Further review of the note revealed the last time the resident was seen by the nurse was around 12:00 P.M. when the resident was eating pizza at a dining room table. Once Resident #03 was brought back to the facility by the police, a full head-to-toe assessment was completed. Vitals and assessment were normal and at baseline and the resident denied any pain. Resident #03 stated he waited until the food tray cart was being collected to sneak behind the cart as the door was opened by staff. Resident #03 stated he went out the front door to go home with his sister. The resident denied being hurt or in any pain. Facility staff were asked if anyone noticed Resident #03 elope and all staff denied seeing the resident. Education was provided to staff on elopement risk and wander guard function check. Resident #03 was placed on one-on-one staff supervision and the responsible party was notified. Full head count was completed, and all residents were accounted for. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Arbors at Streetsboro	1645 Maplewood Dr Streetsboro, OH 44241

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a local police report revealed on 11/02/24 at 1:43 P.M., a call was received from a neighborhood resident who reported seeing an elderly male walking, who was stumbling and fell to the ground. Further review revealed the responding officer arrived on the scene at 1:50 P.M. and found Resident #03 on his hands and knees and appeared disoriented. The officer called EMS, who responded and cleared the resident. EMS transported the resident back to the facility. The police response was cleared at 2:42 P.M. Review of CALS revealed no evidence a self-reported incident (SRI) related to Resident #03's elopement was reported to the state agency. Interview on 11/07/24 at 8:35 A.M. with the Director of Nursing (DON) confirmed Resident #03 eloped from the facility on 11/02/24. The DON further confirmed facility staff were unaware the resident was missing until the local police department contacted the facility after finding the resident approximately 0.7 miles away from the facility. 2. Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included unspecified dementia, hallucination, mild cognitive impairment, acute osteomyelitis of the right ankle and foot, arthritis due to other bacteria to the right ankle and foot, and diabetes mellitus type II with diabetic neuropathy. Review of the quarterly MDS assessment, dated 10/04/24, revealed Resident #18 had a BIMS score of 11, indicating she had moderate cognitive impairment. The resident was independent for ambulation. Review of a nursing note dated 08/13/24 at 7:30 P.M. revealed Resident #18 was seen by oncoming shift staff in the church parking lot approximately 1.1 miles from the facility. Staff informed the writer of her location and staff were able to get the resident safely back to the facility. Once returned, a wander guard was placed on the resident and one-on-one with staff (supervision) was initiated. Resident #18 was assessed with no negative findings and the resident denied pain. She also denied any mental anguish and stated she was just going to get fresh air and grab something from the store, but then found herself lost and did not know how to get back. The Nurse Practitioner (NP), interim DON and Administrator were notified. Review of CALS revealed no evidence an SRI was reported to the state agency related to Resident #18's elopement. Interview on 11/12/24 at 9:22 A.M. with the DON, the Administrator, Regional Director of Clinical Services (RDCS) #160 and RDCS #161 revealed on 08/13/24, Resident #18 was seen in an area church parking lot approximately 1.1 miles from the facility. While Resident #18 was her own responsible person, the facility treated the incident as an elopement because the resident did not inform staff she was leaving the facility. Since the incident, the facility attempted to place a wander guard on Resident #18 and move her to the secured memory care unit, with the resident refusing each intervention. Resident #18 remained on one-on-one staff supervision pending the outcome of a guardianship hearing on 11/18/24. Interview on 11/12/25 at 1:45 P.M. with Regional Director of Operations (RDO) #245 verified the facility did not submit an SRI for either Resident #03 or Resident #18's elopements from the facility. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 10/24/22, revealed the facility would report all alleged violations and all substantiated incidents to the State Agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation. This deficiency was an incidental finding discovered during the complaint investigation.

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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 - 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** 38523 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, medical record review, review of facility video surveillance, review of a local police report, facility policy review and interview, the facility failed to provide adequate supervision for Resident #03, who was assessed to be high risk for elopement, had a history of exit seeking behavior, resided on the secured memory care unit and had a wander guard (wearable device to help keep residents at risk of wandering safe) to prevent elopement. This resulted in Immediate Jeopardy and the potential for serious harm, injury and/or death on [DATE] at 12:44 P.M. when Resident #03 followed dietary staff through the secured memory care door, traveled through the facility and eloped through the front door without staff knowledge. Furthermore, Resident #03's wander guard alarmed (as designed) at the front door when he exited; however, staff failed to timely respond and further failed to adequately investigate the source of the alarm upon response. Resident #03 walked approximately 0.7 miles away from the facility, through a neighborhood with two large ponds of water along the route traveled. Resident #03 was found by the local police after a concerned neighborhood resident saw Resident #03 fall and called 911. Upon police arrival, Resident #03 was found on his hands and knees on the sidewalk. Facility staff were unaware Resident #03 was missing until notified by the local police department (LPD) he had been found, approximately two hours after he was last seen in the facility by staff. In addition, a concern that did not rise to an Immediate Jeopardy occurred when the facility failed to provide adequate supervision for Resident #18 resulting in the resident eloping from the facility without staff knowledge. The resident was found by a facility staff member who was traveling to the facility for their scheduled shift. This affected two residents (#03 and #18) of three residents identified by the facility as being assessed as high risk for elopement. The facility census was 71. On [DATE] at 1:49 P.M. the Regional Director of Operations (RDO) #245, Director of Nursing (DON), Regional Director of Clinical Services (RDCS) #160, RDCS #161 and Licensed Practical Nurse/Unit Manager (LPN/UM) #248 were notified Immediate Jeopardy began on [DATE] at 12:44 P.M. when Resident #03 followed Dietary Aide (DA) #157 off the secured memory care unit, unnoticed. Resident #03 eloped through the front door of the facility and staff failed to respond timely to the wander guard alarm at the front door. When staff did respond, approximately 20 minutes after the alarm sounded, staff did not fully investigate the source of the alarm, turned the alarm off and failed to conduct a resident head count to ensure all residents were accounted for. The facility was unaware the resident was missing until returned to the facility by the LPD, nearly two hours after he eloped. The Immediate Jeopardy was removed, and the deficient practice corrected on [DATE] when the facility implemented the following corrective actions: On [DATE], upon discovery Resident #18 had eloped from the facility, a head count was initiated by Licensed Practical Nurses (LPNs) #136 and #137 and all additional residents were accounted for. On [DATE] at [DATE], LPN #249 completed a head-to-toe assessment on Resident #18. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], Resident #18 was placed on one-on-one staff supervision, which would continue pending the outcome of a guardianship hearing on [DATE]. On [DATE] at 2:10 P.M., LPN #144 was notified by the LPD Resident #03 had been located off facility grounds. On [DATE] at 2:11 P.M., LPN #144 initiated a resident head count to ensure all other residents were accounted for. On [DATE] at approximately 2:30 P.M., the LPD and Emergency Medical Services (EMS) arrived at the facility with Resident #03. EMS and LPN #144 assessed the resident, and the resident was returned to the secured memory care unit. On [DATE], Resident #03 was placed on one-on-one supervision. This would continue while the facility worked with the resident's guardian to determine any additional interventions or alternative placement. On [DATE] at 5:30 P.M., the DON and LPN/UM #248 reviewed the facility cameras and completed a root cause analysis. It was determined Resident #03 was able to elope when staff exited the secured memory care unit without ensuring no residents were following, lack of timely staff response when the wander guard set off the front door alarm and lack of adequate staff response upon investigating the front door alarm. On [DATE] at 5:45 P.M., the DON completed a wander guard audit for all residents (#03, #53 and #54) with wander guards to ensure the intervention was appropriate, orders were in place and care plans were updated with no discrepancies identified. On [DATE] at 6:00 P.M., the DON and LPN/UM #248 reviewed and updated the resident elopement binder to ensure accuracy of information. On [DATE] at 7:30 P.M., the DON completed a second audit of the facility elopement binder with no discrepancies identified. On [DATE] at 8:00 P.M., the DON and LPN/UM #248 completed a reassessment of all facility residents for elopement risk. Care plans for residents at risk for elopement (#03, #18, #53 and #54) were reviewed and updated as appropriate. On [DATE], an elopement drill was completed by the DON and LPN/UM #248. On [DATE] by 11:59 P.M., the DON educated all facility staff in-person and by phone on ensuring residents do not follow them through the locked door of the secured memory care unit, the facility policy for elopement, responding to door alarms and missing resident with 100% of staff receiving the education. On [DATE] by 11:59 P.M., the DON educated all Certified Nursing Assistants (CNA) in-person and by phone on resident supervision, to include checking on residents every two hours, and if unable to locate a resident, to immediately notify the nurse so a headcount of facility residents can be initiated and search conducted per facility policy with 100% of the CNAs receiving the education. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:00 A.M., LPN #249 and LPN #139 completed a whole facility audit of windows and doors to validate all security measures were in place with no concerns identified. On [DATE], Dietary Manager (DM) #156 completed one-on-one education with Dietary Aide (DA) #157 to ensure no residents were following when exiting the secured memory care unit. Beginning on [DATE], the DON/designee would review all risk for elopement assessments and nursing quarterly assessments for four weeks to ensure accuracy and appropriate interventions are in place. Beginning on [DATE], the DON/designee would observe food carts going off the secured memory care unit five times per week for eight weeks to ensure staff are following procedures to prevent residents from following behind them when exiting the unit. Beginning on [DATE], the DON/designee would randomly observe staff entering and exiting the secured memory care unit for eight weeks to ensure procedures are followed to prevent residents from exiting the unit. Beginning on [DATE], the Administrator/designee would complete daily elopement drills on random shifts for two weeks then monthly elopement drills (one on each shift per quarter). Beginning on [DATE], the DON would review progress notes for all residents daily, Monday through Friday, for any documentation of exit seeking behaviors for four weeks to ensure appropriate interventions are implemented and care plans revised. The Interdisciplinary Team (IDT) would continue to identify residents at risk for elopement upon admission/re-admission and change in condition to ensure appropriate interventions are implemented and care planned to address elopement risk. DOM #246 would continue to monitor and validate door alarms and function per facility policy and procedures. On [DATE], an ad hoc Quality Assurance Performance Improvement (QAPI) committee meeting was held, which included the Administrator, DON, Medical Director (MD) #247, Activities Director (AD) #255 and LPN/UM #248 to review the root cause analysis, policies and procedures and corrective action plan. On [DATE], the QAPI Committee met to review the first week audit findings with no concerns identified. Review of five (#08, #41, #42, #46, #54) additional open resident records revealed elopement risk assessments and elopement care plans were updated and accurately reflected resident needs to prevent elopement. No concerns were identified. Interviews on [DATE] with DA #157, LPN #144, Certified Nursing Assistant (CNA) #123, Hospitality Aide (HA) #110, Medication Technician (MT) #102 and CNA #124 verified the facility provided education on the elopement policy and procedure, missing residents, response to door alarms and resident supervision. Findings include: (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of the medical record for the Resident #03 revealed an admitted [DATE] with diagnoses including dementia, mild with agitation; mild intellectual disabilities; impulse disorder; Alzheimer's disease with late onset; wandering in diseases classified elsewhere; and unspecified psychosis not due to a substance or known physiological condition. Further review revealed Resident #03 had a legal guardian and resided on the secured memory care unit of the facility. Review of the current physician orders revealed the resident's orders included may reside on the secure unit due to need for a smaller, more structured environment related to dementia diagnosis, nurse to check function and battery life of wander guard and may go on leave of absence (LOA) with escort and medications. Review of the Risk of Elopement/Wandering Review assessment, dated [DATE], revealed Resident #03 was moderately cognitively impaired with poor decision-making skills (for example, intermittent confusion, cognitive deficits or disoriented). Resident #03 ambulated independently. The resident verbalized the desire to go home, packed belongings to go home or stayed near exit doors. The assessment indicated Resident #03 wandered aimlessly/non-goal directed and this was not a new behavior. Further review of the assessment revealed Resident #03 was at risk for elopement/wandering as evidenced by pushing on the secured unit doors and verbalizing the desire to leave. Resident #03 had a history of leaving the secured unit, but not the facility. Review of the plan of care dated [DATE] revealed Resident #03 was at risk for elopement/wandering behavior related to exit seeking behavior, high risk for elopement and exiting unit. Interventions included every 15-minute checks per nursing judgment, placement of wander guard to lower extremity and check placement and battery life, calmly redirect and divert the resident's attention, distract when wandering/insisting on leaving the facility by offering pleasant diversions and promptly check when alarm system goes off to ensure the resident is safe and remains in the facility. Review of the quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #03 had a Brief Interview for Mental Status (BIMS) score of 09, indicating he had moderate cognitive impairment. The assessment identified the resident to have behaviors of wandering and was independent for ambulation. Review of a nursing note dated [DATE] at 3:58 P.M., and completed by LPN #144, revealed a call was received from the police department at 2:10 P.M. stating a resident (identified to be Resident #03) was on a street 0.7 miles away from the facility. The resident was crying and lost, taken to the police station and then brought back to the facility around 2:30 P.M. Further review of the note revealed the last time the resident was seen by the nurse was around 12:00 P.M. when the resident was eating pizza at a dining room table. Once Resident #03 was brought back to the facility by the police, a full head-to-toe assessment was completed. Vitals and assessment were normal and at baseline and the resident denied any pain. Resident #03 was wearing plaid pajama pants, a grey shirt and black slippers. Resident #03 stated he waited until the food tray cart was being collected to sneak behind the cart as the door was opened by staff. Resident #03 stated he went out the front door to go home with his sister. The resident denied being hurt or in any pain. Facility staff were asked if anyone noticed Resident #03 elope and all staff denied seeing the resident. Education was provided to staff on elopement risk and wander guard function check. Resident #03 was placed on one-on-one staff supervision and the responsible party was notified. Full head count was completed, and all residents were accounted for. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a local police report revealed on [DATE] at 1:43 P.M., a call was received from a neighborhood resident who reported seeing an elderly male walking, who was stumbling and fell to the ground. Further review revealed the responding officer arrived on the scene at 1:50 P.M. and found Resident #03 on his hands and knees and appeared disoriented. The officer called EMS, who responded and cleared the resident. EMS transported the resident back to the facility. The police response was cleared at 2:42 P.M. Review of the current physician orders revealed an order dated [DATE] (following the incident) for Resident #03 to remain on one-on-one with staff (supervision). Interview on [DATE] at 8:35 A.M. with the DON and LPN/UM #248 revealed on [DATE], DA #157 went to the secured memory care unit to collect the meal cart. When DA #157 exited the unit at 12:44 P.M., Resident #03 caught the door just before it closed. The resident then walked up the 600-hall, around the corner, down the 300-hall and out the front door. The administrative staff revealed there was no receptionist that day and the resident did not pass any staff member. The DON verified Resident #03 had a wander guard and the front door alarmed when he exited but stated staff did not respond timely or thoroughly investigate the alarms. The DON further confirmed Resident #03 was found 0.7 miles away by the police after someone in the neighborhood called 911 stating an elderly person was walking around. The DON stated EMS assessed Resident #03 and the resident had no visible injuries and did not require further evaluation at the hospital. Additionally, the DON verified Resident #03 had a history of eloping off the secured memory care unit, but not the facility, and staff were unaware the resident was gone until contacted by the police. Following the incident, the DON stated all facility staff received education on facility policies and procedures. Interview on [DATE] at 10:56 A.M. with Medication Technician (MT) #102 revealed she worked on the secured memory care unit early in the day on [DATE]. MT #102 stated staff were busy caring for other residents and did not see Resident #03 elope from the unit. MT #102 stated (prior to the incident) Resident #03 always tried to run off the unit by following staff through the secured memory care unit door and DA #157 did not look to ensure the resident was not following him when he left the unit with the meal cart. Observation on [DATE] at 4:00 P.M. of the facility video surveillance from [DATE], with the DON, verified Resident #03 eloped from the secured memory care unit by following dietary staff off the unit. Resident #03 proceeded to walk down two halls and exited the facility through the front door. Interview on [DATE] at 10:33 A.M. with DA #157 verified Resident #03 was able to elope on [DATE] when he did not check behind him when exiting the secured memory care unit. Interview on [DATE] at 12:06 P.M. with Hospitality Aide (HA) #110 revealed on [DATE], she heard the front door alarm. HA #110 stated she responded, turned the alarm off and walked the perimeter of the parking lot. HA #110 stated she did not see anything and returned to the building without notifying anyone of the alarm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview on [DATE] at 12:22 P.M. with LPN #144 revealed he was Resident #03's assigned nurse on [DATE]. LPN #144 stated he last saw Resident #03 on that date around 12:00 P.M. when he was eating pizza brought in by his sister. LPN #144 stated he was caught up in his tasks and took a break from 12:25 P.M. to 1:05 P.M. LPN #144 verified he was unaware Resident #03 was missing until the police called around 2:10 P.M. Upon Resident #03's return to the facility around 2:30 P.M., LPN #144 assessed the resident, and no injuries or other concerns were identified. A telephone interview on [DATE] at 12:27 P.M. with RN #148 revealed she worked the 100 and 400-halls on [DATE]. RN #148 stated she was unaware Resident #03 was missing from the facility until she saw the police and EMS arrive to the facility with the resident. Interview on [DATE] at 12:31 P.M. with CNA #123 revealed she worked on the 300-hall on [DATE]. CNA #123 stated she was unaware Resident #03 had eloped from the facility until she saw the police bringing the resident back to the facility. Review of the facility policy titled Unsafe Wandering & Elopement Prevention, revised [DATE], revealed every effort would be made to prevent unsafe wandering and elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. Nursing personnel must report and investigate all reports of missing residents. Additionally, it was the responsibility of all personnel to report any resident attempting to leave the premises, or suspected to be missing, to the licensed nurse. 2. Review of Resident #18's medical record revealed an admitted [DATE] with diagnoses including unspecified dementia with psychotic disturbance, hallucinations, mild cognitive impairment and diabetes mellitus type II. Further review revealed Resident #18 was her own responsible person. Review of a nursing note dated [DATE] at 7:30 P.M. revealed Resident #18 was seen by oncoming shift staff in the church parking lot approximately 1.1 miles from the facility. Staff informed the writer of her location and staff were able to get the resident safely back to the facility. Once returned, a wander guard was placed on the resident and one-on-one with staff (supervision) was initiated. Resident #18 was assessed with no negative findings and the resident denied pain. She also denied any mental anguish and stated she was just going to get fresh air and grab something from the store, but then found herself lost and did not know how to get back. The Nurse Practitioner (NP), interim DON and Administrator were notified. Review of a Social Services (SS) progress note dated [DATE] at 7:59 P.M. revealed Resident #18 was wearing maroon plaid pajama pants, maroon crewneck sweatshirt, grey shoes, a black/tan ball cap and was carrying a red bag. Review of the Risk of Elopement/Wandering Review assessment, dated [DATE], revealed Resident #18 was cognitively impaired with poor decision-making skills (for example, intermittent confusion, cognitive deficits or disoriented), ambulated independently and wandered aimlessly or non-goal directed. This was a new behavior, and, for the first time, Resident #18 left the facility without supervision, when supervision was required. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of care plan revised [DATE] revealed Resident #18 was at risk for elopement related to exit seeking behavior/elopement. Interventions included, but not limited to, one-on-one with staff (supervision), evaluate for need of wander guard use and distraction when wandering/insistent on leaving the facility by offering pleasant diversions. Further review revealed Resident #18 refused the use of a wander guard. Review of a Social Services (SS) progress note dated [DATE] at 10:08 A.M. revealed Resident #18 stated she went outdoors on the evening of [DATE] but was unable to recall the time. The resident stated she went to get fresh air and asked someone in passing, once off the facility property, if they could tell her where a store was. Resident #18 went to the store and purchased snacks. Resident #18 stated she was on her way back to the facility when she was contacted by staff. The resident stated she did not recall being lost. She was upset regarding a wander guard and refused a room change despite concerns regarding her safety being voiced to her. Resident #18 continued to state she was going home one minute, but the next minute voiced she no longer had her apartment as she told the manager she was ending her lease. Nursing also spoke with her regarding a possible psychiatric evaluation and the resident refused to go to the emergency room (ER) for evaluation. Resident #18's sister was aware and attempted to speak with her on the phone; however, Resident #18 became agitated and stated, I am not speaking to my sister or any other family! Review of a written statement, dated [DATE] at 9:05 A.M. and completed by former CNA #177, revealed she was driving to work (on [DATE]), arriving around 7:02 P.M. CNA #177 was on Cleveland-East Liverpool Road when she looked to her right and witnessed an older black female dressed in flannel pajama pants, a long sleeve shirt, shoes, a tan baseball cap, carrying a tote bag and a box and she was wearing a surgical mask. She was standing on the sidewalk in front of the entrance of the driveway of a church. The woman looked familiar to one of the facility residents. Upon arrival at work, CNA #177 approached the nurses' station and stated she believed she saw one of the residents outside, in front of a church. CNA #177 asked if anyone had signed out and other staff indicated they were unaware of any residents outside and gone from the facility. CNA #177 was told to follow a nurse in her car to look for the resident where she was last seen, in front of the church. The resident was not there. CNA #177 pulled into the church parking lot and asked a man and a woman who were leaving the church if they had seen the resident. They said they had not seen her and gave CNA #177 permission to enter the church to look for her. Resident #18 was not located in the church. CNA #177 called the facility and was informed the nurse had searched the building and the resident had not returned. Review of the facility timeline of events, as observed via facility camera footage, revealed on [DATE] at 5:49 P.M., Resident #18 was observed in the facility around the nurses' station, heading in the direction of the front door. At 5:49 P.M. she was observed exiting he front door. From 5:49 P.M. through 6:01 P.M., Resident #18 remained on the facility grounds. At 6:01 P.M., Resident #18 left the property and started walking down the sidewalk. At 7:12 P.M., CNA, nurses and Resident #18 returned to the facility. Resident #18 was immediately assessed, a wander guard placed, and Resident #18 became one-on-one with staff (supervision). Review of the quarterly MDS assessment, dated [DATE], revealed Resident #18 had a BIMS score of 11, indicating she had moderate cognitive impairment. The resident was independent for ambulation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365718	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Streetsboro	1645 Maplewood Dr Streetsboro, OH 44241

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 9:22 A.M. with the DON, the Administrator, RDCS #160 and RDCS #161 revealed on [DATE] Resident #18 was seen in an area church parking lot, approximately 1.1 miles from the facility. CNA #177 informed LPN #137 she thought she saw the resident when she was driving into work. LPN #137, CNA #177 and LPN #136 got in the car and went to the church to bring Resident #18 back. While Resident #18 had never signed out of the facility previously, CNA #177 did not stop when she initially saw her because she was unsure if the resident had signed out. Resident #18 was her own responsible person, but the facility considered this incident an elopement because the resident did not inform staff she was leaving, and staff were unaware the resident left. Since the incident, Resident #18 had remained on one-on-one staff supervision pending the outcome of a guardianship hearing, which the resident appealed. Resident #18 refused the use of a wander guard and placement on the secured memory care unit. Interview on [DATE] at 11:50 A.M. with Resident #18 revealed she recalled the incident on [DATE]. Resident #18 stated she wanted snacks, asked people where the store was located and went. Resident #18 stated she was not lost and knew what she was doing. Resident #18 confirmed she did not tell anyone she was leaving. On her way back to the facility, Resident #18 stated a girl (unable to recall who) stopped her, told her staff were looking for her and took her back to the facility. Review of the facility policy titled Unsafe Wandering & Elopement Prevention, revised [DATE], revealed every effort would be made to prevent unsafe wandering and elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. Nursing personnel must report and investigate all reports of missing residents. Additionally, it was the responsibility of all personnel to report any resident attempting to leave the premises, or suspected to be missing, to the licensed nurse. This deficiency represents non-compliance investigated under Complaint Number OH00159626.