STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365722	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Glen Alzheimer's Community	3800 Summit Glen Drive Dayton, OH 45449

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, observations, staff interviews, review of facility policy, and review of facility documents, 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. Additionally, the facility failed to ensure ordered elopement interventions were in place. This affected one (#1) of three residents reviewed for elopement. The census was 144. Findings include: Review of Resident #1's medical record revealed an admitted [DATE]. Diagnoses listed included erectile dysfunction, alcohol abuse, hypertension, dementia, anxiety, and congestive heart failure. Review of a brief interview for mental status (BIMS) assessment dated [DATE] revealed Resident #1 was severely impaired with score or three out of a possible 15. Review of a admission nursing assessment dated [DATE] revealed Resident #1 was at risk for elopement. Review of Resident #1's care plan dated 08/29/24 revealed Resident #1 was at risk for elopement due to dementia with mood disturbance. An intervention of 1:1 (one on one supervision) was added on 08/30/24. Resident #1 required a secured unit due behaviors, elopement risk, and poor cognition. Review of facility investigative documents revealed Resident #1 was unable to be located in the facility by staff the morning of 08/30/24 at 8:00 A.M. when the nurse went to administer morning medications. Resident #1 was last seen by staff on 08/30/24 at 7:20 A.M. An elopement code was called on 08/30/24 at 8:10 A.M. and staff searched the facility and surrounding areas of the facility. Resident #1 was found near a local park on 08/30/24 at 8:19 A.M. Resident #1 returned to the facility on [DATE] at 8:30 A.M. Resident #1 did not have any injuries. Review of physician orders revealed an order dated 08/30/24 for Resident to be 1:1 at all times every shift for elopement risk. Observation on 09/03/24 at 10:25 A.M. revealed Resident #1 in his room in bed. Resident #1's room door was closed and could not be seen from the hallway. There was not a staff member observed in Resident #1'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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365722	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Glen Alzheimer's Community	3800 Summit Glen Drive Dayton, OH 45449

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	Observation on 09/03/24 at 10:30 A.M. revealed Resident #1 in his room in bed. Resident #1's room door was closed and could not be seen from the hallway. There was not a staff member observed in Resident #1's room. Interview with State tested Nursing Assistant (STNA) #180 and STNA #190 on 09/03/24 at 10:30 A.M. confirmed Resident #1 was ordered to be 1:1 supervision. STNA #180 and STNA #190 confirmed a staff member should be with Resident #1 at all times and there was a brief time that he was not being provided with 1:1 supervision. Interview with the Administrator on 09/03/24 at 10:38 A.M. confirmed Resident #1 had eloped from the facility on 08/30/24. Resident #1 was just admitted the prior evening. Resident #1 was found near a local park. The Administrator was unsure how Resident #1 had eloped. The Administrator confirmed Resident #1 was ordered to be 1:1. The Administrator confirmed the facility conducted an investigation but was unable to determine how Resident #1 eloped so Resident #1 was placed on 1:1 supervision. Interview with the Director of Nursing (DON) on 09/03/24 at 11:24 A.M. confirmed Resident #1 eloped from the building on 08/30/24. Resident #1 was last seen by staff on 08/30/24 approximately 7:30 A.M. Resident #1 was found by Nurse Practitioner (NP) #100 near a local park and returned to the facility on [DATE] at 8:25 A.M. Resident #1 was assessed and had no injuries. The DON confirmed Resident #1 was ordered to be 1:1 and that a staff member was not in his room when observed 09/03/24 at 10:25 and 10:30 A.M. Interview with Business Office Manager (BOM) #120 on 09/03/24 at 2:00 P.M. revealed she searched for Resident #1 when he eloped on 08/30/24. BOM #120 arrived to the location where Resident #1 was located at about the same time as NP #100. BOM #120 transported Resident #1 back to the facility. Resident #1 came back the facility willingly. Phone interview with Licensed Practical Nurse (LPN) #200 on 09/03/24 at 2:24 P.M. revealed she was the dayshift nurse on 08/30/24. LPN #200 was unable to find Resident #1 when she went to his room to get medications on 08/30/24 at approximately 7:30 A.M. LPN #200 informed STNA's who helped search the unit. Resident #1 was unable to be found so an elopement code was called and staff began searching the facility and surrounding areas. Resident #1 was found outside of the facility and returned on 08/30/24 at approximately 8:30 A.M. LPN #200 assessed Resident #1 upon his return and he did not have any injuries. LPN #200 denied hearing any exit alarms, seeing any windows open, or having any family members in the unit the morning on 08/30/24. Phone interview with LPN #150 on 09/03/24 at 2:32 P.M. revealed she was the night shift nurse on 08/29/24 to 08/30/24. LPN #120 reported last seeing Resident #1 on 08/30/24 at approximately 7:00 A.M. when reporting off to the day shift nurse. Resident #1 stuck his head out of his room. Resident #1 was a little restless during the night and walked around. LPN #120 denied seeing Resident #1 push on any doors or attempt to elope. LPN #120 did not hear any exit alarms on 08/29/24 or 08/30/24. LPN #120 was informed Resident #1 was missing form the facility while at a tanning salon and questioned when the last time she had seen him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365722	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Glen Alzheimer's Community	3800 Summit Glen Drive Dayton, OH 45449

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	Interview with NP #100 on 09/03/24 at 2:38 P.M. revealed she found Resident #1 near a local park on 08/30/24. Resident #1 was very pleasant, but confused. NP #100 had not yet seen Resident #1 at the facility before 08/30/24 and did not know him. NP #100 identified Resident #1 by a picture that was sent out by the facility. Resident #1 did not have any injuries. Resident #1 has been assessed and some medication have been adjusted. Review of the facility's undated policy Elopement Prevention and Management Overview revealed elopement is defined as when a resident/patient leaves the premises or a safe area without authorization and/or any necessary supervision and places the resident at risk for harm or injury. Post elopement procedures included complete and document a physical assessment of the resident/patient upon return to the facility to determine if further treatment is required, notify all parties of resident's return to the facility, review and revise the interventions related to prevention of elopement/missing resident, and communicate the modification of interventions to the caregiving staff, resident and/or resident representative. This deficiency represents non-compliance investigated under Complaint Number OH00157403.