Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Heather Knoll Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1134 North Ave Tallmadge, OH 44278	

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** Based on record review, interview, review of AccuWeather forecast and facility policy review, the facility failed to ensure Resident #61 did not exit the facility without staff knowledge, failed to complete a full investigation and health assessment after Resident #61 exited the facility without a coat in 18 degrees Fahrenheit (F) temperatures, and failed to notify Resident #61's responsible party of the incident. This affected one (Resident #61) of three residents reviewed for safety.Findings included:Review of the medical record noted Resident #61 was admitted on [DATE]. Diagnoses included unspecified dementia, anxiety disorder and repeated falls.Review of the plan of care dated 09/22/25 noted Resident #61 had general weakness and was at risk of decline in ambulation. The plan of care was updated on 01/28/26 stating Resident #61 had potential for falls/injury due to weakness, balance deficit, psychotropic medications, dementia, and orthostatic hypotension. No plan of care was created indicating Resident #61 was at risk for elopement.Review of the comprehensive Minimum Data Set (MDS) assessment, dated 11/25/25, revealed Resident #61 had intact cognition. The resident required partial assistance for bed mobility, transfers, and ambulation.Review of the nursing progress notes dated 01/18/26 at 12:59 P.M. noted Resident #61 was observed outside the facility by Certified Occupational Therapy Assistant (COTA) #205. No other documentation was provided, indicating the resident was found outside the facility without staff.Review of the AccuWeather forecast for [NAME], Ohio for 01/18/26 revealed a high temperature of 18 degrees F and a low temperature of 11 degrees F.Interview on 01/29/26 at 8:28 A.M., Certified Nurse Assistant (CNA) #203 stated she provided care for Resident #61, and he should not be outside by himself. CNA #203 stated she was not aware of Resident #61 leaving the facility without staff or family.Interview on 01/29/26 at 9:23 A.M., Unit Manager #204 stated she was not aware of Resident #61 leaving the facility and verified that Resident #61 should not be outside without staff or family.Interview on 01/29/26 at 9:55 A.M., Resident #61 stated he went out to the parking lot to see his car. Resident #61 stated it was dumb to go outside without a coat because it was cold outside. Resident #61 stated a therapy staff member observed him in the lot, put him in her car and drove him back to the entrance of the facility.Interview on 01/29/26 at 10:03 A.M., COTA #205 stated she observed Resident #61 outside in the parking lot which was approximately 20 feet from the building and 50 feet from the door. Resident #61 was assumed to exit the facility. Resident #61 was wearing street clothes, but no hat, coat or gloves. COTA #205 stated Resident #61 stated he was outside because he wanted to get some fresh air.Interview on 01/29/26 at 10:30 A.M., the Administrator, the Director of Nursing, (DON) and the Quality Assurance Nurse #206 stated no investigation was completed because Resident #61 had a BIMS (Brief Interview for Mental Status) of 15 which indicated the resident had intact cognition. The Administrator stated he spoke with Resident #61 who stated he was outside looking for something but was not specific.Interview on 01/29/26 at 11:26 A.M., Licensed Practical Nurse (LPN) #207 stated she administered Resident #61's medications before he left (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to wait on his sister for lunch. LPN #207 stated she observed Resident #61 being wheeled back to the unit by COTA #205 stating he was found outside. LPN #207 could not verify the door Resident #61 used or how long he was outside. LPN #207 stated she spoke to Resident #61 briefly explaining that he needed to sign out next time and make sure he was wearing appropriate clothing for the weather. LPN #207 stated Resident #61 stated he did not realize it was that cold outside. LPN #207 stated no assessments were completed or documented, that she called the DON who said Resident #61 had a BIMS of 15 so nothing else needed to be done. LPN #207 stated the doors that she assumed Resident #61 exited through automatically lock so Resident #61 would not be able to return inside.Interview on 01/29/26 at 12:59 P.M., Nurse Practitioner #208 stated someone called her to tell her Resident #61 was observed outside the facility, but Resident #61 was dressed appropriately and no significant changes were noted. NP #208 stated she spoke with Resident #61 on 01/22/26 but did not ask about the incident on 01/18/26.Interview on 01/29/26 at 1:10 P.M., the family of Resident #61 stated she received a call a couple weeks ago from staff stating they caught Resident #61 trying to leave the facility. The family stated she received calls in the past stating Resident #61 was looking for the door but never left the facility. The family stated Resident #61 had short-term memory dementia with sundowning episodes. The family was not aware Resident #61 was observed outside without the facility without staff and not wearing a coat.This deficiency represents non-compliance investigated under Complaint Number 2723679.