STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365779	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyant Woods Healthcare Center	200 Wyant Rd Akron, OH 44313

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, self-reported incident (SRI) review, review of a police report, personnel file review, facility policy review and interviews, the facility failed to ensure Resident #161 was free from staff to resident physical abuse. This resulted in Immediate Jeopardy, the potential for actual physical harm and actual psychosocial harm on 07/24/24 at approximately 10:40 A.M. when Activity Aide (AA) #307 physically abused Resident #161 by jumping on and punching the resident after the resident hit AA #307 with his cane. Staff in the area told AA #307 to back away from Resident #161 but she did not. AA #307 then had to be restrained by Maintenance Technician (MT) #438 as she continued to kick and further assault Resident #161. Interview with Resident #161 on 07/30/24 at 4:18 P.M. revealed he did not feel safe at the facility due to the incident. This affected one resident (#161) of four residents reviewed for abuse and neglect. The facility census was 161 residents. On 08/01/24 at 2:37 P.M. the Administrator, Director of Nursing (DON) and Regional Director of Clinical Operations (RDCO)/Registered Nurse (RN) #475 were notified Immediate Jeopardy began on 07/24/24 at approximately 10:40 A.M. when AA #307 physically abused Resident #161, resulting in the potential for actual physical harm/injury and psychological harm. The Immediate Jeopardy was removed on 08/01/24 when the facility implemented the following corrective actions: On 07/24/24 at 10:30 A.M. AA #307 was witnessed in altercation with Resident #161. On 07/24/24 at 10:30 A.M. AA #307 was immediately removed from the building by witnessing staff member MT #438. On 07/24/24 at 10:37 A.M. Admissions Coordinator (AC) #309 called police and emergency medical services (EMS). On 07/24/24 at 10:44 A.M. EMS were on-site and assessed Resident #161, found no (physical) injury. No transfer to hospital required. On 07/24/24 at 10:45 A.M. Licensed Practical Nurse (LPN) #423 completed skin and pain assessments on Resident #161 and initiated neurological assessments. Neurological checks continued through 07/29/24 with no negative findings. Resident #161 found to be at baseline. Physician and Resident Representative notified of incident by LPN)/Assistant Director of Nursing (ADON)/Risk #469. (continued on next page)

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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/24/24 at 10:49 A.M. police were on-site conducting staff interviews with the Administrator. On 07/24/24 at 11:30 A.M. the Administrator/Designee began all staff abuse/reporting education. Education completed same day. On 07/24/24 at 1130 A.M. LPN/Unit Manager (UM) #466, LPN/UM #464, LPN/UM#465, and RN/UM #467 interviewed all residents using the Centers for Medicare and Medicaid Quality Indicator Survey abuse tool to identify any additional concerns. On 07/24/24 at 12:06 P.M. the Administrator initiated a self-reported incident (SRI) related to the staff to resident abuse situation. On 07/24/24 (no time) the Administrator added Abuse Quality Assurance to Quality Assurance Performance Improvement (QAPI) process for July 2024. On 07/25/24 (no time) the police filed assault charges against AA #307. On 07/25/24 the Administrator notified AA #307 of termination of employment. On 07/25/24, 07/26/24 and 07/29/24 Licensed Social Worker (LSW) #410 followed up with Resident #161 for concerns regarding incident. LSW #410 to continue offering support to Resident #161 until Resident #161 feels safe. On 07/31/24 Resident #161 had a weekly skin check done and no new areas noted. Re-assessment on 08/02/24 revealed no new concerns. On 08/01/24, Resident #161 received counseling from in-house service. Counseling service to continue offering support to Resident #161 until Resident #161 felt safe. On 08/01/24 RDCO/RN #475 educated the DON and Administrator using Relias Handling Aggressive Behaviors with exit quiz for competency. On 08/01/24 the DON/designee provided Relias Handling Aggressive Behaviors education with exit quiz to demonstrate competency for all staff. (This training was initiated as a result of the facility's identification that the lack of behavioral health training likely contributed to the incident of staff to resident abuse involving Resident #161.) Education completed same day. Staff on vacation or leave to complete on return. At this time, two staff members were on leave and would receive this education upon return. On 08/02/24 the DON/Designee interviewed all residents, then would continue interviews with five residents weekly for four weeks regarding any abuse concerns. This would then continue randomly thereafter until compliance was confirmed. Starting on 08/02/24 Administrator/Designee would interview five staff members weekly for four weeks for any abuse concerns. This would then continue randomly thereafter until compliance was confirmed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Starting on 08/02/24 Administrator/Designee to audit five staff members weekly for four weeks for competency listing the warning signs of aggression and identifying ways to prevent and manage aggressive behaviors. On 08/02/24 the Psychiatrist #476 assessed Resident #161, who remained at baseline. On 08/02/24 the DON/Designee interviewed all residents for any abuse concerns. All non-interviewable residents received skin assessment. The facility implemented a plan for reported incidents to be reviewed by DON/Designee within 24 hours to ensure no other residents were affected. DON/Designee to address issues with reported incidents immediately upon identification. On 08/02/24, the DON/designee would re-educate facility staff on the abuse and neglect policy which would include: (a) What constitutes abuse and types of abuse and neglect; (b) Identification of signs and symptoms in residents and staff of potential abuse and abusers; (c) Actions to take when abuse is witnessed, suspected, or alleged; (d) Timely and appropriate reporting of witnessed, suspected, or alleged abuse to all responsible parties per facility policy; (e) Protection of resident while conducting a thorough investigation of alleged abuse; (f) Proper assessment of residents who have been or suspected to be abused; and (g) Prevention of future incidents of abuse from occurring. Staff on Leave or PTO to be educated upon return and prior to working. Two employees remain on leave and will be educated by the ED/Designee upon return. The facility implemented a plan for the DON/Designee to educate all new staff in Behavioral Health management. This would be ongoing as part of new hire orientation. The facility implemented a plan for the DON/Designee to interview five residents weekly for four weeks for any abuse concerns, then randomly thereafter until compliance was confirmed. The facility implemented a plan for the Administrator/Designee to interview five staff members weekly for four weeks for any abuse concerns, then randomly thereafter until compliance is confirmed. The Administrator or DON would monitor compliance with above in monthly QAPI meeting for three months then as needed for one year. All allegations of abuse would be reported to RDCO/RN #475 by the DON or Administrator as soon as the allegation was made. This would be ongoing. RDCO/RN #475 would monitor compliance during monthly visits for three months then on an as needed basis. On 08/05/24 from 1:40 P.M. to 2:00 P.M. interviews with LPN #425, RN #390, STNA #353 and STNA #319 confirmed they received education regarding abuse and behavior training. Although the Immediate Jeopardy was removed on 08/01/24 the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure continued compliance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Review of Resident #161's medical record revealed an admitted [DATE] with diagnoses including atrial fibrillation, type two diabetes mellitus, vitamin D deficiency, mixed hyperlipidemia, major depressive disorder, Alzheimer's disease with late onset, vascular dementia and osteitis deformans of multiple sites. Review of Resident #161's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #161 had moderate cognitive impairment, no behaviors coded and utilized a walker and a wheelchair. Review of Resident #161's plan of care dated 06/13/24 revealed the resident had impaired cognitive function due to dementia and Alzheimer's disease. A listed intervention also dated 06/13/24 indicated staff were to use resident's preferred name. Face resident when speaking to them. Reduce any distractions- turn off television, radio, close door et cetera. Use consistent, simple, directive sentences. Provide with necessary cues- stop and return if agitated. Review of Resident #161's progress notes revealed a note dated 07/24/24 at 10:45 A.M. and authored by Licensed Practical Nurse (LPN) #423 indicating he did not witness the incident (incident not specified) but was notified by staff. A full head to toe assessment was done and no areas found. Resident #161 stated he was in no pain at this time of care. Vitals were within normal limits, neurological checks (neuros) were put into place and the responsible party had been notified. Review of a facility self-reported incident (SRI) reported to the State Agency (SA) by the Administrator on 07/24/24 at 12:06 P.M. revealed an allegation of physical abuse between Resident #161 and Activity Aide (AA) #307 which was witnessed by Maintenance Technician (MT) #436, MT #438, LPN #427 and Admissions Coordinator (AC) #309. The SRI included Resident #161 was near the nurses' station on the first floor of the facility seated in his wheelchair and holding his cane. Resident #161 approached AA #307 regarding smoking and struck AA #307 with his cane several times. Staff in the area told AA #307 to back away from Resident #161 but she did not move and instead proceeded to strike Resident #161. AA #307 was removed from Resident #161 and police as well as Emergency Medical Services (EMS) were called. The facility found the allegation of physical abuse to be substantiated. AA #307 was terminated, and police were pursuing assault charges against AA #307 as a result of the facility's investigation. Review of a witness statement dated 07/24/24 and authored by MT #436 revealed the following information: On 07/24/24 at 10:40 A.M. I was walking down to the first-floor nurses' station and seen [Resident #161] hitting [AA #307] with the cane that he had, he hit her about five times and AA #307 said, you really [NAME][g] to hit me? AA #307 threw her papers on the floor and started to hit Resident #161 over and over until MT #438 pulled AA #307 off of Resident #161. AA #307 started kicking and swinging breaking stuff, screaming and saying stuff. Review of a witness statement authored by MT #438 revealed the following information: On 07/24/24 at 10:40 A.M. I was walking towards the main nurses' station when I noticed Resident #161 swinging his cane at AA #307. She put her papers down and hit Resident #161 in the head. I then grabbed AA #307 and escorted her out. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A second witness statement authored by MT #438 revealed the following information: On 07/24/24 at 10:40 A.M. I was walking towards the main nursing station when I saw Resident #161 swinging his cane at AA #307. Resident #161 hit her at least three times in her arm. It might have knocked the papers out of her hand then AA #307 tried to hit Resident #161 back but then I grabbed AA #307 and escorted her outside. Review of a witness statement authored by LPN #427 revealed the following information: On 07/24/24 at 10:30 A.M. I witnessed AA #307 having a confrontation with Resident #161. Resident #161 hit AA #307 with his cane. I instructed AA #307 to back up so Resident #161 could not hit her, but AA #307 stood there and let Resident #161 continue to hit her. After being hit four to five times, AA #307 attacked Resident #161 hitting him in the face and head with her fist. AA #307 was restrained and removed away from Resident #161. Review of a witness statement dated 07/24/24 and authored by AC #309 revealed the following information: On 07/24/24 at 10:35 A.M. I was on the other side of the nurses' station when I heard two people yelling. I walked to the other side and saw Resident #161 strike AA #307 with his cane. Resident #161 took another swing and AA #307 yelled out, 'He's hitting me, y'all just going to let him hit me?' I, along with others (not named) told her to move away from Resident #161 as he was in a wheelchair. AA #307 continued to let Resident #161 strike her with the cane. AA #307 then put her paper and pen down and attacked Resident #161, punching him multiple times before we could get her off of him. MT #438 restrained AA #307. As MT #438 picked her up she kicked Resident #161 in the back and in his head. AA #307 was then removed from the area. I called 9-1-1 at 10:37 A.M. and EMS came to check Resident #161 out and reported no injuries. Review of a witness statement for AA #307 dated 07/25/24 and completed by the Administrator via phone revealed the following information: I told multiple people that [Resident #161] was going after me with his cane because I told him he couldn't smoke because of being sick. Ever since he was told he could not smoke, he has been behavioral towards me. He kept going at me with his cane. Resident #161 said he was going to call the police because [I] wouldn't give him his cigarette. Yesterday, Resident #161 hit me with his cane six different times .it does not matter where I got hit, I took six blows. I got on Resident #161 and hit him back and they (not specified) put me in the lobby and that was it. Review of a police report dated 07/24/24 at 10:37 A.M. revealed a call to the facility for assault listing AA #307 as a suspect and Resident #161 as a victim. AC #309 made the call and stated a female employee later identified as AA #307 physically assaulted Resident #161 and left the scene before officers arrived. Resident #161 stated he and AA #307 were involved in a verbal altercation regarding him smoking cigarettes. Resident #161 then stated AA #307 struck him with a closed fist multiple times in the head and kicked him multiple times in the legs. Resident #161 stated he then struck AA #307 with his cane but did not sustain any apparent injuries. AA #307 stated Resident #161 was aggravated that she would not give him a cigarette to smoke and he approached her while in his wheelchair. Resident #161 then struck her in the legs and arms five to six times with his metal cane. AA #307 stated she asked the staff for help when Resident #161 continued to strike her. In AA #307's written statement (not included with the report) she stated 'so I defended myself and put my hands on him.' AA #307 was placed under arrest for assault. Other staff at the facility by the names of MT #436, MT #438, LPN #427 and AC #309 all witnessed the altercation and stated AA #307 had to be restrained from continuing to assault Resident #161. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of AA #307's personnel file revealed a hire date of 06/19/24 and background checks completed on 06/27/24 and 07/10/24. AA #307 signed off on reviewing the facility handbook which included abuse as well as the behavioral management video on 06/19/24. AA #307's employment was terminated with the facility on 07/25/24. Interview on 07/30/24 at 11:40 A.M. with AA #307 revealed on 07/24/24 around 10:30 A.M. in the morning there had been an incident with Resident #161. AA #307 stated she was the only activity staff in the facility due to the facility's COVID-19 outbreak. Around 8:00 A.M. on 07/24/24 Resident #161 had approached her outside wanting a cigarette, but she was told by staff (not identified) Resident #161 had COVID-19 and had to wait until a different smoke break time. AA #307 stated Resident #161 wanted to smoke with everyone else but could not as he was sick. Resident #161's aide, State tested Nursing Assistant (STNA) #323 gave him a cigarette then Resident #161 was telling people that she would not give him a cigarette. AA #307 stated she walked down the hallway and Resident #161 started whacking her arms and legs with his cane. AA #307 told the nurse (not named) to get Resident #161 as he had hit her five times. AA #307 reported she jumped on Resident #161 after the sixth time he had hit her but did not recall if she hit him or not. AA #307 became increasingly upset during the interview, then stated I did not assault that man, that (racial slur) hit me and assaulted me .they let that man beat my (expletive). AA #307 stated she was charged with assault the same date of the incident then ended the interview. Interview on 07/30/24 at 12:03 P.M. with the Administrator verified while the SRI was not yet completed as of the time of the interview, the allegation of staff to resident abuse was going to be substantiated. Interview on 07/30/24 at 2:24 P.M. with MT #436 revealed sometime on 07/24/24 after 10:00 A.M. he was coming down the [NAME] hall and saw Resident #161 in his wheelchair hit AA #307 with his cane five times and AA #307 just stood there. MT #436 stated Resident #161 and AA #307 had been going back and for the last few days but did not further elaborate on this matter. MT #436 continued that AA #307 told Resident #161, Are you going to hit me? and then AA #307 punched Resident #161 fast and more than once. MT #438 pulled AA #307 off of Resident #161, took her to the front desk and she left before the police came. MT #436 stated there was never an instance where hitting a resident was acceptable. Interview on 07/30/24 at 2:32 P.M. with MT #438 revealed on 07/24/24 between 10:30 A.M. and 10:45 A.M. he was coming down the [NAME] hall and AA #307 was coming to get four or five people for smoke break. MT #438 stated how AA #307 was walking, he felt they were about to fight. Resident #161 hit AA #307 with his cane four or five times. AA #307 did not do anything, but MT #438 did not think AA #307 would do anything to Resident #161. AA #307 told Resident #161 you gonna hit me? then yelled out he is hitting me. AA #307 put what was in her hands down then grabbed Resident #161's shirt collar and then went to swing at Resident #161. MT #438 stated he grabbed AA #307, and she was in his arms, kicking like a cat and he took her to the front lobby. MT #438 confirmed he witnessed AA #307 hit Resident #161 two times with an open hand slap. MT #438 also confirmed it was never acceptable to hit a resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/30/24 at 4:18 P.M. with Resident #161 revealed he recalled the incident that had occurred with AA #307. The resident reported last week, AA #307 threw her stuff on the ground, he hit AA #307 one time with his cane then AA #307 hit the back of his head with her fist twice and a male staff (not identified) grabbed AA #307 and dragged her to the front of the facility. Resident #161 asked AA #307 why she did this but did not elaborate further during the interview. Resident #161 stated he did not feel safe at the facility as a result of the incident on 07/24/24. Interview on 07/31/24 at 8:28 A.M. with LPN #427 revealed last week during late morning, the newer activity staff, AA #307 got into a verbal altercation with Resident #161. LPN #427 stated Resident #161 told AA #307, get the (expletive) away from me, I am going to hit you with my cane. Resident #161 then hit AA #307 with his cane in her shoulder and face. LPN #427 reported he told AA #307 to back up and get away from Resident #161 and Resident #161 hit AA #307 again, hitting her three or four times. Then AA #307 began to beat the hell out of Resident #161, punching him in the face and body and one of the maintenance staff had to hold AA #307 in the air, with AA #307 still kicking Resident #161. AA #307 was taken to the lobby, and he had not seen her since. LPN #427 confirmed it was not ok to ever hit a resident. Interview on 07/31/24 at 8:38 A.M. with AC #309 revealed on 07/24/24 around 10:35 A.M. she was walking towards the Hickory hall from the Buckeye hall and saw Resident #161 hit AA #307 with his cane. AC #309 reported she told AA #307 to step away from Resident #161 as AA #307 said, You all gonna let him hit me? AC #309 stated AA #307 was not cornered by Resident #161 and was not stepping away from him. Resident #161 was striking AA #307 and maintenance staff (not specified) came up the hallway and words were exchanged with them and AA #307 but she could not recall what was said. AA #307 then put the pen and paper that was in her hands on the floor and she looked like she was going to attack and jumped on Resident #161 who was in his wheelchair and began to punch Resident #161. AA #307's arms were swinging so fast, and she made contact multiple times with a closed fist. MT #438 put his arms around AA #307 to lift her up and she kept trying to make contact with Resident #161 and did kick him in the back. AA #307 was taken to the lobby and was trying to get back into the facility. AC #307 stated she called 9-1-1 at 10:37 A.M. AC #307 confirmed it was never ok to hit a resident. Interview was attempted with STNA #323 on 07/31/24 at 9:04 A.M. but was unsuccessful. Interview on 07/31/24 at 3:47 P.M. with Medical Director (MD) #470 revealed he was aware of AA #307's employment and stated AA #307 had wanted to be a STNA. MD #470 stated he was made aware of the situation from last week where Resident #161 had tapped AA #307 on the leg with his cane and AA #307 proceeded to challenge Resident #161, put her belongings down and then attacked Resident #161, which was unacceptable, and the facility had no tolerance for that. Interview on 08/01/24 beginning at 10:02 A.M. with LPN/Assistant Director of Nursing (ADON)/Risk #469 and the Administrator revealed the facility determined the root cause of the (abuse) incident involving Resident #161 and AA #307 was due to AA #307's lacking behavioral health training. The administrative staff indicated moving forward the facility was going to utilize a competency packet with quiz for staff regarding behavioral health needs but stated they had not started this process as of the time of this interview. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility undated policy titled, Ohio Abuse, Neglect and Misappropriation, defined abuse as the willful infliction of injury, unreasonably confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish and defined physical abuse as hitting, slapping, pinching, kicking or flicking with fingers or striking in any manner that is demeaning. It was the intent of this facility to prevent the abuse, mistreatment or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property. All investigations of abuse, neglect and misappropriation would be reviewed by the Quality Assurance/Performance Improvement (QAPI) committee who would determine if the investigation was complete and if the action taken had resolved the issue or if a performance improvement plan was needed. Cases of sexual or physical abuse by staff or other residents always required tracking and corrective action by the QAA committee and this coordinated effort would allow the QAA committee to determine if there was further need for systemic action such as: insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation and exploitation. This deficiency represents noncompliance investigated under Master Complaint Number OH00156356 and Complaint Number OH00155912.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 38522 Based on personnel file review, interview and review of the facility policy, the facility failed to hire staff free of disqualifying offenses including abuse. This affected three out of five personnel files reviewed and had the potential to affect all 161 residents in the facility. Findings include: Review of personnel files on 07/30/24 at 12:03 P.M. and 4:25 P.M. with the Administrator revealed the following areas of concern: Review of State tested Nursing Assistant (STNA) #356's personnel file revealed a date of hire of 03/06/23. Review of STNA #356's background check report dated 03/10/23 revealed a charge dated 03/31/04 for cruelty towards child and child neglect and a charge of aggravated child abuse and cruelty towards child with a note that charge was dropped/abandoned on 07/09/04. Both charges occurred in the state of Florida. Review of Maintenance Technician (MT) #438's personnel file revealed a date of hire of 06/19/24. Review of MT #438's background check report dated 07/01/24 revealed a charge dated 11/05/18 for possession of drugs (2925.11). Review of STNA #367's personnel file revealed a date of hire of 04/24/24. Review of STNA #367's background check dated 05/03/24 revealed a charge dated 05/03/21 for endangering children, a charge dated 10/21/20 for possession of drugs (2925.11) and a charge dated 08/30/21 for possession of marijuana (2925.11). Interviews with the Administrator verified the above findings at the time of discovery. The Administrator indicated the internal facility processes regarding questionable background checks was not followed, as any applicant with findings on their background checks that Human Resources staff had questions about would have to go to the Divisional [NAME] President of Human Resources for further review. The Administrator also stated based on STNA #356's findings of child neglect, STNA #356 never should have been hired by the facility. Review of the facility policy, Background Checks/Abuse Checks Under Ohio Law, dated 10/01/19 revealed if an individual had convictions you will see a printout that will list all convictions for that individual not just convictions for disqualifying crimes. You will need to review the printout to determine whether any of the convictions are disqualifying. The printout will also include arrests for which the Bureau of Criminal Investigation (BCII) or the Federal Bureau of Investigation (FBI) has no record of disposition (i.e. they do not know how the matter turned out in the courts). If a job applicant has been arrested for what would be a disqualifying crime but there is no disposition listed, you will have to investigate yourself to find out what the result was. You may put the burden on the applicant to provide you with evidence of what the disposition of the offense was you are not required to hire someone with a prohibited offense regardless of whether they can meet personal care standards or not Any individual found not eligible to work may not be employed. (continued on next page)

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Wyant Woods Healthcare Center	200 Wyant Rd Akron, OH 44313

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the policy, Ohio Prohibited Offenses, dated 10/01/19 revealed applicants coming under final consideration for employment with the facility's corporation may not have been convicted of, plead guilty to or plead no contest to the listed offenses including 2925.11 drug abuse. This deficiency represents noncompliance investigated under Master Complaint Number OH00156356 and Complaint Number OH00155912.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 38522 Based on personnel record review, facility policy review, and interview, the facility failed to implement their abuse policy and procedure regarding checking potential applicants against the Ohio Nurse Aide Registry (NAR). This affected three out of five personnel files reviewed and had the potential to affect all 161 residents who resided in the facility. Findings include: Review of personnel files on 07/30/24 at 12:03 P.M. and 4:25 P.M. with the Administrator revealed the following areas of concern: Review of State tested Nursing Assistant (STNA) #356's personnel file revealed a date of hire of 03/06/23. STNA #356's personnel file lacked evidence she was checked against the NAR prior to 07/30/24. A copy of the NAR ran by the Administrator on 07/30/24 was on top of her personnel file. Review of Maintenance Technician (MT) #438's personnel file revealed a date of hire of 06/19/24. MT #438's personnel file lacked evidence he was checked against the NAR. Review of Activity Aide (AA) #307's personnel file revealed a date of hire of 06/19/24. AA #307's personnel file lacked evidence she was checked against the NAR. Interviews with the Administrator verified the above findings at the time of discovery. The Administrator indicated she ran STNA #356 against the NAR this date for her own peace of mind and confirmed all staff regardless of position were to be ran against the NAR to ensure they do not have a finding of abuse, neglect, mistreatment, exploitation of residents or misappropriation of their property. Review of the policy, Background Checks/Abuse Checks Under Ohio Law, dated 10/01/19 revealed it was policy of the facility's corporation to assure a check of the Ohio STNA registry was completed on all candidates for employment prior to a job offer being made. Review of the facility policy, Ohio Abuse, Neglect and Misappropriation, no date revealed a licensure/registry checks will be performed, as applicable, after the interview to verify the Nurse Aide Registry. All checks will be managed by the facility Human Resources manager/designee and results will be reviewed with the appropriate department head and administration. This deficiency represents noncompliance investigated under Master Complaint Number OH00156356 and Complaint Number OH00155912.

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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** 38522 Based on observations, record review, facility investigation review, police report review, facility policy review, review of weather information from www.wunderground.com and interviews, the facility failed to maintain a safe environment and provide necessary supervision to prevent Resident #158, who had diagnoses including schizoaffective disorder, auditory hallucinations, dementia with other behavioral disturbance, homicidal ideations and delusional disorder from eloping from the facility. This resulted Immediate Jeopardy and the potential for actual harm on 07/14/24 when Resident #158 exited the facility without staff knowledge after State tested Nursing Assistant (STNA) #356 propped the back (locked) door of the secured Buckeye unit open with a wet floor sign. Resident #158 was subsequently located at her father's house in a city approximately 16 miles away from the facility on 07/15/24 around 8:00 A.M. after Family Member (FM) #474 called the facility asking where Resident #158 was and informed Receptionist #451 that Resident #158 was at his home, not at the facility. FM #474 reported the resident had been at his home since 07/15/24 at 4:00 A. M. This affected one resident (#158) of three residents reviewed for elopement. The facility identified 38 residents at risk for elopement (Residents #3, #17, #19, #39, #41, #42, #43, #44, #48, #54, #55, #66, #67, #73, #75, #77, #82, #87, #91, #92, #101, #105, #109, #110, #122, #134, #141, #144, #147, #150, #151, #156, #157, #158, #160, #162, #163 and #167). The facility census was 161 residents. On 08/01/24 at 2:37 P.M. the Administrator, Director of Nursing (DON) and Regional Director of Clinical Operations (RDCO)/Registered Nurse (RN) #475 were notified Immediate Jeopardy began on 07/14/24 when Resident #158, who had a legal guardian and was care-planned as an elopement risk, left the facility unauthorized and without staff knowledge after STNA #356 had placed a wet floor sign in the secured door in the back of the Buckeye unit, rendering it unsecured and accessible to residents. On night shift on 07/14/24, STNA #337 and Licensed Practical Nurse (LPN) #432 did not conduct complete rounding and were unaware Resident #158 had exited the facility. On day shift on 07/15/24, STNA #341, STNA #357 and LPN #431 failed to conduct timely and complete rounding and were unaware Resident #158 had exited the facility until 07/15/24 at approximately 7:45 A.M. when STNA #341 went into Resident #158's room to deliver her breakfast tray and discovered Resident #158 was not there. The facility was unaware of Resident #158's whereabouts until 07/15/24 at 8:00 A.M. when FM #474 called the facility asking where Resident #158 was, and informed Receptionist #451 that Resident #158 was at his home 16 miles away and had been there since 4:00 A.M. that morning. Resident #158 was returned to the facility by the police. The Immediate Jeopardy was removed on 08/02/24 when the facility implemented the following corrective actions: On 07/15/24 at 7:55 A.M. LPN/Unit Manager (UM) #466, LPN/UM #464, LPN/UM #465 and RN/UM #467 completed whole house head count. All residents were accounted for except for Resident #158. On 07/15/24 at 9:45 A.M. Resident #158 returned to facility with police. Full head to toe assessment and Wandering Observation Tool completed by RN/UM #467. No injuries noted on assessment. Brief Interview for Mental Status (BIMS) completed by Minimum Data Set (MDS)/LPN #439. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/15/24 at 9:45 A.M. LPN/Assistant Director of Nursing (ADON)/Risk #469/Designee conducted staff interviews. Staff interviews determined STNA #356 had been responsible for propping open a door on the Buckeye Unit. STNA #356 was immediately suspended by Administrator and was subsequently terminated from employment on 07/25/24. On 07/15/24 at 9:50 A.M. Maintenance Technician (MT) #436 assessed all coded doors to ensure they were working properly and there were no items in them to prohibit proper locking. On 07/15/24 at 11:12 A.M. LPN/ADON/Risk #469 notified Medical Director (MD) #470 of Resident #158's return. MD #470 requested Resident #158 be seen at hospital for further evaluation. Non-emergent transportation requested. On 07/15/24 at 12:00 P.M. the DON/Designee implemented daily audits for resident counts, shift change reports, and removal of items used to prop doors once per week for four weeks, then randomly thereafter. Night shift supervisors LPN #435, LPN #413 or Designee to audit using midnight census, rounding on residents and doors daily for four weeks, then randomly thereafter. All findings would be reported to the Quality Assurance Committee. DON/Designee to audit night shift randomly for three months. On 07/15/24 at 12:30 P.M. Social Service Designee (SSD) #457 spoke with Resident #158 finding that she believed everything was ok, she feels safe and remains at baseline. SSD #457 followed up on 07/16/24 to offer support. Licensed Social Worker (LSW) #410 and in house counseling services to continue offering support to Resident #158 as needed. On 07/15/24 at 12:45 P.M. RN/UM #467 made Psychiatrist #476 aware of Resident #158's elopement. Psychiatrist #476 made medication adjustments for Resident #158. Psychiatrist #476 to continue following Resident #158 as needed. On 07/15/24 the DON/Designee educated all staff regarding elopement prevention and management, emergency door use, not propping doors open, as well as nurse shift change and walking rounds procedures. Education completed same day. All staff not scheduled during education were educated via telephone. On 07/15/24 door vendors called to building to inspect doors. On 07/15/24 Elopement drills completed on day and night shift by DON/Designee. Drills to capture 6:00 A. M. to 2:00 P.M. shift completed 08/02/24 by LPN/UM #465. On 07/15/24 DON/Designee reviewed all facility elopement books. Elopement books included a list of residents at risk for elopement, the face sheets, photos, contact information, diagnosis, of all residents at risk. There was an elopement binder at each nurse's station on the first and the second floor as well as the front receptionist's desk. On 07/15/24 DON/Designee assessed all residents for elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 07/15/24 night shift supervisors LPN #435, LPN #413 or Designee to complete head count daily on night shift using midnight census report and this would be ongoing. This was to be signed and documented on the midnight census report generated in Point Click Care (electronic medical record). Interview on 07/30/24 at 1:53 P.M. with STNA #367 revealed she was aware of Resident #158's elopement from the facility but was not physically present that date. STNA #367 was asked if STNA #357 was available for interview, and she reported STNA #357 had left for the day already before shift change at 2:00 P.M. Interview on 07/31/24 at 5:48 A.M. with STNA #337 indicated nothing different was occurring with staff at shift change since Resident #158 eloped from the facility. Interview on 08/01/24 at 7:38 A.M. with STNA #341 also indicated the facility was not auditing staff at shift change to ensure staff did not leave before the on-coming shift arrived and there remained no STNA to STNA report since Resident #158 eloped from the facility. On 08/02/24 DON/Designee re-assessed Resident #158 for elopement risk and reviewed the resident's care plan to provide structured activities, diversional tasks, redirection of ambulation pattern, and utilization of safe wandering areas (safe and highly visible areas). On 08/02/24 DON/Designee re-reviewed all residents' elopement risk assessments with no changes. On 08/02/24 DON/Designee re-educated all staff regarding elopement prevention/management, emergency door use, not propping doors open, as well as nurse shift change and walking rounds procedures. The facility implemented a plan for the DON/Designee to audit resident counts at shift change log on locked units weekly for four weeks then randomly thereafter. Unit Managers (LPN/UM #466, LPN/UM #464, LPN/UM #465 and RN/UM #467) and Night shift supervisors (LPN #435 and LPN #413) or Designee to audit walking rounds weekly for four weeks then randomly thereafter. Walking rounds and door check logs to be placed on all units and these would be audited by the DON/Designee weekly for four weeks. The facility implemented a plan for the Administrator/Designee to audit all coded doors to ensure they were latched and had no props in or near them weekly for four weeks then randomly thereafter. The facility implemented a plan for the Administrator to monitor compliance in monthly Quality Assurance Performance Improvement meetings for three months then as needed until compliance was maintained. On 08/05/24 from 1:40 P.M. to 2:00 P.M. interviews with LPN #425, RN #390, STNA #353 and STNA #319 confirmed they received education regarding elopement, not propping emergency doors open, emergency door use, nurse shift changes and walking rounds procedures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although the Immediate Jeopardy was removed on 08/02/24 the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure continued compliance. Findings include: Review of Resident #158's medical record revealed an admitted [DATE] with diagnoses including obsessive-compulsive personality disorder, schizoaffective disorder-bipolar type, polydipsia, attention-deficit hyperactivity disorder, auditory hallucinations, dementia with other behavioral disturbance, generalized anxiety disorder, delusional disorders, other psychoactive substance abuse in remission and homicidal ideations. Record review revealed Resident #158 had a legal guardian, identified as Legal Guardian (LG) #472. Review of a historical social service note dated 01/23/23 revealed Resident #158 lived at a group home prior to nursing home stay and was homicidal at that time. She was not following any of the rules at the group [NAME] and was using a family member's money to use Uber and not let anyone know where she was going. Resident #158 was not safe in the community. Resident #158 was incompetent with a guardian and the guardian reported the plan was for Resident #158 to be placed permanently. Review of a court order dated 01/26/23 revealed Resident #158's guardianship was to continue as FM #474 enabled her harmful behavior. FM #474 would give Resident #158 large sums of money and a cell phone and Resident #158 would use these items to purchase such things as Uber (rideshare service) rides to spend time at a homeless shelter in Cleveland and Amazon orders of food, drink and dietary supplements. A crack pipe was found in her room at her previous group residence after one such visit. Due to her diagnosis of psychogenic polydipsia her nutrition intake must be closely monitored. Resident #158 continued to require LG #472 as her insight and judgement was severely impaired due to her mental illness, her insight and judgement were too limited due to psychosis to make decisions and Resident #158 remained detached from reality and unable to make reasoned decisions. The order found it was in Resident #158's best interests to not be allowed to visit FM #474 and FM #474 could only have contact with Resident #158 via phone going forward. Review of historical wandering observation tools for Resident #158 dated 06/08/23 and 02/15/24 indicated Resident #158 had a history of elopement and was at risk for elopement. Review of a historical nurse practitioner note dated 09/27/23 revealed Resident #158 remained on the locked unit for safety of potential elopement. Review of a historical social service note dated 02/05/24 revealed Resident #158 continued to have behaviors on the behavior unit, was delusional and was not appropriate to be moved off of the locked unit. Doctors recommend no discharge for resident, and she needed continued placement on the locked unit. Failed attempts in the community due to her non-compliance make her unsafe and she already has a guardian in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #158's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #158 had moderate cognitive impairment, experienced delusions, displayed other behavioral symptoms not directed towards others one to three days in the seven-day look-back period and wandered one to three days in the seven-day look-back period. Resident #158 required set up assistance for most activities of daily living, supervision or touching assistance for bathing/showering and required supervision for ambulation. Review of Resident #158's physician's orders revealed an order dated 01/04/24 for Haloperidol (antipsychotic medication) oral tablet 5 milligrams (mg) give three tablets by mouth at bedtime for schizophrenia; an order dated 02/15/23 for Depakote (anticonvulsant medication) oral tablet delayed release 250 mg give 250 mg by mouth three times a day for mood; an order dated 06/26/23 for Invega (antipsychotic medication) oral tablet extended release 24 hour 3 mg give 3 mg by mouth in the morning for schizoaffective disorder bipolar type; an order dated 10/23/23 for Propranolol Hydrochloride (beta blocker medication) tablet 20 mg give one tablet by mouth every morning and at bedtime for anxiety; an order dated 07/11/24 for secured unit placement due to need for decreased stimuli and controlled environment and an order dated 07/16/24 for Invega Sustenna intramuscular suspension pre-filled syringe 234 mg inject 234 mg intramuscularly every day shift every four weeks on Tuesday for schizoaffective disorder bipolar type. Review of Resident #158's wandering observation tool dated 04/23/34 and completed by RN/UM #467 revealed Resident #158 was not identified as a risk for elopement at the time of this assessment. Review of the next available wandering observation tool dated 07/15/24 and completed by RN/UM #467 revealed Resident #158 was identified at risk for elopement. Review of Resident #158's care plan (dated 01/04/23) revealed Resident #158 required a secured unit due to schizophrenia diagnosis. Listed interventions also dated 01/04/23 included provide diversionary activities as needed and redirect as appropriate. Review of Resident #158's care plan (dated 01/09/23) revealed Resident #158 was an elopement risk. Listed interventions dated 01/09/23 included: assess for hunger, thirst, ambulation and toileting needs; complete wandering evaluation upon admission, re-admission, quarterly and as-needed (PRN); educate resident/resident representative of the need for secured unit/device to maintain resident safety; evaluate for need of secured unit, notify medical provider as needed; notify medical provider, resident representative of behavior changes; notify staff of elopement risk; and obtain a current photograph and list of identifiable characteristics and place in the elopement risk identification book. An additional intervention dated 07/17/24 instructed staff to provide diversionary activities as needed and redirect when appropriate. Review of an incident log from May 2024 through July 2024 revealed Resident #158 had an elopement incident on 07/15/24 at 7:55 A.M. Review of a late entry nurse's note dated 07/15/24 at 9:45 A.M. and authored by RN/UM #467 on 07/16/24 revealed Resident #158 returned to facility at this time, full head to toe assessment completed, no skin impairments noted. Guardian notified of Resident #158's return. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of historical weather data from www.wunderground.com revealed on 07/14/24 the high temperature was 87 degrees Fahrenheit (F) with a low temperature of 68 degrees F and on 07/15/24, the high temperature was 88 degrees F with a low temperature of 70 degrees F. Review of the facility's investigation regarding Resident #158's elopement revealed a root cause analysis meeting was conducted on 07/15/24 with the Administrator, DON, ADON/LPN/Risk #469, LPN/UM #464, LPN/UM #465 and RN/UM #467. The investigation revealed at approximately 1:00 A.M. Resident #158 left the facility unauthorized using an emergency exit door that was propped open by staff. The investigation documented Resident #158 walked to the Speedway gas station in Fairlawn and from there, called for a ride to FM #474's house in [NAME] (approximately 16 miles away). Resident #158 arrived at FM #474's house at approximately 4:00 A.M. FM #474 immediately called the facility and the police to notify them of Resident #158's whereabouts. Staff called a Code [NAME] (missing person) prior to FM #474 calling the facility. Contributing factors to the elopement included nurses and STNAs not completing rounds upon shift change. Review of a witness statement dated 07/15/24 and completed by the Administrator and the DON for FM #474 included the following information: Resident #158 walked out [of the facility], walked down the street (not named) and then somebody somewhere gave her a ride and dropped her off down the street (not named) then Resident #158 was walking on my door. Somebody (not named) picked her up from the gas station in Fairlawn Resident #158 called me from the gas station (time not given). Resident #158 arrived at my house at approximately 4:00 A.M. and she was happy and glad to be here and to see me. I tried calling the facility and police almost immediately. I tried calling the facility multiple times and it rang and rang. Resident #158 said she does not want to be at the facility and she wants to come home as she is confined to a small area and she wants to go out and participate in activities. Review of a witness statement dated 07/15/24 and completed by LPN/ADON/Risk #469 for Resident #158 included the following information: I wanted to see FM #474 because he doesn't eat home cooked meals and I worry about him. I want to go somewhere where I can lay out in the sun and not pace all day. Review of a witness statement dated 07/15/24 and authored by RN/UM #467 included the following information: I asked Resident #158 what she did while she was at FM #474's house and how she got there. Resident #158 stated she walked to FM #474's house. Review of a witness statement dated 07/15/24 and authored by STNA #341 included the following information: I got here at 6:30 A.M. and I got Resident #106 washed and dressed. My co-worker (not named) was getting Resident #14 washed and dressed. Breakfast trays came and we checked Resident #158's room and she was not there. Nursing was notified and a Code [NAME] was called. Review of a witness statement dated 07/15/24 and authored by Receptionist #451 included the following information: Call received from FM #474 at approximately 8:00 A.M. to 8:05 A.M. FM #474 asked where Resident #158 was at and I told him she was on her hall. FM #474 stated no, Resident #158 wasn't as she was at his home. FM #474 stated Resident #158 arrived around 4:00 A.M. and he had tried calling here, the DON and the police. FM #474 also stated that the door [on the Buckeye unit] was propped open. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a witness statement dated 07/15/24 and authored by LPN #471 included the following information: At 7:55 A.M. Buckeye nurse (not named) came to me and stated Resident #158 was missing. I immediately did a hall check, looked in all opened and unlocked doors and Resident #158 was not found. I called a Code Green, staff responded and a search was started. Receptionist #451 came back at 8:00 A.M. and said FM #474 just called and Resident #158 was at his house since 4:00 A.M. Code [NAME] was canceled and LG #472 was notified. Review of a witness statement dated 07/15/24 and authored by STNA #357 included the following information: I came in at 6:20 A.M., I checked the rooms and Resident #158 was not in her bed but the bathroom door was closed so I assumed she was using the bathroom. About an hour later we were passing breakfast trays and noticed Resident #158 was missing. Review of a witness statement dated 07/15/24 and authored by LPN #432 included the following information: I came in at 6:00 P.M. for my shift (6:00 P.M. to 6:30 A.M.). I passed before bed (HS) medications on the unit and Resident #158 was present. When I came back to Buckeye at approximately 12:00 A.M. the aide (not identified) was having a conversation with Resident #158 about the time and encouraging Resident #158 to try to go to sleep. That was the last time I had physically seen Resident #158. A text-message screen shot from LPN #432 dated 07/15/24 at 6:09 P.M. revealed the following information: I had heard a conversation with STNA #356 from Buckeye hall admitting to propping the door open with a wet floor sign as STNA #356 stated it was too hot and muggy in the dining room. STNA #356 also stated she was not owning up to it as she would get fired if she did. Review of a witness statement dated 07/15/24 and authored by LPN #413 included the following information: I did not know Resident #158 was missing. I never knew the door at the back of the unit was propped open. Review of a witness statement dated 07/19/24 and authored by LPN #413 included the following information: I was told by STNA #356 that she accidentally left the door open. Review of a text-message screenshot between the Administrator and STNA #356 on 07/19/24 revealed STNA #356 would not provide a statement. Review of a witness statement dated 07/15/24 and authored by LPN #431 included the following information: Average morning, nothing reported to me during shift change. Rounds made around 8:00 A.M. and noticed Resident #158 was not in her room. Complete check of the hall was done when we (not specified) noticed the back door was propped open with a wet floor sign. This was reported. Review of a [NAME] police report dated 07/15/24 at 8:35 A.M. revealed a call placed from RN/UM #467 regarding Resident #158 who was at FM #474's house but was supposed to be at the facility but had escaped. Resident #158 had a legal guardian identified as LG #472. Dispatch personnel had reached out to FM #474 who indicated Resident #158 was wearing a blue dress and had left his home but FM #474 was not sure where. LG #472 believed Resident #158 may have enough money to have gotten an Uber to leave the area. There is a history of FM #474 giving Resident #158 money as well as Resident #158 taking an Uber to Cleveland for a purchase. Resident #158 was with RN/UM #467 in the facility at 9:52 A.M. (continued on next page)

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	365779	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyant Woods Healthcare Center	200 Wyant Rd Akron, OH 44313

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of STNA #356's personnel file revealed a date of hire dated 03/06/23. STNA #356's employment was terminated with the facility on 07/25/24 due to failure to cooperate with an investigation related to a serious resident incident. Interview on 07/29/24 at 3:56 P.M. with LPN #431 revealed on 07/15/24 she arrived at the facility to start her shift at 6:00 A.M. and received shift report from LPN #432 but nothing out of the ordinary had been reported to her. As Buckeye was her normal hall, she knew who to get up and reported that Resident #158 and her roommates all slept in, so she did not check on them. Between 7:45 A.M. and 8:00 A.M. she was in the dining room and the STNA (name not known) went to take Resident #158 her breakfast tray and Resident #158 was not there. LPN #431 acknowledged at this point she had not done rounds during her shift which had started at 6:00 A.M. LPN #431 stated a head count was done and only Resident #158 was missing. It was discovered at this time a folded up wet floor sign was propping the back door of the Buckeye unit open. LPN #431 stated she contacted LPN #471, and a Code [NAME] was called. Interview on 07/29/24 at 4:15 P.M. with Resident #158 revealed she was missing a book. This surveyor asked Resident #158 if she ever left the facility. Resident #158 stated yes, she left as the door was open and had left the facility between 10:30 P.M. to 11:00 P.M. but was unable to provide a date. Resident #158 said she went to [NAME] and had walked this way (pointed) then that way (pointed). Resident #158 stated the door had been left open two times but was unable to elaborate further. Interviews were attempted with STNA #356 on 07/30/24 at 11:37 A.M., 07/30/24 at 11:55 A.M. and 07/31/24 at 8:59 A.M. but were unsuccessful. Interview on 07/30/24 at 12:43 P.M. with LG #472 revealed she had been Resident #158's guardian for about two years. LG #472 stated FM #474 was to have no physical contact with Resident #158, but they were allowed to talk on the phone. LG #472 explained Resident #158 had psychogenic polydipsia and would drink fluids in excess and make herself sick so her fluid intake had to be monitored but FM #474 did not understand this and instead would give her drinks or money to buy drinks. LG #472 stated she was made aware of Resident #158's elopement from the facility and shared she was aware someone had left a wet floor sign in the secured door at the back of the unit and Resident #158 had observed people coming in and out of that door and had gotten out of the facility through that door sometime after 11:00 P.M. on 07/14/24. LG #472 stated Resident #158 told her and Resident #158's mother that she walked to [NAME] then a friend (not named) came to get her. LG #472 stated at the meeting with the facility, Resident #158 reported to them she had hitchhiked to [NAME]. LG #472 shared Resident #158 had a history of using Uber to go to Cleveland and reiterated Resident #158 required supervision and could not be out in the community alone. LG #472 shared at the meeting with the facility, a wander guard (device that would automatically lock doors upon approach) was discussed to be used for three or four weeks but stated she was unaware this had not been put in place for Resident #158. (Record review revealed no physician order for a wander guard device was noted and the resident resided on a unit that was not equipped with the wander guard system). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/30/24 at 1:27 P.M. with LPN #471 revealed on 07/15/24, LPN #431 told her at 7:55 A.M. that Resident #158 was missing. They did a head count, and a Code [NAME] was called. While responding to the Code Green, Receptionist #451 came back to the unit to report FM #474 had just called the facility and told them Resident #158 had been at his house since 4:00 A.M. LPN #471 stated they cleared the code and did a facility-wide head count before working on obtaining witness statements from staff. LPN #471 shared Resident #158 was not an elopement risk for nursing but would not be safe outside of the facility as she had poor coping and decision-making skills and would not take her medications. LPN #471 revealed Resident #158 was independent with most of her activities of daily living and worked with therapy to do laundry for herself. Interview on 07/30/24 at 3:34 P.M. with LSW #410 revealed SSD #457 previously addressed any social service needs for Resident #158's unit but he no longer worked for the facility. LSW #410 explained the facility had three secured units: Buckeye and Hickory were on the first floor and were for behavioral management and Birch was on the second floor and was for dementia management. LSW #410 indicated a resident with elopement risk could reside on any of the three secured units. LSW #410 indicated nursing would decide if a resident required a wander guard. LSW #410 shared she had only limited interactions with Resident #158 but reported Resident #158 had a (legal) guardian, made a lot of delusional statements and was currently an elopement risk at the facility. Interviews were attempted with SSD #457 on 07/30/24 at 3:49 P.M. and 07/31/24 at 9:01 A.M. but were unsuccessful. Interview on 07/30/24 at 3:53 P.M. with Receptionist #451 revealed on 07/15/24 sometime between 8:00 A.M. and 8:30 A.M. FM #474 called and asked her where Resident #158 was. Receptionist #451 stated she told FM #474 that Resident #158 was on her unit and then FM #474 reported Resident #158 was at FM #474's house and had been there since 4:00 A.M. Interview on 07/31/24 at 5:04 P.M. with LPN #432 revealed Resident #158 was currently an elopement risk but was not at risk before. LPN #432 stated she worked the night shift starting on 07/14/24 at 6:00 P.M. and did before bed medication administration around 8:00 P.M. LPN #432 stated she last saw Resident #158 around 11:00 P.M. with STNA #337 and Resident #158 wanted coffee and STNA #337 was encouraging her to try to lay down. LPN #432 reported she rounded on the halls at 1:00 A.M., 3:00 A.M. and 5:00 A.M. but indicated she did not look in Resident #158's room at those times. LPN #432 explained there were certain residents who were an elopement risk, and those rooms were specifically checked during rounds. LPN #432 stated she completed shift report with LPN #431 and left the faciity on [DATE] around 6:30 A.M. but got a call around 8:00 A.M. from LPN #431 asking her where Resident #158 was and that was how she learned Resident #158 had left the facility. LPN #432 stated STNA #356 had worked until 10:00 P.M. on 07/14/24 and knew the back door code but she herself did not know that code. LPN #432 stated she went to school with LPN #431 and LPN #413 and LPN #413 had called STNA #356 to ask her about the back door and STNA #356 had admitted she had left the back door popped open but was concerned about losing her job. Interview on 07/31/24 at 5:48 A.M. with STNA #337 revealed she worked on 07/14/24 from 10:00 P.M. to 6:00 A.M. with LPN #432 and last saw Resident #158 on 07/15/24 around 1:00 A.M. when she asked for coffee. STNA #337 stated she did not check on Resident #158 at all after that time and left at the end of her shift around a little after 6:00 A.M. STNA #337 stated she was made aware the door to the unit had been propped open all night when LPN/ADON/Risk #469 called her later that morning but had not noticed this while on the unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/31/24 at 8:06 A.M. with STNA #357 revealed she came in to work on 07/15/24 at 6:20 A.M. and was running behind but did her hall check around 6:40 A.M. When asked to elaborate what a hall check entailed, STNA #357 stated this was when she checked all the rooms on the hall to make sure all the residents were present and breathing. STNA #357 stated she went into Resident #158's room and noticed Resident #158 was not in her bed but the light was on in the bathroom and the door was shut so she assumed Resident #158 was in the bathroom. Around 8:00 A.M. they were passing breakfast trays, and it was at that point she realized Resident #158 was not in her room and stated she told LPN #431. STNA #437 reported Resident #158 told staff she left the faciity on [DATE] between 11:00 P.M. and 12:00 A.M. STNA #437 stated she did not think Resident #158 was an elopement risk prior to this event and stated staff would tell her who was at risk for elopement in addition to looking at the elopement book. Interviews were attempted with FM #474 on 07/31/24 at 8:23 A.M. and 07/31/24 at 11:16 A.M. but were unsuccessful. Interview on 07/31/24 at 9:38 A.M. with LPN #413 revealed she worked the night shift as a supervisor on 07/14/24 from 6:00 P.M. to 07/15/24 until 6:30 A.M. and shared she checked each unit that evening and they were fine, nothing out of the ordinary had occurred on night shift. LPN #413 explained the expectation was staff were to round every two hours on residents, but stated this process was not documented. Later that morning between 8:30 A.M. and 9:00 A.M. she was on her way to school and LPN #431 called her to ask if she knew Resident #158 was missing which she stated she did not. LPN #413 stated she did not know the code to the back door, but supervisors had a sheet with the door codes on them. LPN #413 stated she knew her staff and STNA #337 did not know the code so she called STNA #356 and STNA #356 confirmed to her that she had left the door open but would not divulge how long the door had been propped open for. LPN #413 stated Resident #158 was an elopement risk and there was a book at the nurses' station which listed residents at risk for [TRUNCATED]