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	06/12/2025

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 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 interview, record review and review of facility policies, the facility failed to ensure residents were appropriately supervised while smoking, resulting in an elopement. This affected one resident (#144) and had the potential to affect all 11 residents who smoked on the Hickory Unit (#24, #55, #75, #101, #102, #122, #129, #134, #144, #148 and #157). Facility census was 163. Findings include: Review of Resident #144's medical record revealed an admission date of 06/05/18 and diagnoses including alcohol dependence with alcohol-induced persisting dementia, major depressive disorder, paranoid schizophrenia, bipolar disorder, delusional disorder, mild cognitive impairment, impulsive disorder, intermittent explosive disorder, cocaine abuse and dementia in other diseases, severe, with other behavioral disturbances, psychotic disturbance and mood disturbance. Review of a plan of care dated 02/18/21 and revised 07/18/22 revealed Resident #144's guardian had no plans for discharge secondary to Resident #144 walked away from about 20 group homes and was not safe to live alone. Interventions included invite and encourage to attend activities of interest; monitor for signs and symptoms of anxiety, distress, withdrawal or depression relating to not returning to previous home environment and provide visits for support and observe for any concerns. Review of a plan of care dated 02/18/21 and revised 12/14/23 revealed Resident #144 wished to smoke and her guardian agreed to implement a money plan where Resident #144 would receive four dollars a week for spending money and the rest would be set aside to purchase cigarettes so that she could smoke; Resident #144 would attempt to go outside to smoke outside of designated smoking times. Interventions included complete smoking evaluation; educate resident/resident representative to designated smoking areas and long term side effects of extended nicotine use; educate resident/resident representative to facility smoking policy and obtain resident signature and provide supervision during designated smoke times. Review of Resident #144's current physician's orders revealed an order dated 04/13/25 for secured unit placement due to paranoid schizophrenia and need for decreased stimuli and a controlled environment. Review of a wander observation tool dated 04/13/25 revealed Resident #144 was at risk for elopement. (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	Review of a plan of care dated 04/13/25 and revised on 04/15/25 revealed Resident #144 was an elopement risk. Interventions included assess for hunger, thirst, ambulation, toileting needs; complete wandering evaluation, upon admission/readmission, 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 and resident representative of behavior changes; notify staff of elopement risk; obtain a current photograph and list of identifiable characteristics, and place in the elopement risk identification book; provide diversionary activities as needed and redirect when appropriate; provide structured activities at times of increased elopement risk, diversional tasks, redirection of ambulation pattern and utilization of safe wandering area. Review of a quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #144 was cognitively intact, displayed verbal behaviors four to six days, wandered one to three days and displayed other behaviors one to three days of the review period. Resident #144 was independent or required set up for activities of daily living and required supervision for walking 150 feet. Review of a nurses' note dated 05/22/25 timed 4:30 P.M. and signed by the Director of Nursing (DON) revealed Resident #144 was returned safely to her room by the DON. Resident #144 stated she wanted food from a restaurant. Resident #144 voiced no complaints or concerns. Resident #144 denied pain or discomfort, and did not display any signs or symptoms of pain, discomfort, or distress. A head to toe assessment was completed including vital signs and skin assessment which was within normal limits to resident's baseline, no injuries or skin alterations noted, skin warm to touch. All required parties were notified with new orders for psychiatric medication changes. The note indicated to see new orders for detailed medication changes. The guardian was notified and guardian noted that Resident #144 had a history of exit seeking and the police did not need to be notified at that time. Review of the facility investigation into Resident #144's elopement on 05/22/25 revealed a timeline including the following: • On 05/22/25 at 4:05 P.M. Former Activities Director (FAD) #211 called the DON and explained while leaving for the day, he saw Resident #144 in the parking lot. The DON told FAD #211 to remain with Resident #144 and instructed unit managers and floor nurses to call a Code Green and complete head counts while Director of Maintenance (DOM) #205 checked gates and doors. • On 05/22/25 at 4:06 P.M. the DON arrived to the parking lot and saw Resident #144 and began to talk to her. • On 05/22/25 at 4:07 P.M. the DON spoke with Resident #144 who stated she did not want to return to the facility because she wanted to see her family and eat at a restaurant. When asked, Resident #144 would not state how she left the secured unit. Resident #144 was returned safely to her secured unit and placed on one on one (1:1) supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a witness statement dated 05/22/25 and authored by Certified Nursing Assistant (CNA) #210 revealed he let the residents out to smoke and watched from the window because it was raining. The witness statement indicated Resident #144 must have eloped while CNA #210 helped Resident #129 back into the building, which was when the code green was called. Review of a witness statement dated 05/22/25 and authored by Registered Nurse (RN) #23 revealed she last saw Resident #144 just right before she was about to start passing medications at 4:00 P.M. Resident #144 was standing a few feet away from the medication cart at that time. Review of a witness statement dated 05/22/25 and authored by FAD #211 revealed on 05/22/25 at approximately 4:15 P.M. while he was leaving the facility/premises for the day, he observed Resident #144 walking through the employee parking lot in the front of the building down towards the entrance and exit. FAD #211 immediately called the DON who arrived moments later and began conversing with Resident #144. Continued review of the facility investigation identified CNA #210 and CNA #212 as the staff responsible for supervising the smoke break on 05/22/25 at 4:00 P.M. CNA #210 and CNA #212 failed to supervise smoke break which led to a resident [Resident #144] kicking the courtyard gate during smoke break and eloping. Both staff were suspended and received final written warnings on 05/27/25 for violating facility policy and failing to supervise smoke break resulting in a resident elopement. Review of a plan of care dated 05/23/25 revealed Resident #144 wandered aimlessly from place to place. Interventions included assess for hunger, thirst, ambulation, toileting needs; complete wandering evaluation, upon admission/readmission, quarterly, and PRN; evaluate for need of secured unit, notify medical provider as needed; notify medical provider, resident representative of behavior changes; notify staff of wandering risk; personalize room with familiar objects and/or photographs; provide diversionary tactics/activities as needed and redirect when appropriate and provide structured activities at times of increased wandering, diversional tasks, redirection of ambulation pattern, and utilization of safe wandering areas. Interview on 06/12/25 at 10:18 A.M. with Resident #144 revealed she had been at the facility 37 years and had eloped from the facility twice. Resident #144 stated she was caught within 20 minutes this last time. When asked why she left the facility, Resident #144 stated she did not like the facility. Interview on 06/12/25 at 2:00 P.M. with CNA #210 revealed on 05/22/25 they were doing smoke break on the unit between 4:00 P.M. and 5:00 P.M. and the snack cart had come so staff were waiting on a few residents to come out for smoking. CNA #210 stated it was raining so he was watching smoking from the window inside the Hickory unit. CNA #210 stated at this time Resident #144 slipped out and estimated she was gone 15 minutes as they began to count the residents and heard the Code [NAME] over the overhead paging system. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/12/25 at 3:38 P.M. with the DON and Corporate Nurse #209, the DON verified the content of the investigation provided and indicated the root cause of Resident #144's elopement was staff not supervising the resident smoke break appropriately on the Hickory unit. The DON stated when she interviewed CNA #210 he admitted he was looking away at the time of the actual elopement and was not actually outside during the smoke break. The DON confirmed both CNA #210 and CNA #212 did not supervise the smoke break appropriately which enabled Resident #144 to elope from the Hickory courtyard. When asked how long Resident #144 was gone for, the DON estimated Resident #144 was gone for five or six minutes. Review of the facility's undated policy Resident Smoking Guidelines revealed the facility would promote resident centered care by providing a safe smoking area for residents that requested to smoke. Supervised smoking would be performed by a staff member. Review of the facility's undated policy Elopement Prevention and Management Overview revealed elopement was defined as when a resident left the premises or a safe area without authorization and/or any necessary supervision and placed the resident at risk for harm or injury . The interdisciplinary team planned the least restrictive interventions to promote mobility and safety and to meet the individualized needs and goals of the resident. This deficiency represents noncompliance investigated under Master Complaint Number OH00166205.