STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365812	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellspring Health Center	8000 Evergreen Ridge Drive Cincinnati, OH 45215

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 review of the medical record, review of the Emergency Medical Services (EMS) report, staff interviews, review of witness statements, review of door repair invoices, review of maintenance work orders, review of facility Self-Reported Incident (SRI), review of hospital records and review of the facility policy, the facility failed to provide adequate supervision to prevent an elopement from the Memory Care Unit (MCU) of one resident (#45) who ambulated through a door on the MCU with a malfunctioning alarm and into the East side stairwell where Resident #45 fell down 11 cement stairs. This resulted in Immediate Jeopardy and the potential for serious-life threatening injuries, negative health outcomes and/or death for one resident when Resident #45 exited the third-floor MCU on 03/27/25 through a door with a malfunctioning alarm and into the East side stairwell and fell down the stairs without staff's knowledge. Resident #45 was missing for approximately one hour before the staff determined the resident was missing, and the resident was found lying on the landing between the second and third floors. Nine-one-one (911) was called, and Resident #45 was sent to the hospital for evaluation and treatment of multiple fractures. This affected one (#45) of three residents reviewed for accidents. The facility identified four residents (#28, #32, #37, and #39) at risk for elopement. The facility census was 44. On 04/15/25 at 12:47 P.M., the Administrator, the Director of Nursing (DON), and Operations Specialist (OS) #70 were notified that Immediate Jeopardy began on 03/27/25 at approximately 6:20 P.M., when Resident #45 who was cognitively impaired due to diagnosis of dementia, assessed as being at high risk for elopement and was observed in the lobby by the DON wandering and displaying exit seeking behaviors, exited the third-floor MCU through a door with a malfunctioning alarm and into the East side stairwell. Resident #45 was assessed as being at high risk for elopement; however, no care plan was implemented for the resident being cognitively impaired or at risk for elopement. On 03/27/25 at 7:20 P.M., Certified Nursing Assistant (CNA) #10 found Resident #45 in the East side stairwell at the bottom of the landing between the second and third floors where the resident fell down 11 cement stairs and suffered multiple fractures including fracture to the left scapula, right fifth rib, left second, fifth and sixth ribs, had left parietal abrasion, lacerations to the left frontal scalp and contusions to the left lateral abdomen and pelvis. The Immediate Jeopardy was removed on 04/16/25 when the facility implemented the following corrective actions: • (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/27/25, after the elopement and fall, Resident #45 was transferred to the hospital and was admitted and did not return to the facility. • On 03/27/25, a loud temporary door alarm was placed on the East stairwell. The door was fixed on 03/31/25. During the time between the discovery of the resident's incident and the new door alarm being placed, the staff members took turns sitting at the door to ensure the door was protected from any further incident. If any alarms were to go off, the staff members were instructed to immediately investigate the alarm. • Starting on 03/27/25 and completed on 04/16/25, each resident was assessed upon admission for elopement concerns and thereafter quarterly. Anyone who triggered for an elopement was moved to the third floor and had a Wanderguard (device to help memory care residents against elopement) placed on their person. When a new behavior was encountered, a new assessment was completed, and the care plan was updated as well. All 44 residents have been assessed for elopements/falls and care plans were updated as needed. No new concerns were identified. • On 03/29/25, the electrician contractor discovered the wires controlling the door alarm and door control panel had been eaten through by rodents. • Starting on 3/31/25, daily checks of the door were implemented by the Administrator. Checks were completed by the DON and OS #70. On 04/09/25, during routine testing, an intermittent lock-out occurred, and maintenance staff came to evaluate and fix any issue found to be occurring. The issue noted was the door did not reset completely from being pushed open to test. The staff entered the code, closed the door and the issue did not occur again. The issue was resolved with the door being reset. • On 04/04/25, the DON was educated on the elopement and fall policy by the OS #70. • On 04/04/25, the DON conducted in-services on elopement and fall polices (only 20 of 74 staff were educated). On 04/15/25, the facility restarted the in-services and completed education with another 41 staff members. All staff have been messaged and have been told they will not be allowed to work a shift until they have read the policy and sign off or send an email confirming they have received and read the policy. • (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/15/25, an elopement drill was completed by Assistant Maintenance Director (AMD) #41. There were no concerns noted during this drill. • On 04/15/25, an Ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held with Medical Director (MD) #100 in attendance. Also in attendance was the DON, OS #70, Administrator, Dining Director #110, Social Services Director (SSD) #50, Therapy Director #120, and Business Office Director (BOM) #130 to discuss the incident and plan of action to mitigate any further issues. • On 4/15/25, the elopement policy was reviewed with Divisional Director of Health and Wellness #80 and Regional Director #90 and found to be up to date with no changes made. • Starting on 04/16/25, all four doors located at the East and [NAME] ends of the second and third floors will be checked by Administrator/designee five times a week for four weeks, then three times a week for eight weeks. Once this 12-week cycle is completed, the compliance will be turned over to the maintenance staff to be completed once a week through the TELS system (an electronic work order and preventative maintenance program that allows tracking of maintenance tasks). All these checks will be reviewed in the morning meetings and QAPI by the Administrator/designee. Although the Immediate Jeopardy was removed on 04/16/25, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the closed medical record for Resident #45 revealed an admission date of 03/27/25 with a discharge date of 03/27/25. Diagnoses included vascular dementia, atrial fibrillation, and heart failure. The resident was severely cognitively impaired. Review of the maintenance work orders from 02/01/25 through 04/14/25, revealed no documented maintenance work orders indicating the door alarms were not working. Review of a progress note dated 03/27/25 at 1:00 P.M., revealed Resident #45 was admitted to the facility for a seven-day hospice respite (temporary care for relief of a primary caregiver). Resident #45 was oriented to room with no concerns. Review of a progress note dated 03/27/25 at 6:04 P.M., revealed Resident #45 was moved onto the third floor (secured MCU) and a Wanderguard was applied by the DON. Review of a progress note dated 03/27/25 at 6:28 P.M., revealed Resident #45 was welcomed to his room. Resident #45 was ambulating with a walker around the MCU with poor safety awareness. (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 the EMS report dated 03/27/25, revealed the paramedics arrived on scene at 7:42 P.M. Resident #45 was assessed to be oriented to self and had fallen down approximately 15 steps with laceration to forehead. Resident #45 did not recall falling. Resident #45 was transported to a local hospital for evaluation and treatment. Review of a progress note dated 03/27/25 at 9:56 P.M., authored by the DON, revealed Resident #45 was observed lying on his left side with his walker on the third-floor landing of the stairs alert and responsive. Resident #45 had been exit-seeking and difficult to redirect. A Wanderguard was present on the resident's right ankle. The resident had been given snacks, drinks, was toileted, and placed in common area prior to the fall. When paramedics arrived, Resident #45 had approximately a two-inch laceration to his forehead. Resident #45 was transported to the hospital. Review of a witness statement dated 03/27/25 at 7:00 P.M., authored by Director of Hospitality #500, revealed he was made aware of Resident #45's disappearance at approximately 7:25 P.M. Resident #45 was then found shortly afterwards by the DON and CNA #10 on the third-floor East side stairwell. Resident #45 had obviously fallen down several steps due to the laceration on his forehead. EMS came and he was transported to the hospital. EMS notified the resident's daughter of the fall. The facility discovered that the wires to the alarm system were chewed through by a pack of rats causing the door to not alert staff once it was opened. The witness statement indicated that Resident #45 was injured and required medical attention by EMS. Review of the hospital records dated 03/27/25 at 10:40 P.M., revealed Resident #45 presented to the emergency room via EMS after falling down 15 stairs, unwitnessed, and found at the bottom of the stairs. Resident #45 did not remember the events and could not recall if he lost consciousness. Resident #45 was diagnosed with a fracture to the left scapula, right fifth rib, left second, fifth and sixth ribs, had left parietal abrasion, and contusions on the left lateral abdomen and pelvis. Review of the Elopement Risk assessment dated [DATE], revealed Resident #45 had an incomplete elopement risk assessment upon admission to the facility. Resident #45 had a history of wandering and verbalized the desire to leave the facility. Review of the care plans for Resident #45 dated 03/27/25, revealed there was no care plan implemented for Resident #45 with impaired cognition and being at risk for elopement. (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 facility document titled Incident Audit Report dated 03/28/25 at 7:15 P.M., revealed Resident #45 had an unwitnessed fall in the hallway. Resident #45 was a newly admitted resident today, was exit seeking and had poor adjustment to new facility. The resident was educated not to open the stairway doors because the doors were alarmed. A Wanderguard was in place on the resident's right ankle when the resident eloped from MCU via a stairway. The staff were unable to hear the alarm. The nurses assessed the resident without moving him with the assistance of two nurses and two CNAs. The resident's vital signs were assessed and kept the resident in place until EMS arrived. The resident was alert and able to talk with no change in speech and was able to answer questions. The resident denied any pain, but stated his left arm was uncomfortable. The resident was lying on his left side on the concrete. The resident was able to stand with assistance of two firefighters, but legs were shaky. There was an approximately four-centimeter (cm) laceration to left frontal scalp area with small amount of blood. The resident was secured to a stretcher chair then transferred to the ER via EMS. The incident details indicated that a nurse informed the DON that Resident #45 was missing. The DON instructed all staff to look for the resident in every room and down the stairs. The DON joined the search after completing a wound dressing change and securing the resident in a safe position. A search of the second and third floors was completed, and the resident was found in the stairwell on the landing lying on the floor with his walker. The resident was alert and responsive, not in distress but unable to explain what happened. The resident was originally admitted to the second floor. The hospice nurse assessed the resident soon after his admission. Approximately 30 minutes after the hospice nurse left, therapy informed the nurse that Resident #45 was in the lobby. The resident was returned to the second floor. The resident was oriented to the floor and staff. The resident roamed the halls looking around. The resident soon started exit-seeking and stated he wanted to go home. The resident was oriented to the reason for his stay and reassured and given dinner and snacks. The resident continued to exit seek. The decision to move the resident to the third floor and put a Wanderguard on the resident was made. The staff were updated. The staff repeated the orientation to the resident and the resident continued to roam and exit seek. The resident was in the common area of the MCU for staff to monitor and approximately 40 minutes later, the floor nurse informed the DON Resident #45 was missing. The family and the physician were notified. The section titled Injuries Report Post Incident, revealed the resident had fractured left shoulder (front), left rib and clavicle. The predisposing factors to the elopement indicated the resident was confused with impaired memory and was admitted within the last four hours. Review of an invoice dated 03/29/25, revealed an emergency service call to restore (splice) rodent damaged cabling on the third-floor east stairwell door (delayed egress). The service provider repaired the second-floor east door (door latch not contacting sensor, pulled strike plate and modified opening to accept latch) then tested and manually reset the remaining doors. The Legacy East door was unresponsive, and continued troubleshooting was required. A temporary door contractor with an alarm was installed at non-functional doors pending further troubleshooting and repairs. (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 the SRI created on 03/31/25 at 12:17 P.M., revealed Resident #45 was admitted from a home setting as a seven-day hospice respite. Shortly after admission, Resident #45 presented with wandering and was moved from the second floor to the third floor with a Wanderguard in place. Resident #45 was placed in the common area near the nurse's station and was given a snack. The Administrator was informed of the elopement on 03/27/25 at 7:19 P.M. The Administrator was informed that Resident #45 was found at 7:26 P. M. in the third-floor stairwell on the East Hall. Resident #45 had fallen down the stairs but was alert and responsive. EMS was called, and the resident was transported to the hospital. Resident #45's family and other necessary parties were notified. AMD #41 came onsite during the evening of 03/27/25 after the incident occurred with Resident #45. After inspection, AMD #41 determined the door alarm to be non-functional due to the wires that appeared to be chewed through by rodents. When the door was opened, no alarm in the immediate area was sounding; however, it triggered an alarm at the nurse's station. AMD #41 placed a loud temporary door alarm on the door as an immediate intervention. AMD #41 contacted a contractor to come onsite to fix the existing door alarm and contacted an exterminator to handle the rodent issue. The Administrator followed up on 03/28/25 with the DON and AMD #41 to ensure door alarms were operational including temporary door alarm on the third-floor East stairwell. AMD #41 provided photos showing the chewed wires that prevented the door alarm from sounding. A call light system report was pulled to verify Resident #45 did not utilize a call light. The Administrator directed the DON to conduct in-services on elopement and fall policies. On 03/31/25, the door on the third-floor east stairwell had been fixed and was functionally operating. Review of an invoice dated 03/31/25, revealed the continued troubleshooting of Legacy East delayed egress door. The service provider installed a local controller reset circuit and attempted to isolate the open circuit to the magnetic lock. A temporary door contractor with an alarm was installed at non-functional doors pending further troubleshooting and repairs. Reset the surface raceway, surface junction box, a cover plate, and momentary normally open push button reset switch. Interview on 04/14/25 at 11:48 A.M. with AMD #41 revealed the wires were chewed through by rodents. AMD #41 revealed the red and black wires were chewed through which was why the door alarm did not sound. The gray wires were chewed through, which was the main power source for the door alarm and caused it to malfunction. AMD #41 revealed he was called to the facility on [DATE] at approximately 7:00 P. M. related to Resident #45 falling down the stairs due to the door alarm not functioning. AMD #41 stated he placed a temporary door alarm on the door until the contractor could come out to the facility. AMD #41 noted the secondary alarm that triggered at the nurse's station on the night of the elopement, was a very faint audible alarm and only could be heard if someone was sitting at the nurse's station, and likely no one would even know what it was alarming for. (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 04/14/25 at 12:13 P.M. with CNA #10, revealed she came on shift on 03/27/25 at 6:00 P.M. CNA #10 was informed by the DON that Resident #45 was moved from second floor to the third floor related to wandering and exit-seeking behaviors. CNA #10 gave Resident #45 snacks and sat him in front of the nurse's station around 6:10 P.M. At approximately 6:15 P.M., CNA #10 and the DON went into another resident's room to provide care. CNA #10 reported Resident #45 was walking down the hall with his walker, and she told CNA #11 to keep an eye on him. CNA #10 explained around 7:00 P.M. LPN #20 informed the DON and herself that Resident #45 was missing. CNA #10 checked all the rooms on the third floor, and then she went to the [NAME] side stairwell to the outside of the building and then up to the second floor with no sign of Resident #45. CNA #10 came back up to the third floor and checked the East side stairwell where she found Resident #45 on the landing of the second and third floor stairs at approximately 7:20 P.M. CNA #10 stated he was on his left side, and she asked if he was okay and told the resident not to move. The DON was next on scene and EMS was called. Interview on 04/15/25 at 12:47 P.M. with AMD #41, revealed the door alarms including the Wanderguard system were last checked on 02/13/25 and 02/14/25. AMD #41 explained the wires had been chewed through by rodents to the sound system and the main power box. Interview on 04/15/25 at 1:48 P.M. with the DON, revealed Resident #45 was admitted to the facility on [DATE] for a seven-day hospice respite. The DON stated the resident was initially admitted to the unsecured second floor. Shortly after admission, the DON was informed Resident #45 was down in the lobby. The DON stated she moved Resident #45 to the third floor (MCU) and placed a Wanderguard on his right ankle after testing the functionality of the Wanderguard. The DON explained Resident #45 was displaying exit-seeking behaviors and stated he wanted to go home. The DON stated she redirected Resident #45 several times and informed the staff to keep a close watch on him. Between 6:00 P.M. and 6:10 P.M., Resident #45 was last seen by the nurse's station eating a snack. The DON reported her, and CNA #10 went into a resident's room to complete a wound vacuum (vac) dressing change. Approximately 40 minutes later, LPN #20 informed them that Resident #45 was missing. The DON stated she instructed all staff to start looking for Resident #45 and have one staff remain on the third floor. The DON reported she finished the dressing change before going to look for Resident #45, which took about 15 minutes. The DON heard voices and talking coming from the East side stairwell, so she opened the door and saw CNA #10 and Resident #45 on the landing between the second and third floors. The DON completed a non-invasive assessment with a blood pressure (BP) check because she did not want to move Resident #45. The DON called EMS at 7:25 P.M. EMS arrived and transported Resident #45 to the hospital. There was no additional witness statements collected from CNA #10, CNA#11, LPN #20 or the DON, who were directly involved in the incident concerning Resident #45. Review of an undated facility form titled Security Personnel to Complete Only and authored by AMD #41, revealed security was notified of the event and asked to pull the footage of the incident. The footage was not in good condition once obtained. AMD #41 indicated he came into the facility to secure the door to the stairwell where the incident took place. AMD #41 indicated he placed a temporary alarm to the door and the cause of the malfunctioning door was faulty wiring and steps have been taken to resolve this issue. (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 the facility policy titled, Elopement Response Procedure Policy, reviewed on 08/19/24, revealed Senior Lifestyle was committed to the safety and well-being of the residents. Communities will follow a procedure if/when a resident goes missing. A plan would be implemented for conducting a community search. Once the community has identified a missing resident, inform the front desk. Identify a search coordinator who would be tasked with coordinating the search, gathering, and disseminating information. The front desk will notify the Administrator and manager on duty. If an alarm was activated, silence the alarm after the Administrator had been notified. Two people would be assigned to conduct an immediate search of the community perimeter and one team member to search the missing resident's room. Once the resident is found, conduct a thorough examination. Contact the family/responsible party and emergency services if needed. Document the incident in resident progress notes and update the service plan to reflect the incident and risk of further elopement. This deficiency represents non-compliance investigated under Complaint Number OH00164468.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, and policy review, the facility failed to ensure infection control measures were followed when providing catheter care. This affected one (#20) of three residents reviewed for urinary tract infections. The facility census was 44. Findings include: Review of the medical record for Resident #20 revealed an admission date of 11/15/24. Diagnoses included dementia, benign prostatic hyperplasia with lower urinary tract symptoms, and obstructive and reflux uropathy. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12. This resident was assessed to require setup with eating, dependent with toileting, bathing, and dressing, and substantial assistance with transfers. Review of Section H for Bowel and Bladder of the Significant Change MDS assessment dated [DATE] revealed Resident #20 had an indwelling catheter and was frequently incontinent of bowel. Observation on 04/15/25 at 1:15 P.M. revealed catheter care and peri care was completed to Resident #20 by Certified Nursing Assistant (CNA) #12. While providing peri care, CNA #12 used wash cloths that she had cleaned Resident #20's frontal peri area with to clean his backside where he had had a bowel movement. CNA #12 did not change her gloves during care and touched items with soiled gloves including resident's sheets, bed control, resident's head, and pillow. Interview on 04/15/25 at 1:30 P.M. with CNA #12 verified she used the same wash cloths to clean Resident #20's front and back side. CNA #12 also verified she did not change her gloves until after care was provided and touched items (bed control, sheets, resident's head, and pillow) with soiled gloves. Review of the facility policy titled, Hand Hygiene vs Alcohol-based Hand Rub, dated 10/23/24 revealed staff should practice hand hygiene at key points in time to disrupt the transmission of microorganisms to residents including before resident contact, after contact with blood, body fluids, or contaminated surfaces (even if gloves were worn); before invasive procedures; and after removing gloves (wearing gloves did not replace hand hygiene). This deficiency is based on incidental findings discovered during the course of this complaint investigation.