STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365950	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Rehabilitation and Care Center	1605 Northwest Professional Plaza Columbus, OH 43220

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 Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the police reports, review of the facility Self-Reported Incidents (SRI), review of the website www.accuweather.com, review of the incident/accident log, review of the hospital discharge record, review of the incident report, review of the staff witness statements, and policy review, the facility failed to provide adequate interventions and/or supervision to prevent a cognitively impaired resident (Resident #10), who was assessed at risk for elopement, from leaving the facility without staff knowledge. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injury, and/or death on [DATE] when Resident #10 eloped from the facility and the resident was found by the police 0.5 miles from the facility. Additionally, Resident #10 eloped from the facility a second time on [DATE] and was missing for over 17 hours and was eventually found by the police sitting in the middle of an intersection of a residential street with a speed limit of 25 miles per hour and a low overnight temperature of 46 degrees Fahrenheit (F). This affected one (Resident #10) of three (#10, #74, #85) residents reviewed of a total of six (#10, #74, #85, #88, #98, and #99) residents identified by the facility at risk for elopement. The facility census was 106. On [DATE] at 1:04 P.M., the Administrator, Regional Director of Operations (RDO) #7777, Regional Registered Nurse (RRN) #1021, and Director of Nursing (DON) #525 were notified Immediate Jeopardy began on [DATE] at 6:50 A.M. when facility staff were notified Resident #10, who was assessed at risk for wandering and elopement and had documented intermittent confusion and impaired decision-making abilities. On [DATE] at 6:50 A.M. the police were dispatched for a confused elderly man, and Resident #10 was found 0.5 miles aware from the facility. The facility was not aware Resident #10 had eloped from the facility until they were contacted by the police. Additionally, the Immediate Jeopardy continued when Resident #10 eloped from the facility a second time on [DATE] at approximately 5:59 P.M., when staff failed to complete the ordered 15-minute checks and were unaware he was missing until 8:15 P. M. Resident #10 was found on [DATE] at 11:35 A.M., when the police were dispatched for an elderly man with dementia using a walker approximately 2.6 miles from the facility. He was found 17 hours later, sitting in the intersection of two roads that had speed limits of 25 miles per hour. Although the Immediate Jeopardy was removed on [DATE], the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until it was verified as corrected on [DATE] when the facility implemented the following corrective actions: -On [DATE] at approximately 7:45 P.M., Resident #10 was not in his room, and it was determined that he was last seen between 5:30 P.M. and 6:00 P.M. on [DATE]. The facility immediately initiated a search for Resident #10. -On [DATE] at approximately 8:00 P.M., the facility initiated a head count, and all residents were accounted for except for Resident #10. -On [DATE] at approximately 8:30 P.M., the facility administrator notified the Upper Arlington Police of Resident #10's absence. -On [DATE], the Upper Arlington Police requested assistance from the City of [NAME] Police Department who had access to a [NAME] with Thermal capabilities. -On [DATE], the Ohio Bureau of Criminal Investigations was contacted and at approximately 9:52 P.M., a silver alert was completed and sent out statewide. -On [DATE] around 10:30 P.M., the Hocking County Sheriff's Office was notified and assisted with the search for Resident #10. -On [DATE] at approximately 9:30 A.M., the facility Administrator, RDO #7777, RRN #1021, Regional Clinical Manager (RCM) #4728, Unit Manager #333 and DON #525 conducted an AD HOC Quality Assurance and Performance Improvement (QAPI) meeting. -On [DATE], Resident #10 was found at approximately 11:35 A.M. approximately 2.5 miles from the facility. The Upper Arlington Police along with the emergency medical services (EMS) responded and transported Resident #10 to Riverside Methodist Hospital for an evaluation. -On [DATE], RCM #4728 and RDO #7777 reviewed and updated the facility elopement policy. The facility updated the policy to reflect clearer definitions on elopement, more concise instructions to staff on reporting elopement, investigation procedures, and notification to appropriate agencies and medical staff. -On [DATE] at approximately 2:00 P.M., Resident #10's care plan was updated by the facility DON #525 to reflect resident now resides on the secured unit. -On [DATE] at approximately 2:00 P.M., the facility staff completed a whole house head count as part of the facility's daily audits of residents. All residents were accounted for. -On [DATE] at 2:30 P.M., Resident #10 returned to the facility and was immediately placed on the facility secured unit. -On [DATE] at approximately 3:11 P.M., Resident #10 was assessed by the facility nurse with no significant injuries. The assessment revealed two open areas on the right foot assessed as abrasions. -On [DATE], a whole house audit of all residents was completed to