

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365980	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/30/2024
NAME OF PROVIDER OR SUPPLIER  Forest Hills Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2841 East Dublin-Granville Road Columbus, OH 43231	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48568</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, observations, staff and resident interviews, review the National Weather Forecast, and review of facility policies, the facility failed to prevent Resident #25 from eloping. This affected one (Resident #25) of three reviewed for elopement. The facility census was 74.</p> <p>Findings include:</p> <p>Record review revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including encephalopathy, alzheimer's disease, type II diabetes mellitus, and anxiety disorder.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #25 revealed severe cognitive impairment. Resident #25 required supervision for Activities of Daily Living (ADLs) and did not require any mobility devices.</p> <p>Review of the Admission Assessment with Baseline Care Plan dated 04/26/24 revealed Resident #25 had impaired cognition and impaired cognition or decision making skills with an intervention to reorient and redirect as needed. The assessment also indicated Resident #25 was alert, oriented, and had clear verbal communication.</p> <p>Review of the care plan dated 04/27/24 revealed Resident #25 was at high risk for elopement. Resident #25 was alert and oriented to self but required reorientation to time and place. Resident #25 had impaired cognitive process for daily decision making and was at risk for further decline in cognitive status.</p> <p>Review of the nursing progress note by previous Director of Nursing (DON) #400 dated 04/27/24 at 07:09 A. M. revealed Resident #25 was up throughout the night socializing with others. Resident #25 kept a personal belonging bag with him reporting he wanted to leave. Resident #25 was noted to have a wallet but refused to allow nurse to check. Resident #25 was pleasant and cooperative.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing progress note by Licensed Practical Nurse (LPN) #110 dated 4/27/24 at 1:00 P.M. revealed LPN #110 came out of the med room and noted that the doors linking to second street were open. LPN #110 immediately ran down to the floor, alerted the State tested Nurse Aides (STNAs), did a quick census of residents in the unit, and noted that Resident #25 could not be found on the unit. LPN #110 went down to the front office to ask Receptionist #254 if Resident #25 was seen. Receptionist #254 noted that Resident #25 was out of the facility. LPN #110 alerted the other nurse on first street, called the DON and 911. LPN #110 and STNAs set out to search for Resident #225. Resident #25 was found by police and brought back to the facility. Head to toe assessment completed with no new skin impairment or pain noted. Resident #25 moved to room a different room and placed on one-on-one supervision. Guardian and Certified Nurse Practitioner (CNP) notified.</p> <p>Review of the Wander and Elopement Assessment on 04/27/24 at 01:03 P.M. revealed Resident #25 was at risk of elopement with interventions including moving to a secured unit, addition of personal items in room, photo in elopement risk book, and staff aware of resident's elopement risk.</p> <p>Review of the Wander and Elopement Assessment on 04/27/24 at 01:18 A.M. revealed Resident #25 was not at risk for elopement at this time.</p> <p>Review of the Elopement Incident Report dated 04/27/24 revealed the nursing description as LPN #110 came out of the med room and noted that the doors linking to second street were open. LPN #110 immediately ran down to the floor, alerted the STNAs, did a quick census of residents in the unit, and noted that Resident #25 could not be found on the unit. LPN #110 went down to the front office to ask Receptionist #254 if Resident #25 was seen. Receptionist #254 noted that Resident #25 was out of the facility. LPN #110 alerted the other nurse on first street, called the DON and 911. LPN #110 and STNAs set out to search for Resident #225. Resident #25 was found by police and brought back to the facility. Head to toe assessment completed with no new skin impairment or pain noted. Resident #25 was moved to a different room and placed on one-on-one supervision. Guardian and CNP notified. The resident description reported the resident was alert to self only. The report detailed the immediate action taken which was search for resident in the facility, inform DON, call 911, form search party, complete a head to toe assessment, place resident on one on one supervision, and notify guardian and CNP. No injuries were observed at time of incident. The resident was alert, ambulatory without assistance, oriented to person. No injuries were observed post incident. The predisposing environmental, physiological, and situation factors sections were not filled out in the report. The report states the resident is new to the facility, keeps going to exit doors and insisting on going home. No witnesses were found.</p> <p>Review of the police report revealed Police Officer #500 reported on 04/27/24 at 1:14 P.M. and entered on 4/27/24 at 2:02 P.M. The report specifies a missing person from the facility occurred on 4/27/24 at 1:00 P.M. The narrative stated On the listed date, time and location, Victim was reported to have walked away from his long-term facility after following a staff member out the door. Victim was located a short time later, where staff arrived and transported Victim back to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Administrator's timeline revealed on 04/27/24 at 1:03 P.M., Receptionist #254 let Resident #25 out thinking he was part of a pack of visitors. On 04/27/24 at 1:03 P.M., LPN #110 noticed Resident #25 was gone and alerted staff. The DON was notified. On 04/27/24 at 1:04 P.M., the DON notified the Administrator of the elopement. On 04/27/24 at 1:24 P.M., police arrived at the facility. On 04/27/24 at 1:33 P.M., police notified the facility Resident #25's location. On 04/27/24 at 1:37 P.M., the DON and Administrator arrive arrived at the local mexican restaurant to meet Resident #25. On 04/27/24 at 1:50 P.M., Resident #25 returned to the facility, assessed and found to have no concerns.</p> <p>Review of the temperature data from the National Centers for Environmental Information, located at <a href="https://www.ncei.noaa.gov/">https://www.ncei.noaa.gov/</a>, for 04/27/24 revealed the ambient air temperatures were a low of 64 degrees Fahrenheit (F) and a high temperature of 80 F.</p> <p>Review of the Forest Hills Center Accident Log for the last six months revealed that Resident #25 was listed as the only elopement incident.</p> <p>Review of the witness statement of the 04/27/24 elopement for LPN #110 revealed she came out of the med room and saw that the door linking to second street was open. She ran to the floor and searched for Resident #25 and alerted the STNAs that he was not on the floor. She ran immediately to the reception area, gave a description, and Receptionist #254 said the front door had been opened for him to leave the facility. The statement also revealed Resident #25 insisted he needed to go home to care for his parents.</p> <p>Review of the witness statement of the 04/27/24 elopement for Receptionist #254 revealed she observed a man at the front door who she thought was a family member and she let him out. She was usually made aware of a new admission but was not given this information.</p> <p>Review of the witness statement of the 04/27/24 elopement for STNA #256 revealed she was working first street and after lunch she saw a second street nurse running and shouting out a resident eloped. The first street and second street aide immediately ran out to look for the resident. She stood on the floor to check other residents.</p> <p>Review of the witness statement of the 04/27/24 elopement for STNA #284 revealed a third street nurse was called to come to second street because they could not find one resident.</p> <p>Review of the witness statement of the 04/27/24 elopement for STNA #335 revealed she was not assigned to the resident and did not bear witness to the incident. She was notified to call 911 and begin searching rooms.</p> <p>Review of the witness statement of the 04/27/24 elopement for LPN #102 revealed she was the nurse on third street and had no knowledge of the incident. She only found out when the DON called her to tell her to call 911.</p> <p>Review of the witness statement of the 04/27/24 elopement for STNA #250 revealed they were working with LPN #110. LPN #110 went in the Med room and when she came back, she asked STNA #250 for Resident #25 and she was looking for him in the building and did not find him, so STNA #250 got in their car to check in the area.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the witness statement of the 04/27/24 elopement for LPN #112 revealed another nurse alerted her that a resident was missing. She immediately went out and started surveying the environment. She asked how long he was gone and got into the car with other staff and started driving and looking around.</p> <p>Interview on 05/28/24 at 6:10 P.M. with Resident #25 revealed he said he has left the facility.</p> <p>Interview on 05/28/24 at 9:16 A.M. with the Administrator revealed a family propped a door open when they were leaving and Resident #25 walked out with the family. He was found at a mexican restaurant drinking water with two women.</p> <p>Interview on 05/28/24 at 10:30 A.M. with the Adminstrator revealed Resident #25 arrived on 04/26/24 and eloped on 04/27/24. The Administrator said immediately when staff noticed Resident #25 was missing they called the Administrator and DON. Staff called police as well. The Administrator said she had a conversation with the family member who left the door open. The family member confirmed she let Resident #25 out and wasn't sure if he was a visitor.</p> <p>Interview on 05/29/24 at 9:35 A.M. with STNA #267 revealed Resident #25 eloped last month and she searched for him outside and inside the building.</p> <p>Interview on 05/29/24 at 9:39 A.M. AM with STNA #250 revealed Resident #25 eloped from first street. STNA #250 said she was working first street and he was one of her residents. STNA #250 said he had breakfast that morning. STNA #250 said he was agitated and wanted to leave. STNA #250 said he was new and came the night before. STNA #250 said a nurse talked to him. When the nurse came from the med room after breakfast, she asked STNA #250 where was Resident #25. STNA #250 replied Resident #25 was just there. STNA #250 said he was all dressed up and had a green bag in his hand. STNA #250 said he walked out of two locked doors to get out. She said someone would have had to let him out the front door since it has a code. STNA #250 said the Admin and DON were called. STNA #250 said she got in her call and drove all around Cleveland Avenue to look for Resident #25. STNA #250 said she was gone for 20 minutes and then got a phone call that said to come back and they found him. STNA #250 said she couldn't remember when she noticed he was gone. She said it was after lunch and he walks around a lot. It was less than five minutes from when she saw him and he was gone.</p> <p>Interview on 05/30/24 11:14 A.M. with LPN #102 revealed Resident #25 eloped last month. She said she was looking around him. She said all staff looked everywhere and out in the complex too. She said she received instruction to call 911.</p> <p>Interview on 05/30/24 at 09:02 A.M. with Guardian #600 revealed she was notified when there are any changes in care to Resident #25. Guardian #600 said she was notified when the elopement happened to Resident #25 and she had no concerns with his care at the facility at this point.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/30/24 at 9:29 A.M. with Receptionist #254 revealed Resident #25 got out on 04/27/24 when a family let him out of a set of doors. Receptionist #254 reported she saw the resident walk out of the facility, but he did not go with the family to their car. She saw him go up the driveway and then turn and realized something wasn't right. She saw him separate from the family and then she realized a new resident was coming, but she didn't know who he was yet and didn't see a picture. Receptionist #254 notified the DON and Administrator of this. When Receptionist #254 was asked if she checked to see if a resident was in the group of people leaving, she said, No, because they all blended together. When asked how she would know a person leaving would be a resident, Receptinist #254 reported she would see a picture of the resident beforehand. Receptionist #254 reported she later found out Resident #25 came int he night before and the facility did not have a picture of him in the elopement binder. Receptionist #254 reported she knows most of the residents by face.</p> <p>Interview on 05/30/24 at 12:59 P.M. with LPN #110 revealed Resident #25 was assigned to her hall the day he eloped. LPN #110 said she met him that morning of 04/27/24. Resident #25 told her he wasn't supposed to be there and the doctor was supposed to discharge him. LPN #110 said she calmed him down. She then went into med room after lunch. LPN #110 saw double doors linked to the long hallway were open. One side of the door was open wide. LPN #110 went to her unit to see who is missing. She counted and noticed Resident #25 was missing. The seat where he sat and ate lunch was empty. LPN #110 came to the front desk and asked Receptionist #254 if she saw a man with a green plastic bag. Receptionist #254 said he went out. Resident #29's family was outside. LPN #110 talked to Resident #29's family. Resident #29's family didn't know it was a resident who left with them. Resident #29's family said their husband is in a wheelchair so they propped the door so he could wheel out and didn't put the door back. They thought Resident #25 who was behind them was visiting. LPN #110 called the DON and ran back to the unit. The DON told her to go out as Resident #25 could not have gone too far. LPN #110 told LPN #112 there was an elopement and asked her to join LPN #110 in the search. The third street nurse called 911 and gave a description of the residents. LPN #110 and an aide went in one direction and LPN #112 and another aide went in the other direction. The DON was at the facility at this time and gave the police a description of Resident #25. The police said more people searching doesn't cost anything so more people went out and searched more areas. The facility got called later and were told the resident was found. The total length of time was 40 to 50 minutes total from when LPN #110 noticed he was missing.</p> <p>Review of the policy titled, Elopements and Wandering Residents, dated 10/01/22 revealed adequate supervision will be provided to help prevent accidents or elopements.</p> <p>Review of the policy titled, Elopement Prevention, dated 05/01/17 revealed if an employee observes a resident leaving the premises, he/she should attempt to prevent the departure in a courteous manner.</p> <p>The deficient practice was corrected on 04/29/24 when the facility implemented the following corrective actions:</p> <p>Immediately following the incident on 04/27/24 at 1:47 P.M., Residents #25 was assessed for injuries and pain and had no findings.</p> <p>On 04/27/24, Resident was placed on one-to-one staff supervision until 05/01/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/27/24, an elopement incident report with notifications to the physician and emergency contact was completed.</p> <p>On 04/27/24, Resident #25's care plan was updated.</p> <p>On 04/27/24 at 2:00 P.M., Receptionist #254 was re-educated on elopement policy and procedure, abuse policy and procedure, and not allowing individuals to enter/exit the facility without verifying their identity.</p> <p>On 04/27/24 at 2:00 P.M., a headcount of all residents in the facility was taken.</p> <p>On 04/27/24, witness statements were taken of all staff members.</p> <p>On 04/27/24, all doors and windows were checked and were functioning properly.</p> <p>On 04/27/24, all resident pictures were updated.</p> <p>On 04/27/24, wandering and elopement assessments for all residents were completed.</p> <p>On 04/27/24, the Administrator developed a timeline of the elopement incident.</p> <p>On 04/27/24, elopement drills were planned daily for one week and two times a week for the next four weeks, starting on 04/29/24.</p> <p>On 04/27/24, the elopement book was updated.</p> <p>On 04/27/24 at 4:00 P.M., secure door education was sent out to all staff.</p> <p>On 04/27/24 at 4:07 P.M., secure door education was sent out to all resident families.</p> <p>On 04/27/24 at 4:15 P.M., elopement and abuse education was sent out to all staff.</p> <p>On 04/28/24 at 3:12 P.M., family member of Resident #29 was given one on one in person education on the facility elopement/abuse/ensuring doors are secure policies and procedures.</p> <p>On 04/29/24, a visitor badge policy was developed and implemented.</p> <p>On 04/29/24 at 12:25 P.M., a message was sent to all families about the new facility check in/out policy and visitor badge policy.</p> <p>On 04/29/24, all staff were educated on the new visitor badge policy.</p> <p>On 04/29/24, the visitor badges are being audited daily.</p> <p>This deficiency substantiates Complaint Number OH00153535.</p>		