

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Woodside Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 841 W Marion Rd Mount Gilead, OH 43338	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48568</p> <p>Based on record review, interview, review of facility investigation, and policy review, the facility failed to ensure adequate supervision of residents when Resident #5 eloped from the facility. This deficient practice affected one (Resident #5) out of three residents reviewed for elopement. The facility census was 64.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including dementia, spondylosis without myelopathy or radiculopathy, depression, and post-traumatic stress disorder.</p> <p>Review of physician orders revealed Resident #5 had an order dated 01/27/24 for a wanderguard in place to his left ankle and placement and function was to be checked each shift.</p> <p>Review of Resident #5's care plan dated 02/07/24 revealed the resident experienced wandering that placed the resident at risk of getting into potentially dangerous places with an intervention that included check left ankle wander guard placement and function per facility protocol. Another care plan dated 02/28/24 revealed the resident could no longer safely care of himself at home and he required 24 hour care/supervision with interventions that included staff were to provide 24 hour care and supervision.</p> <p>Review of the significant change in status assessment Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #5 had severely impaired cognition. Resident #5 required supervision or touching assistance to walk 10 feet, walk 50 feet with two turns, and walk 150 feet.</p> <p>Review of Resident #5's progress note on 10/22/24 at 6:50 P.M. revealed Registered Nurse (RN) #95 noted a window was opened in an office and a trash can had fallen over. The happy feet protocol (a facility term for when there was an elopement) began immediately.</p> <p>Review of Resident #5's progress note on 10/22/24 at 7:02 P.M. revealed Resident #5 was returned to the facility via facility transport vehicle. Resident #5's wife, doctor, and hospice were made aware.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Woodside Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 841 W Marion Rd Mount Gilead, OH 43338	
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>Review of Resident #5 progress note on 10/22/24 at 11:10 P.M. revealed an elopement assessment was completed. Resident #5 was noted as an elopement risk and the wanderguard was to stay on his ankle.</p> <p>Review of Resident #5 progress notes from 10/22/24 through 10/24/24 revealed Resident #5 was on 1:1 supervision. The resident was then placed on 15 minute checks from 10/24/24 through 10/27/24, 30 minute checks from 10/27/24 through 10/29/24, and one hour checks starting on 10/30/24 to current.</p> <p>Review of the elopement incident report for Resident #5 revealed Resident #5 was last seen by staff at approximately 6:30 P.M. to 6:35 P.M. on 10/22/24 in the hallway outside of the north nurse's station. Resident #5 was wearing a white T-shirt, long sleeve flannel, flannel pants, yellow socks, and black slipper shoes. RN #95 entered the Director of Nursing (DON) office at approximately 6:45 P.M. and observed the trash can, that was sitting under the window, was flipped over and papers from the trash can were scattered. The window and screen were raised and the tabs to lift the window had been pushed in to allow the window to open. Outside of the window, papers were scattered on the grass. RN #95 immediately notified the staff and initiated a head count with Resident #5 not located in the building. RN #95 and RN #150 went outside to search [NAME] of the facility and Certified Nursing Assistant (CNA) #25 searched East. A gentleman on Orchard Street (one street over) directed CNA #25 to Resident #5 sitting in a driveway. The weather was 65 degrees Fahrenheit with no precipitation. The report noted that Resident #5's wanderguard did not alert due to the resident exiting the facility by window. The resident was assessed by ambulance personnel. RN #95 and RN #150 also assessed Resident #5 who showed no areas of skin impairment. Resident #5 stated he was in the barracks and looking for men. The resident's wife, physician, and hospice were notified. It was concluded that Resident #5 was outside of the facility for approximately five minutes.</p> <p>Review of the local County Emergency Medical Services report revealed on 10/22/24 at 7:00 P.M. they were dispatched by 911 to the driveway where Resident #5 was found, and they arrived at the scene on 10/22/24 at 7:05 P.M. The narrative report revealed a caller saw Resident #5 walking down the road and stopped him. It stated that Resident #5 didn't know where he was and was mumbling. The medic arrived on scene and observed Resident #5 sitting in a rocking chair at the end of the driveway. As the medic was interviewing the caller, a nurse from the facility was running down the road yelling Resident #5's name, followed by the DON. They said Resident #5 had been missing for five minutes. The DON stated she left her office window open and Resident #5 climbed out of it. The DON also refused the residents need for vital signs and she stated that she did not want Resident #5 taken to the hospital because he had severe dementia. Resident #5 stated he was just trying to get out into the great wide open. The medic reported Resident #5 did not appear to be in immediate distress, no injuries were noted, and the resident denied pain. Resident #5 was alert and oriented to person and event only, which was his normal. A stroke exam was performed with negative findings and no further assessment was completed.</p> <p>Interview on 11/18/24 at 4:19 P.M. with RN #95 revealed Resident #5 eloped from the facility on 10/22/24 when he went out of the DON's office window. RN #95 stated she went to put her laptop away and felt a breeze and upon observation, noticed the window was up, the screen was out, and trash was on the ground. She revealed she went to the hallway and asked where Resident #5 was, and everyone started looking for him. RN #95 stated she went outside with the DON to search the grounds and CNA #25 came out to help search and found Resident #5 on the next road over. RN #95 then went back into the building and received a call from the DON to bring a vehicle over to pick up Resident #5. She revealed the EMTs completed an assessment of Resident #5 with no negative findings and she further stated that Resident #5 had a wanderguard on, but they did not work on the windows.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Woodside Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 841 W Marion Rd Mount Gilead, OH 43338	
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>Interview on 11/18/24 at 5:47 P.M. with CNA #190 revealed Resident #5 eloped from the facility on 10/22/24 out of the DON's office window, about an hour after she left for the day. CNA #190 further revealed that Resident #5 had a wanderguard in place.</p> <p>Interview on 11/18/24 at 5:59 P.M. with CNA #255 revealed Resident #5 eloped from the facility through a window on 10/22/24. CNA #255 stated she was working, but she was in a different area when the elopement occurred. CNA #255 revealed that Resident #5 had a wanderguard in place.</p> <p>Interview on 11/18/24 at 6:11 P.M. with LPN #45 revealed Resident #5 eloped from the facility through a window on 10/22/24. LPN #45 revealed she was not at the facility when it occurred, but was called in to start one-on-one supervision with Resident #5. LPN #45 revealed that Resident #5 had a wanderguard in place.</p> <p>Interview on 11/18/2024 at 6:18 P.M. with the DON revealed she received a call from RN #95, on 10/22/24, that the RN noticed the DON's window was open and Resident #5 was up walking during the day. The DON stated they completed a head count and noticed Resident #5 was missing. The DON revealed she went outside with CNA #25 and walked the perimeter, they heard a squad siren and saw the ambulance go down the road to the right of the building, then CNA #25 called her and said he was with Resident #5. Resident #5 was sitting at the end of a driveway in a rocking chair. An individual told the DON that she was driving and saw Resident #5 stumble into a trash can, and she called 911. The DON revealed that the squad asked her if the wanderguard worked on the windows and DON replied that it did not and that no one had tried to climb out of a window before.</p> <p>Interview on 11/18/24 at 6:42 P.M. with CNA #25 revealed Resident #5 eloped from the facility on 10/22/24 and his supervisor told him to check the perimeter outside the facility when it occurred. CNA #25 revealed he heard sirens and saw lights so he went that direction and observed Resident #5 sitting in a rocking chair and talking to the people that had found him. CNA #25 revealed that Resident #5 had a wanderguard in place.</p> <p>Review of the Happy Feet binder revealed Resident #5 and Resident #215 were listed as elopement risks. Each resident had a picture and an information sheet that included a description of the resident, physical characteristics, behavior patterns, how to approach, responsible party, former residence, and former place of employment.</p> <p>Review of the policy titled Elopement Prevention and Management Program dated January 2024 revealed the facility was to ensure that residents who exhibited wandering behaviors and/or were at risk for elopement, received adequate supervision to prevent accidents and the residents received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159217.</p>		