STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366036	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendora Health Care Center	1552 North Honeytown Road Wooster, OH 44691

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** 34298 Based on observation, medical record review, review of a facility investigation, facility fall policy review, facility assessment review and interviews, the facility failed to provide adequate supervision to Resident #1, who had a diagnosis of dementia with intermittent confusion and resided on the facility secured memory care unit on 06/08/24 to prevent a fall into a shallow pond outside the facility. This resulted in Immediate Jeopardy and actual harm on 06/08/24 when Resident #1 was unattended/unsupervised outside and fell into a pond. Upon assessment, the resident's hair and clothing were wet and she was observed to be coughing. The resident was subsequently transferred to the hospital for evaluation and treatment of aspiration (of pond water). Resident #1 returned from the hospital with an order for an antibiotic. Following the incident, Resident #1 also had emesis that looked like pond water per the nurse. The lack of supervision, at the time of the incident placed Resident #1 at risk for additional injury/death from possible drowning. In addition, a concern that did not rise to Immediate Jeopardy occurred when the facility failed to ensure comprehensive, accurate and individualized elopement assessments and care plans were in place for Resident #2, #3, #4, #5, and #7 to prevent actual and/or potential elopement. This affected six residents (#1, #2, #3, #4, #5 and #7) of six residents reviewed for accidents and/or elopement. The facility census was 33. On 07/01/24 at 4:25 P.M., the Licensed Nursing Home Administrator (LNHA) and Corporate Minimum Data Set (MDS) Nurse #151 were notified Immediate Jeopardy began on 06/08/24 at 5:25 P.M. when Resident #1 was left unattended outside the facility and fell into a pond located near the patio off the facility secured memory care unit. Following the incident, on 06/08/24 at 5:50 P.M. Resident #1 was transported to the hospital for evaluation and treatment of possible aspiration of pond water. Resident #1 returned from the hospital on 06/08/24 at 11:31 P.M. with a new order for an antibiotic treatment due to aspiration pneumonia. The Immediate Jeopardy was removed on 06/12/24 when the facility implemented the following corrective actions: On 06/08/24 at 5:40 P.M. Licensed Practical Nurse (LPN) #101 completed an assessment on Resident #1. At 5:50 P.M. the resident was transported to the emergency room . (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	On 06/08/24 the Administrator/Director of Nursing (DON) provided 1:1 education to staff including Registered Nurse (RN) #103, LPN #102, and LPN #101 who were directly involved in the Resident #1's fall/incident. An emphasis was placed on ensuring residents were not left alone outside and had on proper footwear. On 06/08/24 the DON and/or designee educated all staff (three RNs, nine LPNs, 14 State tested Nursing Assistants) on facility Fall Prevention Program guidelines, following care plan/Kardex interventions, as well as all facility fall related policies including proper footwear and not leaving residents unattended outside. All nursing staff were educated except one LPN, LPN #100 who was out on medical leave and would be educated prior to her return to work. On 06/08/24 an audit revealed no other residents were at risk for being left alone outside as this and the root cause analysis determined that the fall would not have occurred had Resident #1 not been left alone outside. Immediate education provided to staff. On 06/08/24 audits of risk management were conducted and would be reviewed by the LNHA twice weekly for four weeks to ensure no other incidents occur related to residents being left alone outside unattended twice weekly times four weeks. On 06/10/24 Resident #1's care plan was reviewed and updated to reflect Resident #1 was not to wear flip flops while outside. On 06/10/24 the LNHA conducted a formal and written Root Cause Analysis (RCA) with members of the AD HOC Quality Assurance and Performance Improvement (QAPI) that included the Medical Director, DON, Maintenance, LNHA and social service designee. On 06/10/24 a QAPI Performance Improvement Plan (PIP) was initiated to report on the above monitoring and auditing procedures. All findings from the PIP would be presented at the monthly Quality Assessment and Assurance (QAA) meeting. Monitoring/auditing and reporting would continue for a minimum of three months On 06/12/24 Maintenance Director #150 filled in the pond with dirt. On 06/12/24 assessments were completed by LPN #102 and LPN #108 for all 30 facility residents to identify residents who are at risk for elopement. On 07/01/24 Regional MDS Nurse #151 verified elopement assessments and care plans were completed to ensure accurate and consistent information and assessments. On 07/01/24 Regional MDS Nurse #151 verified fall assessments and care plan audit for all 33 residents were completed to ensure accurate and consistent information. Although the Immediate Jeopardy was removed on 06/12/24, the deficiency remains at Severity Level 2 (potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing and monitoring corrective actions and addressing inaccurate resident assessments and care plans related to safety/elopement risk. Findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including idiopathic epilepsy, anxiety disorder, dementia, and bipolar disorder. Review of a plan of care dated 06/13/23 revealed Resident #1 required assistance with mobility related to weakness and impaired balance. Interventions included assistance as needed from staff, wheeled walker, and manual wheelchair for locomotion. An additional plan of care dated 06/23/23 revealed Resident #1 was at risk for falls related to muscle weakness with impaired mobility, decreased balance, and endurance. Interventions included staff to ensure Resident #1 was wearing appropriate footwear (correct client footwear i.e. non-skid socks/shoes) when ambulating or mobilizing in wheelchair, review information on past falls and attempt to determine cause of falls and educate resident/family/caregivers/ as to causes of falls. A physician order dated 07/05/23 revealed Resident #1 was to reside on the memory care unit due to diagnosis of dementia. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1's Brief Interview Mental Status (BIMS) score was 15 which indicated Resident #1 was cognitively intact. The MDS also revealed Resident #1 used a walker. Once Resident #1 was standing, Resident #1 required partial/moderate assistance with walking 10 feet. Resident #1 required supervision or touching assistance to walk 50 feet and make two turns. An occupational therapy note dated 06/07/24 revealed Resident #1 had been going out with nursing staff outside to water plants. Resident #1 appeared to be in good spirits with gardening activity. Collaborated with staff to ensure carryover with new activity over the weekend. Review of the census on 06/08/24 revealed there were a total of 30 facility with 11 of the residents (including Resident #1) residing on the secure unit. On 06/08/24 four of the 11 residents required one person assistance, two residents were frequently incontinent, and one resident was identified to be at risk for elopement. A progress note dated 06/08/24 at 5:25 P.M. revealed Resident #1 was outside watering plants. Resident #1 went to retrieve water from pond. Resident #1 was wearing flip flops and slid into the pond. Resident #1 was removed from the water and assessed by Registered Nurse (RN) #103. Resident #1 was assisted in the shower to wash pond gunk off and to further assess skin. Audible crackles were heard in all of Resident #1's lung fields. A call was placed to the on-call provider and an order was received to transfer Resident #1 to the emergency department (ED) for evaluation of possible aspiration of pond water. A progress note dated 06/08/24 at 5:50 P.M. revealed Resident #1 was transported to the emergency department (ED). Review of hospital records dated 06/08/24 revealed Resident #1 was seen due to a fall with aspiration into respiratory tract. Resident #1 was ordered antibiotics (to treat the aspiration). A progress note dated 06/08/24 at 11:11 P.M. revealed a RN from the hospital called and reported Resident #1 had a chest x-ray that revealed minimal left lower lobe infiltrate. Resident #1 was started on an antibiotic at the hospital and was ordered the antibiotic, Amoxicillin to be continued at the facility. A progress note dated 06/08/24 at 11:31 P.M. revealed Resident #1 returned from ED with new orders for Amoxicillin. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A written statement by RN #103 dated 06/08/24 revealed RN #103 was being oriented on the memory care unit by LPN #101. LPN #101 left the memory care unit to make a phone call. RN #103 was charting at the nurse's station. Resident #1 requested to water the vegetable plants in the courtyard that was directly to the left of the nurse's station. RN #103 entered a code to unlock the door and allowed Resident #1 to exit into the courtyard. LPN #101 had stated therapy wanted Resident #1 to water plants over the weekend as part of the therapy program. The statement revealed RN #103 had complete visualization of Resident #1 and refilled the kitchen sized water pitcher approximately three times. Resident #1 would come to the door each time the pitcher needed refilled, and RN #103 would put the code in and open the door. The statement indicated Resident #1 was alert and oriented to person, place, time, and situation. Resident #1 ambulated without any assistive devices and had a steady gait. While Resident #1 was watering plants, another resident (Resident #2), had been walking in the hallway past the nurse's station several times. Resident #2 walked down the hall towards the dining room and pushed open the exit door. RN #103's statement revealed she ran from the nurse's station to the alarming exit door and observed Resident #2 on the sidewalk rounding the corner towards the front of the facility. RN #103 used the walkie-talkie to call for assistance but did not hear a response from anyone. Resident #1 was back at the courtyard door holding up an empty water pitcher. RN #103 held up one finger and told Resident #1 to hang on for a minute. RN #103 ran to the door at the front of the unit to see if staff could be summoned to get Resident #2. When RN #103 opened the door from the memory care unit, LPN #102 was observed walking Resident #2 inside. Resident #2 was taken back onto the memory care unit. RN #103 immediately ran back to check on Resident #1. RN #103 opened the door to the courtyard but could not see Resident #1. Resident #1 called out, I'm over here. RN #103 thought Resident #1 had fallen into some weeds. RN #103 ran to Resident #1 and asked if she was okay and if Resident #1 had hit her head. Resident #1 was completely wet. Resident #1's hair was wet with muddy particles. RN #103 was unaware there was a pond in the courtyard area. The statement indicated Resident #1 stated she was okay and felt stupid and hoped no one was looking out the windows. Resident #1 denied hitting her head and denied any pain. Resident #1 stated she was bending over to fill the water pitcher and lost her balance and slipped. Resident #1 was wearing flip flop style sandals. RN #103 asked Resident #1 if she went all the way under the water. Resident #1 answered yes. Resident #1 was coughing and stated she felt she had swallowed some of the water. LPN #101 showed up in courtyard and assisted RN #103 with getting Resident #1 out of the pond. As RN #103 was assisting Resident #1 back to the building, Resident #1 slipped in the grass and fell to her knees. RN #103 told Resident #1 not to put shoes back on because they were wet and slippery. Resident #1 struggled to get from knees to standing with RN #103 assistance. Resident #1 had a small laceration to the right knee and stated her second toe hurt. Resident #1 requested a shower. Resident #1 had expiratory coarse crackles in posterior left base of lung and frequent loose sounding cough. LPN #101 made notification calls and Resident #1 was transferred to the ED for evaluation. A written statement by LPN #102 dated 06/08/24 revealed she was notified by RN #103 that Resident #2 was outside the facility. LPN #102 met RN #103 in the parking lot and assisted Resident #2 back into the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility investigation dated 06/08/24 revealed Resident #1 was heard yelling for help while RN #103 was assisting Resident #2. Resident #1 was found sitting in the fishpond in courtyard. Resident #1 stated she went over to the pond to rinse her hands and slipped and fell into the pond. Resident #1 was assisted out of the pond and no injuries were noted. Resident #1 denied any pain. Neurological checks were initiated. Auscultation of Resident #1's lungs revealed some crackles. Resident #1 was assisted into the shower and was resting in bed. The immediate intervention was to send Resident #1 to the ED for evaluation and treatment. The facility investigation noted Resident #1 was oriented to person, place, and situation. Predisposing physiological factors included impaired memory; and predisposing situation factors included Resident #1 was wearing improper footwear (flip flops). A progress note dated 06/09/24 at 12:52 A.M. revealed Resident #1 was sitting on the side of the bed and had a medium watery emesis that was tan/orange in color. A progress note dated 06/09/24 at 1:22 P.M. revealed Resident #1 continued an antibiotic for aspiration pneumonia. Some crackles were heard in Resident #1's lower lungs. A progress note dated 06/10/24 at 9:55 A.M. revealed an interdisciplinary team (IDT) meeting put a new intervention in place for Resident #1 to wear proper footwear while outside. A progress note dated 06/11/24 at 1:24 P.M. revealed IDT also implemented interventions to educate Resident #1 on safety awareness and for Resident #1 to have staff assistance while outside. A psychiatric note dated 06/12/24 revealed Resident #1 reported feeling bored and her mood was lousy. Resident #1 reported chronic depression and anxiety due to being in the facility. Resident #1 had ongoing confusion and agitation at times. Resident #1 was being treated for aspiration pneumonia. An occupational therapy note dated 06/12/24 revealed Resident #1 ambulated without a device in room with supervision. An occupational therapy note dated 06/25/24 revealed Resident #1 was encouraged to participate in activities to promote safety and independence. Resident #1 reported not being able to water the garden due to not being allowed outside. Interview on 07/01/24 at 8:41 A.M. with STNA #126 revealed there was usually only a nurse on the memory care unit. STNA #126 stated there were several residents on the memory care unit who were exit seeking. (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 07/01/24 at 8:50 A.M. with RN #103 revealed she had been orienting with LPN #101 on 06/08/24, the day Resident #1 fell in the pond. RN #103 stated LPN #101 had left the memory care unit and Resident #1 asked to water the plants in the courtyard. Staff had been told to let Resident #1 water the plants on the weekends. RN #103 stated she filled the water pitcher several times for Resident #1. Resident #2 had been stating he needed to leave. Resident #2 went to the exit door in the dining room and pushed the door until it alarmed, and the door unlocked. RN #103 ran to the exit door and saw Resident #2 was going around the building towards the front. RN #103 used the walkie-talkie to alert other staff that assistance was needed, and Resident #2 had exited the building. RN #103 stated she ran towards the other end of the hall where the door to the facility was located to see if she could get a staff member to help her. RN #103 stated as she ran past the nurse's station, she saw Resident #1 standing at the door where the courtyard was. RN #103 stated she held up her index finger and asked Resident #1 to give her a minute. When RN #103 opened the door from the memory care unit to the front hallway, she observed LPN #102 bringing Resident #2 back into the facility. After Resident #2 was back on the memory care unit, RN #103 ran to check on Resident #1. When RN #103 went out to the courtyard, she did not see Resident #1. Resident #1 then called out over here. RN #103 stated she was not aware there was a pond in the courtyard until she found Resident #1. RN #103 revealed she found the resident, her head was wet, and Resident #1 was still in the pond. Resident #1 stated she went to get water from the pond to fill up the pitcher and fell into the pond. Resident #1 was vomiting up muddy water and was sent to the hospital for evaluation. RN #103 stated LPN #101 arrived and assisted with getting Resident #1 out of the pond. RN #103 stated the pond had been filled with dirt after Resident #1 fell . Observation on 07/01/24 at 8:58 A.M. revealed bare dirt in the courtyard where the pond used to be. Observation of the memory care unit revealed the nurse's station and exit to the courtyard were approximately halfway down the hall from the entrance to the memory care unit. The exit door where Resident #2 exited was at the opposite end of the hall from the entrance to the memory care unit. Interview on 07/01/24 at 9:03 A.M. with Resident #1 revealed she was not allowed to go out to the courtyard now. Resident #1 stated (on 06/08/24) she fell into the pond headfirst. Resident #1 stated she was wearing flip flops and it was slimy around the pond, and she lost her balance and fell . Resident #1 stated she was very embarrassed that she fell . An Interview on 07/01/24 at 10:50 A.M. with the family of Resident #1 revealed therapy requested Resident #1 be permitted to water the plants in the courtyard. The family member stated they were told an alarm had sounded and was reset and Resident #1 fell in the pond. The family member stated they were not told Resident #1 had been left alone when the fall occurred. Interview on 07/01/24 at 12:16 P.M. with the LNHA revealed the pond Resident #1 fell into was about a foot deep. The LNHA then indicated the pond may have gotten deeper in some parts. The LNHA stated there was a net across the top of the pond and there were lilies growing through the netting. The LNHA revealed RN #103, who was working on the unit at the time of the incident was a new nurse and 06/08/24 was her third day of being oriented. The LNHA verified RN #103 was the only staff member on the memory care unit when Resident #1 was outside watering plants and Resident #2 exited to the outside of the facility. The LNHA verified Resident #1 was left unattended in the courtyard while RN #103 located Resident #2 and brought Resident #2 back to the memory care unit. The LNHA verified Resident #1 was not being supervised when Resident #1 fell into the pond. (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 07/01/24 at 12:26 P.M. Maintenance Director #150 revealed the pond was approximately six feet wide, 10 to 12 feet long and probably 12 to 18 inches deep. Maintenance Director #150 stated there was netting under the water in the pond and there were lilies and cattails growing in the pond. Maintenance Director #150 stated the pond had been there a long time. It looked like someone had dug a hole, lined it with rubber, filled it with water, and placed rocks around the sides of the pond. Maintenance Director #150 stated he drained the pond and rented a skid steer to fill the pond in after Resident #1's fall. Review of the Fall Prevention Program policy revised on 02/2023 revealed residents with low/moderate risk were encouraged to wear shoes or slippers with non-slip soles when ambulating. When a resident experienced a fall, the facility obtained witness statements in the case of injury and documented all assessments and actions. Review of the facility assessment revised on 05/21/24 revealed the facility was licensed for 49 beds with 16 beds being on the (secured) memory care unit. The facility assessment indicated assessments were completed on all residents and the care plan was personalized to help meet resident's preferences related to daily schedules, waking, bathing, activities, naps, food, and going to bed. 2. Review of the medical record revealed Resident #2 was admitted on [DATE] with diagnoses that included vascular dementia, chronic kidney disease, and anxiety. The quarterly MDS dated [DATE] revealed Resident #2 had a BIMS score of eight which indicated cognitive impairment. The MDS revealed Resident #2 had wandering behavior. The elopement risk assessment dated [DATE] revealed Resident #2 was up ad lib without assistive devices. Resident #2 had a history of elopement at home, leaving the facility without informing staff and wandered aimlessly. Resident #2 was at risk for elopement as evidenced by wandering and exit seeking. A progress note dated 06/08/24 at 5:53 P.M. revealed Resident #2 had agitation, was exit seeking, and packing belongings. At approximately 4:00 P.M. Resident #2 exited the emergency exit door in the dining room. Resident #2 was met in front of the facility by LPN #102 and brought back into the memory care unit. An elopement risk assessment dated [DATE] revealed Resident #2 was at risk for elopement and appropriate interventions had been reviewed. An elopement risk assessment dated [DATE] revealed Resident #2 was at risk for elopement and the appropriate interventions had been initiated and reviewed. A progress note dated 06/14/24 at 3:34 P.M. revealed Resident #2 was exit seeking and pushing on the doors. A care plan dated 06/14/24 revealed Resident #2 was at risk for elopement. Interventions included to distract resident from wandering, assess Resident #2 for proper footwear, and offer snacks and activities. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note dated 06/15/24 at 12:40 A.M. revealed Resident #2 was redirected back to his room multiple times. A progress note dated 06/22/24 at 8:00 P.M. revealed Resident #2 was found at the nurse's station and had called 911. A progress note dated 06/22/24 at 9:27 P.M. revealed Resident #2 had been exit seeking throughout the day. Resident #2 was redirected but continued to wander and look out exit doors. A behavior note dated 06/23/24 at 12:55 A.M. revealed the nurse was at the nurse's station and did not hear Resident #2 exit the entrance door to the unlocked part of the facility. Resident #2 was redirected back to the memory care unit. A progress note dated 06/24/24 at 12:29 A.M. revealed Resident #2 was pacing and exit seeking. Interview on 07/01/24 at 2:39 P.M. Regional MDS Nurse #151 verified Resident #2 was identified as an elopement risk and did not have an elopement care plan in place until 06/14/24. Regional MDS Nurse #151 verified the assessments and care plans were not accurate. Regional MDS Nurse #151 stated she was currently auditing assessments and care plans. 3. Review of the medical record revealed Resident #3 was admitted on [DATE] with diagnoses that included schizoaffective disorder, major depressive disorder, dementia, and anxiety disorder. An elopement risk assessment dated [DATE] revealed Resident #3 was not at risk for elopement. A care plan dated 09/06/23 revealed Resident #3 was an elopement risk with interventions to distract Resident #3 from wandering, provide structured activities, and identify a pattern of wandering. An elopement risk assessment dated [DATE] revealed Resident #3 was not at risk for elopement. An elopement risk assessment dated [DATE] revealed Resident #3 was not at risk for elopement. A progress note dated 03/06/24 at 8:13 A.M. revealed Resident #3 was pacing back-and-forth, going in and out of other resident's rooms. A progress note dated 03/20/24 at 4:12 A.M. revealed Resident #3 was pacing the unit. A progress note dated 04/13/24 at 5:53 P.M. revealed Resident #3 had been pacing most of the day. The quarterly MDS dated [DATE] revealed Resident #3 had a BIMS score of 7 which indicated cognitive impairment. The MDS revealed Resident #3 did not have wandering behavior. An elopement risk assessment dated [DATE] revealed Resident #3 was not at risk for elopement. An elopement risk assessment dated [DATE] revealed Resident #3 was not at risk for elopement. A progress note dated 06/22/24 at 9:25 P.M. revealed Resident #3 had been exit seeking in the morning. (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 07/01/24 at 2:39 P.M. Regional MDS Nurse #151 verified Resident #3 had a care plan in place for being at risk for elopement, had documentation of wandering and exit seeking, but was assessed as not being an elopement risk. Regional MDS Nurse #151 verified the assessments and care plans were not accurate. Regional MDS Nurse #151 stated she was currently auditing assessments and care plans. 4. Review of the medical record revealed Resident #4 was admitted on [DATE] with diagnoses that included dementia, schizophrenia, and developmental disorder. A care plan dated 12/04/23 revealed Resident #4 was at risk for elopement with exit seeking behaviors at times. Interventions included to distract Resident #4 from wandering, identify pattern of wandering, and provide structured activities. The quarterly MDS dated [DATE] revealed Resident #4 was cognitively intact and had no wandering behavior. An elopement risk assessment dated [DATE] revealed Resident #4 was at risk for elopement. An elopement risk assessment dated [DATE] revealed Resident #4 was not at risk for elopement. Interview on 07/01/24 at 2:39 P.M. Regional MDS Nurse #151 verified Resident #4 had a care plan in place for risk of elopement. Resident #4 had been identified as at risk for elopement on 05/22/24. On 06/12/24 Resident #4's elopement risk assessment revealed Resident #4 was not at risk for elopement. Regional MDS Nurse #151 verified the assessments and care plans were not accurate. Regional MDS Nurse #151 stated she was currently auditing assessments and care plans. 5. Review of the medical record revealed Resident #5 was admitted on [DATE] with diagnoses that included schizoaffective disorder, mood disorder, mild cognitive disorder, epilepsy, and dementia. A care plan dated 01/17/23 revealed Resident #5 was at risk for elopement. Interventions include to assess for fall risk. The quarterly MDS dated [DATE] revealed Resident #5 had a BIMS score of 3, which indicated severe cognitive impairment. Wandering behaviors was not completed on the MDS. An elopement risk assessment dated [DATE] revealed Resident #5 was at risk for elopement. An elopement risk assessment dated [DATE] revealed Resident #5 was not at risk for elopement. Interview on 07/01/24 at 2:39 P.M. Regional MDS Nurse #151 verified Resident #5 was identified as an elopement risk on 05/30/24 with an elopement risk care plan in place. On 06/12/24 Resident #5 was not identified as an elopement risk. Regional MDS Nurse #151 verified the assessments and care plans were not accurate. Regional MDS Nurse #151 stated she was currently auditing assessments and care plans. 6. Review of the medical record revealed Resident #7 was admitted on [DATE] with diagnoses that included dementia, history of traumatic brain injury, and anxiety disorder. (continued on next page)

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	366036	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendora Health Care Center	1552 North Honeytown Road Wooster, OH 44691

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An elopement risk assessment dated [DATE] revealed Resident #7 was at risk for elopement. A progress note dated 06/29/24 at 6:05 P.M. revealed Resident #7 was exit seeking several times and setting the alarms off. Resident #7 was redirected but continued to exit seek. Review of Resident #7's care plan revealed no care plan in place for elopement risk. Interview on 07/01/24 at 2:39 P.M. Regional MDS Nurse #151 verified Resident #7 was identified as an elopement risk and did not have an elopement care plan in place. Regional MDS Nurse #151 verified the assessments and care plans were not accurate. Regional MDS Nurse #151 stated she was currently auditing assessments and care plans. This deficiency represents non-compliance investigated under Complaint Number OH00155248.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on observation, record review and interview the facility failed to maintain sufficient levels of staff on the secured care unit to meet the supervisory and total care needs of all residents. This affected two residents (#1 and #2) and had the potential to affect the 11 residents residing on the facility secured memory care unit. Findings include: On 07/01/24 at 8:11 A.M. the surveyor entered the facility to conduct the complaint investigation. There were two licensed nurses and three State tested Nursing Assistants (STNA) on duty to provide care for 33 residents currently residing in the facility. Eleven of the resident's resided on the memory care unit. Staffing on the memory care unit included one Registered Nurse (RN) and one STNA. Review of the facility staffing schedules and assignment sheets from May and June, through 06/27/24 revealed the facility only staffed one nurse on the secured memory care unit, with no other assigned/dedicated staff. Interview on 07/01/24 at 8:31 A.M. with STNA #120 revealed the facility had recently started staffing three STNA's so there was now an STNA scheduled to work on the memory care unit with the scheduled nurse for the unit. Interview on 07/01/24 at 8:41 A.M. with STNA #126 revealed the facility just started putting an STNA on the memory care unit. STNA #126 stated there was usually only one nurse working on the memory care unit. STNA #126 stated there were several residents on the memory care unit who were exit seeking. An interview during the onsite investigation with a staff member who requested to be anonymous revealed with only one staff member working on the memory care unit it was difficult to provide good care, pass breakfast and lunch trays, provide fluids, medications, incontinence care and showers. During the onsite investigation, a request was made to review the facility staffing policy. The facility did not provide a policy for staffing or policy related to staffing for the secured care unit. The LNHA verified the facility the facility did not have a policy for staffing and indicated staffing information was part of the facility assessment. However, the facility assessment did not address the memory care unit specifically. Review of the facility census on 06/08/24 revealed there were a total of 30 residents in the facility. Eleven of the residents resided on the secured memory care unit. On 06/08/24 four of 11 residents required one person assistance, two residents were frequently incontinent, and one resident was at risk for elopement. In addition, concerns for Resident #1 and Resident #2 were identified which correlated to a lack of staffing and resident supervision on 06/08/24: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated 06/08/24 at 5:25 P.M. revealed Resident #1 was outside watering plants. Resident #1 went to retrieve water from pond. Resident #1 was wearing flip flops and slid into the pond. Resident #1 was removed from the water and assessed by Registered Nurse (RN) #103. Resident #1 was assisted in the shower to wash pond gunk off and to further assess skin. Audible crackles were heard in all of Resident #1's lung fields. A call was placed to the on-call provider and an order was received to transfer Resident #1 to the emergency department (ED) for evaluation of possible aspiration of pond water. A progress note dated 06/08/24 at 5:50 P.M. revealed Resident #1 was transported to the emergency department. (ED). Review of hospital records dated 06/08/24 revealed Resident #1 was seen due to a fall with aspiration into respiratory tract. Resident #1 was ordered antibiotics. A written statement by RN #103 dated 06/08/24 revealed RN #103 was being oriented on the memory care unit by LPN #101. LPN #101 left the memory care unit to make a phone call. RN #103 was charting at the nurse's station. Resident #1 requested to water the vegetable plants in the courtyard that was directly to the left of the nurse's station. RN #103 entered a code to unlock the door and allowed Resident #1 to exit into the courtyard. LPN #101 had stated therapy wanted Resident #1 to water plants over the weekend as part of the therapy program. The statement revealed RN #103 had complete visualization of Resident #1 and refilled the kitchen sized water pitcher approximately three times. Resident #1 would come to the door each time the pitcher needed refilled, and RN #103 would put the code in and open the door. The statement indicated Resident #1 was alert and oriented to person, place, time, and situation. Resident #1 ambulated without any assistive devices and had a steady gait. While Resident #1 was watering plants, another resident (Resident #2), had been walking in the hallway past the nurse's station several times. Resident #2 walked down the hall towards the dining room and pushed open the exit door. RN #103's statement revealed she ran from the nurse's station to the alarming exit door and observed Resident #2 on the sidewalk rounding the corner towards the front of the facility. RN #103 used the walkie-talkie to call for assistance but did not hear a response from anyone. Resident #1 was back at the courtyard door holding up an empty water pitcher. RN #103 held up one finger and told Resident #1 to hang on for a minute. RN #103 ran to the door at the front of the unit to see if staff could be summoned to get Resident #2. When RN #103 opened the door from the memory care unit, LPN #102 was observed walking Resident #2 inside. Resident #2 was taken back onto the memory care unit. RN #103 immediately ran back to check on Resident #1. RN #103 opened the door to the courtyard but could not see Resident #1. Resident #1 called out, I'm over here. RN #103 thought Resident #1 had fallen into some weeds. RN #103 ran to Resident #1 and asked if she was okay and if Resident #1 had hit her head. Resident #1 was completely wet. Resident #1's hair was wet with muddy particles. RN #103 was unaware there was a pond in the courtyard area. The statement indicated Resident #1 stated she was okay and felt stupid and hoped no one was looking out the windows. Resident #1 denied hitting her head and denied any pain. Resident #1 stated she was bending over to fill the water pitcher and lost her balance and slipped. Resident #1 was wearing flip flop style sandals. RN #103 asked Resident #1 if she went all the way under the water. Resident #1 answered yes. Resident #1 was coughing and stated she felt she had swallowed some of the water. LPN #101 showed up in courtyard and assisted RN #103 with getting Resident #1 out of the pond. As RN #103 was assisting Resident #1 back to the building, Resident #1 slipped in the grass and fell to her knees. RN #103 told Resident #1 not to put shoes back on because they were wet and slippery. Resident #1 struggled to get from knees to standing with RN #103 assistance. Resident #1 had a small laceration to the right knee and stated her second toe hurt. Resident #1 requested a shower. Resident #1 had expiratory coarse crackles in posterior left base of lung and frequent loose sounding cough. LPN #101 made notification calls and Resident #1 was transferred to the ED for evaluation. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A written statement by LPN #102 dated 06/08/24 revealed she was notified by RN #103 that Resident #2 was outside the facility. LPN #102 met RN #103 in the parking lot and assisted Resident #2 back into the facility. Interview on 07/01/24 at 8:50 A.M. RN #103 revealed she had been orienting with LPN #101 the day Resident #1 fell in the pond. RN #103 stated LPN #101 had left the memory care unit and Resident #1 asked to water the plants in the courtyard. Staff had been told to let Resident #1 water the plants on the weekends. RN #103 let Resident #1 go to the courtyard to water plants. RN #103 stated she was able to see Resident #1 and filled the water pitcher several times for Resident #1. Resident #2 had been stating he needed to leave and wandering up and down the hallway. Resident #2 went to the exit door in the dining room and pushed the door until it alarmed, and the door unlocked. RN #103 ran to the exit door and saw Resident #2 was going around the building towards the front. RN #103 used the walkie-talkie to alert other staff that assistance was needed, and Resident #2 had exited the building. RN #103 stated no one answered her call for help. RN #103 ran towards the other end of the hall where the door to the facility was located to see if she could get a staff member to help her. RN #103 stated as she ran past the nurse's station, she saw Resident #1 standing at the door where the courtyard was. RN #103 held up her index finger and asked Resident #1 to give her a minute. When RN #103 opened the door from the memory care unit to the front hallway, she observed LPN #102 bringing Resident #2 back into the facility. After Resident #2 was back on the memory care unit, RN #103 ran to check on Resident #1. When RN #103 went out to the courtyard, she did not see Resident #1. Resident #1 called out over here. RN #103 was not aware there was a pond in the courtyard until she found Resident #1. Resident #1's head was wet, and Resident #1 was still in the pond. Resident #1 stated she went to get water from the pond to fill up the pitcher and fell into the pond. Resident #1 was vomiting up muddy water and was sent to the hospital for evaluation. RN #103 stated LPN #101 arrived and assisted with getting Resident #1 out of the pond. Interview on 07/01/24 at 12:16 P.M. with the LNHA revealed the pond Resident #1 fell into was about a foot deep. The LNHA then indicated the pond may have gotten deeper in some parts. The LNHA stated there was a net across the top of the pond and there were lilies growing through the netting. The LNHA revealed RN #103, who was working on the unit at the time of the incident was a new nurse and 06/08/24 was her third day of being oriented. The LNHA verified RN #103 was the only staff member on the memory care unit when Resident #1 was outside watering plants and Resident #2 exited to the outside of the facility. The LNHA verified Resident #1 was left unattended in the courtyard while RN #103 located Resident #2 and brought Resident #2 back to the memory care unit. The LNHA verified Resident #1 was not being supervised when Resident #1 fell into the pond. At the time of the interview, the LNHA stated the facility had since increased in census so a nurse and STNA were now scheduled on the memory care unit. Interview on 07/01/24 at 3:36 P.M. LPN #102 revealed staff went outside and brought Resident #2 back into the facility on [DATE]. LPN #102 verified she was not aware where LPN #101 was when Resident #1 fell in the pond or when Resident #2 exited the building. LPN #102 revealed there was one STNA working on 06/08/24 and the STNA was not on memory care unit. Interview on 07/03/24 at 10:19 A.M. LNHA revealed staffing was based on census and what was going on with residents. The LNHA clarified an STNA had been scheduled to work the memory care unit with a nurse since 06/27/24 due to increase in census for the facility. The LNHA stated other nursing staff, dietary, and activities could assist on the memory care unit when needed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Complaint Number OH00155248.