STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366076	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Eastern Star Hlth Care Ctr The	1451 Gambier Road Mount Vernon, OH 43050

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 - Minimal harm or potential for actual harm 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** 43064 Based on interview and record review the facility failed to ensure Resident #67 who was elopement risk did not leave the facility unsupervised. This affected one resident (#67) of three residents reviewed for elopement. The facility census was 71. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses including dementia, pain, insomnia, depression, hyperlipidemia, and anxiety. Review of Resident #67's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had a severe cognitive impairment and had wandered during the lookback period. Review of Resident #67's plan of care initiated 11/12/23 and revised 08/19/23 revealed the resident was at risk for elopement due to wandering off of her neighborhood (unit), diagnosis of dementia, and being found outside of the neighborhood on 08/07/24. Interventions were dated 11/12/23 and included wanderguard to the right ankle, checking the placement of the wanderguard every shift, redirecting the resident when she is seen heading towards the exit door, and checking the wanderguard system and bracelet according to policy to ensure functioning. Review of Resident #67's physician order dated 11/13/23 revealed an order for a wanderguard to the right ankle that needed checked every shift to ensure placement. Review of Resident #67's progress note dated 08/07/24 revealed Resident #67 had been found wandering outside of the neighborhood. She was brought back without incident and her vitals were assessed. Resident #67 denied pain. She was anxious that morning and had been redirected multiple times, her wanderguard was in place. (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
	366076	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Eastern Star Hlth Care Ctr The	1451 Gambier Road Mount Vernon, OH 43050

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facilities self-reported incidents (SRI) revealed an incident dated 08/07/24 at 2:31 P.M. of neglect or mistreatment. The initial note indicated at 2:00 P.M. the Administrator had been notified that Resident #67 had been found by the facilities general contractor walking by the construction trailer on the property. Maintenance Director #107 had received a call from the contractor at 1:29 P.M. notifying him of this. Maintenance Director #107 and Human Resources (HR) Assistant #120 went to retrieve the resident. HR Assistant #120 noted the resident to be physically fine and escorted her back to the building. She called the nursing staff on the walk back to inform them of their imminent return and the need for an assessment. The nurse had been unaware that the resident had been missing. The nurse completed the assessment and noted no injuries, she then called the power of attorney and nurse practitioner. The nurse manager initiated 15-minute checks for the resident for 24 hours following the incident. All staff were messaged and told to avoid going in and out of neighborhood doors unnecessarily for the next 24 hours. Resident #67 did not recall the incident but was dressed appropriately for the weather. The summary of the incident indicated on 08/08/24 they were able to access the camera and put together a timeline of the incident. At 1:15 P.M. the resident was observed at the back door of the [NAME] neighborhood which leads directly outside. She was observed to have turned the handle for 15 seconds to activate the alarm, and the door lock disengaged. She was observed at 1:17 P.M. walking through the north parking lot walking in the direction she was later found. At the same time (1:17 P.M.) Housekeeper #131 noted the alarm, she looked outside quickly and deactivated the alarm. Housekeeper #131 did not notify anyone of the alarm going off. Maintenance Director #107 was notified by the Contractor at 1:29 P.M. and HR Assistant #120 walked the resident back into the building at 1:33 P.M. When staff were interviewed it was discovered that nobody could hear the alarm at the front of the neighborhood. On 08/08/24 maintenance was asked to move the sound device box from the ceiling and mount it on the wall. The alarm was tested for appropriate volume along with all other door alarms in the neighborhood and it was ensured the alarms could be heard from all parts of the neighborhood. These changes were made in the other three sections of the long-term care neighborhoods. On 08/08/24 Housekeeper #131 was educated on turning off alarms without alerting nursing staff for them to do a headcount. A message was sent out by the administrator to all staff to inform nursing staff when turning off any alarm and for nursing staff to perform a headcount to ensure the safety of all residents. This information was repeated in the facility conclusion. The allegation was substantiated. Review of Resident #67's 15-minute checks dated 08/07/24 revealed the resident was observed every 15 minutes from 08/07/24 at 2:00 P.M. to 08/08/24 at 2:30 P.M. Review of the employee coaching form dated 08/08/24 revealed Housekeeper #131 was educated on an event that occurred on 08/07/24. Housekeeper #131 did not alert a nurse or aide that an alarm was going off for a fire door. She shut off the alarm, looked outside to see if she saw someone, and went about her job. Her education included the need to alert the nurse or aide of the alarm so they can evaluate the situation and make sure all residents are safe. Review of the unlabeled message to staff from the Administrator dated 08/07/24 revealed staff were not to go through the [NAME] neighborhood to get to the parking lot or dumpster due to a resident that wanted to go home. The next message (later revealed to be on 08/08/24 by the Administrator) indicated if a door was alarming nursing should be alerted. Nursing staff was then to complete a visual headcount to ensure no residents were missing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366076	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Eastern Star Hlth Care Ctr The	1451 Gambier Road Mount Vernon, OH 43050

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the all-staff meeting dated 08/22/24 from 7:00 A.M. to 8:00 A.M. and 2:00 P.M. to 3:00 P.M. revealed the agenda included elopements there were 72 employees marked as being present by zoom without a signature and 106 had no indication that they were present or received the training. Review of the after-action report by Director of Technology #142 undated, revealed it repeated the timeline indicated in the SRI. His recommendations included a louder audible signal on access-controlled egress doors, if staff member responding to a door that alarms the nurse on the neighborhood should be alerted, and looking for newer devices that could be used for tracking and triangulation of residents wearing a device like a wanderguard. Interview on 09/04/24 at 11:10 A.M. with HR Assistant #120 revealed she had been with Maintenance Director #107 when he received a call from a construction worker. She reported she heard about the missing resident and went with him to get the resident. HR Assistant #120 reported the construction worker stayed with the resident while they were headed to her, and they were outside of the fenced in construction area when she arrived. The resident had been wearing a grey t-shirt, a zip-up sweater, long pants, and tennis shoes. HR Assistant #120 reported it had been warm that day so she asked the resident if she was hot and wanted to remove the sweater but the resident indicated she did not. She then walked the resident back into the building and the nurses and aides were informed of the incident. She reported the resident did not look injured or dirty. Interview on 09/04/24 at 11:10 A.M. and at 2:16 P.M. with Maintenance Director #107 revealed he received a call from the contractor that there was a resident near the construction trailer on their campus. He and HR Assistant #120 went to get her and the contractor stayed with her until they arrived. The contractor explained that she had not been in the construction zone. The contractor had began walking her back to the facility when they arrived. He reported they found the alarm had not been loud enough for the nursing staff to hear and it had been adjusted. Interview on 09/04/24 at 1:38 P.M. with Registered Nurse (RN) #111 revealed she had been the nurse on duty when Resident #67 eloped. She reported the alarm was not heard by nursing staff and she did not learn of the issue until they were bringing the resident back to the unit. She reported she did a complete assessment, her vitals were normal, she was uninjured and did not appear dirty or dusty. Interview on 09/04/24 at 2:05 P.M. and 3:06 P.M. and email at 2:53 P.M. with the Administrator revealed they believed Resident #67 had walked down the out of use road to the construction trailer. The initial messages sent out on 08/07/24 and 08/08/24 was via their internal messaging system and went out to 227 employees. She reported the messaging system had informed her that all but 12 people reviewed the message but she was unable to identify which 12 people. Additional reinforcing of the education was given during the all-employee meeting on 08/22/24 and various departmental meetings thereafter. This deficiency represents non-compliance investigated under Complaint Number OH00156739.