

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER Woodland Country Manor Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4166 Somerville Rd Somerville, OH 45064	

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** Based on record review, review of a Self-Reported Incident (SRI) and investigation, policy review, resident and staff interviews, and observations, the facility failed to ensure staff provided adequate supervision to prevent a resident from leaving the facility unsupervised and failed to conduct a thorough investigation into the resident's elopement. This affected one (Resident #27) of three residents reviewed for elopement. The facility identified 11 residents at risk for elopement. The facility census was 51.</p> <p>Findings include:</p> <p>Record review for Resident #27 revealed the resident was admitted to facility on 03/13/25. Diagnoses included dementia, delirium, insomnia, depression, and auditory hallucinations.</p> <p>Review of the physician orders dated 03/14/25 revealed Resident #27 was to wear a wanderguard to the left ankle.</p> <p>Review of the care plan dated 03/18/25 revealed Resident #27 was an elopement risk/wanderer due to disoriented to place, impaired safety awareness, and wandered aimlessly. The goals were for Resident #28 will not leave the facility unattended and the resident's safety will be maintained. Interventions included to distract the resident from wandering, provide structured activities, and the resident's triggers for wandering/elopeing are wanting to go back home. The resident's behavior is de-escalated by one-to-one talks and walking the halls with her, and wander alert device. On 05/17/25, a new intervention was implemented to have dietary staff lock the dining room windows and pull blinds before leaving at 7:00 P.M. On 05/19/25, a new intervention was implemented to add motion detector in bedroom window sill.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 suffered with sleep disturbance, being short tempered, and a history of wandering. Resident #27 had impaired cognition.</p> <p>Review of the elopement risk assessment dated [DATE] revealed Resident #27 was at risk for elopement.</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 progress note dated 05/16/25 revealed staff discovered Resident #27 missing from her room around 2:00 A.M. during resident checks. Staff were able to locate Resident #27 outside of the building, wearing a wander guard monitoring device, in a parking lot next to the facilities assisted living (AL) unit around 2:45 A.M. Resident #27 willingly returned to facility with Certified Nursing Assistant (CNA) #50.</p> <p>Review of the facilities SRI and investigation dated 05/16/25 revealed there was an allegation of neglect reported to the State Survey Agency. Resident #27 was found outside the facility and the facility suspected that no alarms sounded. Allegedly, Resident #27 went out the dining room window. The facility's investigation only had two witness statements which were from Licensed Practical Nurses (LPN) #11 and #21. The facilities investigation did not include specific times Resident #27 was last seen or details of how the resident was found. There were no specific identifications of staff involved in the incident. There were no other staff interviews who were working the evening and night shift. There was no evidence the dining room window was assessed on how the resident could elope using that window, and/or an assessment of the windows throughout the facility, and any new interventions on prevention of other residents eloping from the dining room window, and/or other windows of the facilities.</p> <p>Review of the nursing schedules revealed CNAs #63, #66, #60, #68, #49, and #50 worked on 05/16/25 at 2:00 A.M. and there was no evidence the staff had been interviewed or witness statements obtained.</p> <p>Interview on 05/28/25 at 9:17 A.M. with Resident #27 revealed she had left the facility a few days ago by climbing out a low window. Resident #27 stated her brothers had arranged the plan for her to meet them, prompting her to leave the facility. Resident #27 stated she got into her brother's car and put her coat inside the car. Resident #27 stated her medical doctor found her outside the facility and assisted her back into the building.</p> <p>Observation of the dining room windows on 05/28/25 at 9:20 A.M. revealed the window which Resident #27 used to get outside of the facility was closed and locked. The window was unlocked and opened by the Administrator, and the screen easily removed. The Administrator verified Resident #27 could have opened the locked window and exited through the open window as the window was large enough and could be easily unlocked.</p> <p>Interview on 05/28/25 at 11:35 A.M. with the Director of Nursing (DON) stated the DON was notified of Resident #27's elopement the morning of 05/16/25. The DON confirmed Resident #27 had left the building early in the morning 05/16/25 via window in the dining room. The DON stated Resident #27 had a history of having long periods of being awake, wandering and exit seeking, then sleeping for long periods of time. The DON stated Resident #27 regularly expresses her desire to return home and has a history of attempts to leave the facility.</p> <p>Interview on 05/28/25 at 11:51 A.M. with Social Services (SS) #91 revealed the investigation had been done by herself under the direction of the Administrator who was training her on doing an investigation of an elopement. SS #91 confirmed she only obtained two LPN (#11 and #21) witness statements regarding the events leading up to and including finding Resident #27. SS #91 denied she interviewed or obtained witness statements from any other staff.</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 05/28/25 at 12:05 P.M. with LPN #7 stated Resident #27 was continually packing her things and saying she was leaving to go home. LPN #7 stated Resident #27 was exit seeking throughout most days, with staff intervening to keep her in the building or bring her back in the building when she gets out an exit door.</p> <p>Interview on 05/28/25 at 12:57 P.M. with CNA #63 stated Resident #27 left the building in the early morning on 05/16/25, without an alarm sounding to alert staff that she was outside. CNA #50 found Resident #27 in the parking lot behind the facilities AL unit on 05/16/25 around 2:45 A.M. CNA #63 confirmed once Resident #27 returned to the facility, Resident #27 was able to lead them to the window which she used to get out of the facility. CNA #63 stated she had provided SS #91 a statement about the situation several days after the incident and was not interviewed.</p> <p>Interview on 05/28/25 at 12:58 P.M. with CNA #68 stated she last observed Resident #27 at 1:30 A.M. wandering in the hallways with her coat, which was common. At rounding at 2:00 A.M., Resident #27 was not in her room. CNA #68 stated she assisted with inside room searches. Resident #27 returned inside of the facility without injuries at around 3:00 A.M. CNA #68 stated she had not been interviewed by any manager.</p> <p>Interview on 05/28/25 at 1:17 P.M. with CNA #66 stated Resident #27 was in the hallway around 2:00 A.M. and had was found by CNA #50 around 3:00 A.M. in the parking lot. CNA #66 assisted in searching the facility and observed Resident #27 returning into the facility with CNA #50. Resident #27 was self-ambulating and had no visible injuries. CNA #66 stated she a had not been interviewed by the managers and not documented her observations of 05/16/25.</p> <p>Interview on 05/28/25 at 1:30 P.M. with CNA #50 stated Resident #27 was walking around the hallway at 2:00 A.M., which was usual for Resident #27. CNA #50 stated Resident #27 was not in her room at about 2:30 A.M. and began the inside search and then began outside search. The weather was cool and not raining. Resident #27 was found around 3:00 A.M. in the facilities AL parking lot near an employee car, standing with the car door slightly opened. Resident #27's coat was in the passenger seat. Resident #27 ambulated back into the facility without difficulty and there were no apparent injuries or complaints of pain. CNA #50 stated she had submitted a written statement to SS #91. It was discovered the dining room window was opened, and the screen had been put back in position.</p> <p>Interview on 05/28/25 at 1:11 P.M. with Maintenance Director #92 stated he had been unaware of the elopement situation involving Resident #27 until recently and he had no discussions about window security with other managers at the time of the elopement. Maintenance Director #92 verified a resident could unlock the top window locking mechanism and climb through the larger dining room windows.</p> <p>Review of the facility's policy titled Elopement Policies and Procedures dated 02/26/25 revealed the facilities staff are to immediately implement policies and procedures for locating a resident in a timely manner in the event of elopement A complete and thorough investigation of the elopement along with an accident /incident report are to be completed in a timely manner.</p> <p>This deficiency represents non-compliance investigated under Control Number OH00165841.</p>		