STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366203	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orrville Pointe	230 South Crown Hill Road Orrville, OH 44667

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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** Based on record review, review of the Self-Reported Incident (SRI), interviews and review of facility policy, the facility failed to ensure that Resident #41 was adequately supervised to prevent elopement and risk of accident hazards. This affected one resident (#41) out of three residents reviewed for accident hazards. The facility census was 44.Findings include:Review of the medical record for Resident #41 revealed an admission date of 09/01/25 with pertinent diagnoses including schizoaffective disorder bipolar type, delusional disorder, obsessive compulsive disorder, auditory hallucinations, unspecified dementia moderate with other behavioral disturbance, generalized anxiety disorder, homicidal ideations, and attention deficit hyperactivity disorder.Review of Resident #41's care plan, initiated on 09/09/25, revealed Resident #41 exhibited symptoms that were not easily altered and potentially harmful to the resident or others and wandered with no discernable, rational purpose. Goals included staff will be aware of resident's whereabouts at all times, and resident will not wander from unit. Interventions included giving medications per physician order; monitor mood, affect, and behaviors with all hands-on care and contacts; encourage to verbalize feelings. Give positive, realistic feedback; take resident on supervised walks inside or outside the facility weather permitting; allow the resident to utilize enclosed patio, garden, outdoor walking path weather permitting; and psych services as needed.Review of Resident #41's modified quarterly Minimum Data Set (MDS) assessment, dated 02/10/26, revealed the resident was severely impaired cognitively; exhibited fluctuating inattention and disorganized behaviors; had hallucinations and delusions; exhibited other behavioral symptoms not directed toward others on a daily basis; wandered daily; and was independent for mobility, which included being able to walk 150 feet without any assistive devices. Further review of Resident #41's medical record revealed a progress note dated 03/31/26 and time stamped 8:30 P.M. which stated while out in the courtyard smoking, resident walked up to the gate and pushed it open and ran. CNA (Certified Nursing Assistant) ran after her. The resident ran and made it to the sidewalk by the street until the CNA yelled stop! Resident turned around quickly and put her fists up. CNA talked to the resident and said it was not safe. Resident #41 had stated, I don't want to be here anymore let's go play in traffic, its ok you can go with me, we can go together and be free. The resident was then able to be brought safely back into the building.Review of Resident #41's progress note dated 04/18/26 and time stamped 4:33 P.M. revealed Resident #41 was taken out to smoke break by an Activities Aide at 1:15 P.M. At 1:37 P.M. a CNA (name removed) had went to lunch break and noted Resident #41 walking down Market Street. The CNA immediately called the facility and spoke with the nurse. The CNA attempted to get Resident #41 to stop and get in the car with her to keep her safe and back to facility. Resident #41 refused and started running. Nurse arrived, police were called, and EMS (Emergency Medical Services) called. Resident #41 became aggressive with the CNA and nurse while they were trying to stop her from running. The resident picked up rocks, was hitting staff, biting, punching, broke nurse and CNAs' glasses, and was trying to stab the nurse with a pen. The nurse had to restrain the resident for residents own safety until police arrived and handcuffed resident. Resident #41 had been wrestling with staff and running barefoot, down the road, over gravel, and through a junk (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 - Minimal harm or potential for actual harm Residents Affected - Few	yard. Police met EMS at the facility and the resident was transferred to [NAME] Orrville for evaluation and treatment. The guardian, administrator, and MD (Doctor of Medicine) were all notified of the incident. A new order was received from the MD for lorazepam (an anti-anxiety medication) one milligram (mg) three times a day (TID) as needed (PRN), and 15min checks upon return until further notice.Review of Resident #41's progress notes dated 04/18/26 and time stamped 5:30 P.M. revealed the facility had received a call from a nurse at the hospital. After an evaluation of Resident #41, there were no signs or symptoms of distress, and all evaluations were negative. An order has been placed for Resident #41 to be transported back to the facility from the hospital.Review of the facility's April 2026 Incident Tracking Log revealed on 04/18/26 Resident #41 had an elopement from the facility.Review of the Ohio Department of Health's Application Gateway website revealed the facility had created a Self-Reported Incident (SRI) number 273478 on 04/18/26 at 2:18 P.M. and completed on 04/21/26 for an allegation/suspicion of neglect/mistreatment abuse, which stated on 4/18/26 at approximately 1:30 P.M. it was reported that Resident #41 left facility property after a scheduled, sanctioned smoke break. Activities Aide (AA) #377 who monitored the smoke break had successfully escorted all 10 first-floor smoking residents back inside the facility, into their locked unit. Headcounts were completed by AA #377 before taking the residents outside to smoke and completed upon bringing them back inside on the unit; both counts accounting for all 10 smoking residents. After all 10 smoking residents were back on their unit, AA #377 left the unit, stating that no residents were by the door when she left, and then went back upstairs to continue to complete her assigned activities aide tasks. The first-floor unit was a locked unit, with the door at-the-time automatically locking after 30 seconds of entering the code. Within that 30 second timeframe, Resident #41 was able to exit the first-floor unit without any alarms sounding and allegedly walked out of the front door and out onto the street sidewalk. From there, CNA #335 witnessed Resident #41 walking down [NAME] Market Street and attempted to persuade Resident #41 to go to McDonald's with her. At 1:37 P.M, CNA #335 placed a call to the facility to notify the nurse on duty that Resident #41 was located and to request assistance to bring the resident back to the facility. LPN #324 left the facility to assist CNA #335, where they both followed and monitored Resident #41. LPN #324 exited her vehicle and ran after Resident #41, while attempting to persuade her to go back to the facility with her. CNA #335 proceeded to follow LPN #324's lead and exit her vehicle as well, attempting to bring Resident #41 back to the facility safely. Resident #41 was noncompliant with LPN #324 requests, continuously looking back at LPN #324, and running further away. Resident #41 then became physically combative with both staff members; breaking both of their eye glasses and hitting, biting, and kicking LPN #324. At 1:48 P.M., CNA #335 called Orrville Police for assistance, who quickly arrived at their location, detained Resident #41, and escorted her safely back to the facility. The facility then called EMS to have her taken out to the hospital and evaluated. Resident #41 was evaluated and returned the same day with no new orders given and no injuries noted. Resident #41's legal guardian and medical director were both notified about the incident involving the resident. Medication orders were updated and implemented as ordered. ADON #317 interviewed Resident #41 regarding the incident upon return to the facility on 4/18/26. The resident stated that she was apologetic for what had happened and thought peers didn't want her in the facility because she perceived them as not looking at her during their scheduled smoke break. Resident #41 was reported at baseline and denied any pain, discomfort, or stress. On 4/20/26, the Administrator interviewed Resident #41 to which resident stated that she wanted to stay in the rain outside and that her book was calling to her to leave the facility. Resident stated that she felt as if Administrator was present with her during the entire incident and was just leaving to get her book from her old home in [NAME] and bring it back. Resident mentioned her father, whom the court ordered she was not allowed to visit, resided at the [NAME] home she was attempting to get to. Resident stated she did not want to leave the facility and that she felt good and was noted to be at baseline with no signs of visible injury or distress. Further review of the SRI revealed the facility had unsubstantiated the allegation since evidence had not indicated abuse, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neglect, or misappropriation had occurred.Review of Resident #41's elopement risk assessment, dated 04/18/26, revealed the resident was at risk for elopement since the resident has a history of wandering/elopement; verbalized a strong desire to leave; had a diagnosis of dementia; and exhibited high level of anger or frustration. An interview on 05/01/26 at 9:38 A.M. with AA #377 revealed she normally did the smoke breaks while she was working at the facility. The normal procedure for smoke breaks was to gather the residents and tell them it was smoke time. She would then line the residents up who go and smoke, take them to the courtyard where they smoked, and hand the residents a cigarette and then light it for them. Smoke breaks normally last 10 to 15 minutes depending on how long it takes residents to smoke their cigarette, and then she would line them back up to take back to their unit. She normally counted the residents before and after the smoke breaks. On 04/18/26 she lined everyone up after they were done smoking. She thought she had counted ten residents. After she brought them all in, she counted ten residents. The smoke break had started at 1:15 P.M. and she brought them back maybe around 1:30 P.M. She counted everyone when they came in from that same break and then left the unit to go grab the cart for snacks. When she got back to the unit, that was when they noticed Resident #41 was gone. She assumed Resident #41 was in the line and taken back to the unit, but she hadn't seen her exit the courtyard. She confirmed she hadn't waited to make sure the keypad from the door from the unit to the hallway had turned red to ensure the lock had reset until she left the door to the unit to go and get the snack cart. AA #377 stated Resident #41 could have gotten out through that door before the door had locked and went through the front door. Since the incident, AA#377 stated the facility now has two staff members observe smoke breaks, and one of the staff stands by the gate of the courtyard.An interview with Guardian #400 on 05/01/26 at 10:11 A.M. revealed Resident #41 had escaped from a previous facility she had been residing at in Akron.An interview with LPN #324 on 05/01/26 at 10:25 A.M. revealed a couple weeks prior to the elopement incident Resident #41 had escaped from a fence door in the courtyard. The aide was able to redirect and get Resident #41 back into courtyard and bring her back to facility. When she talked to maintenance about putting a lock on the fence after that happened, he said he couldn't lock the gate to the courtyard but could put a code on it. LPN #324 stated no changes came after that incident on 03/31/26. Prior to the 1:15 P.M. smoke break on 04/18/26, the resident had asked to use a phone. She dialed number and said she was talking to her sister. The resident got off the phone and lined up and went to smoke. LPN #324 saw them counting on the way out. At 1:37 P.M. on 04/18/26 the phone rang and it was CNA #335 telling her that Resident #41 was off the facility property and was close to Market and [NAME] Street. When LPN #324 had gotten the call from CNA #335, LPN #324 told CNA #338 to contact the upstairs nurse that she was leaving facility and to call the police and that someone escaped and the approximate area where that resident had been found. LPN #324 then called CNA #335 to see what area they were in and jumped into her car and drove to Terminal and Elm streets. Resident #41 was in the yard of a house. LPN #324 stated she parked along the road and tried to persuade Resident #41 to take a ride with the CNA #335. At that point she got closer to the resident and then the resident took off running. LPN #324 ran after her, and CNA #335 was still in her car. Resident #41 ran into a junk yard. LPN #324 followed her into junk yard. It was cold and rain poured down and the resident had no shoes on. LPN #324 stated she didn't know where the resident's shoes went. At that point, CNA #335 was also now running after the resident. Resident #41 then hit CNA #335 in the face and twisted her glasses. LPN #324 was then able to bear hug her, but the resident then bit her. They then went down to the ground, and the nurses pens fell out of her pocket, and the resident tried to grab one of the pens to possibly use as a weapon. The resident was picking up rocks and was trying to hit her. The resident's safety was LPN #324s' first concern. CNA #335 and LPN #324 were able to contain her until the cop pulled in. When the resident saw the cop, the fight went out of her; she said hi; and then held hands out for him to cuff her. The cop took her back to the facility and then EMS took her for evaluation at the hospital. The resident came back the same day. The next day LPN #324 worked, the resident gave her a hug and apologized. LPN #324 asked her how (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she got out and the resident told LPN ##24 that she got out of fenced gate during smoking and denied ever coming back from smoke break. LPN #324 stated the resident does talk off the wall at times but other times she was with it and it depended on who you are if she makes sense. Resident #41 vaped and went out during smoke breaks to vape. Since the incident, two staff members have to observe smoke breaks, staff were educated to ensure they making sure door locks are reset before walking away from the doors, and the time it takes to reset the door lock once the code was put in for the door leaving the first floor unit to the hallway was decreased from 30 seconds to 10 seconds.An interview on 05/01/26 on 11:05 A.M. with CNA #335 on 04/18/26 revealed the CNA was working on 04/18/26 and went out at approximately 1:30 P.M. for her lunch break. At that time, it was down pouring rain, and she sat in her car for a couple minutes waiting for the rain to die down. She then exited the parking lot and turned right onto Crownhill Street and right again on Market Street. Resident #41 has a noticeable walking gait, and the CNA saw her from behind. When she passed the resident in her car, Resident #41 was bare foot and had short shorts, a tank top and a cardigan. When the CNA saw her, she pulled into a driveway and said, Hey girl lets go get McDonalds, Resident #41 screamed no and ran down a side street. The CNA then pulled into random driveways and Resident #41 went down Mohican Street and threw her cardigan into a random yard. The resident was snaking through houses running up driveways and then behind houses. They ended up on Terminal Street. The CNA had called the facility when she was on Market Street to alert them, and that was when LPN #324 came out in her vehicle and caught up with them on Terminal Street. There was a house with a car port and chain link fence which cornered the resident. The CNA and LPN tried to talk to her and she screamed and ran again. LPN #324 followed on foot and the CNA followed in car and they ended up in a junk yard where there were dumpsters with jagged sheet metal pieces on the ground and gravel. Resident #41 and LPN #324 traveled straight and the CNA went the opposite direction around the dumpsters. They met in the middle and Resident #41 came after her with both fists. CNA #335 caught the resident's fists and then Resident #41 grabbed CNA #335 ?s glasses off of her face, crunched them, and held them between her legs. That was when LPN #324 came from behind and bear hugged her. Everyone ended up on the ground. LPN #324 was able to get control of the resident, and the CNA ran to a phone and called 911. The facility had already called 911. While on phone with 911, Resident #41 was grabbing gravel and trying to smash the gravel into LPN #324's face. The CNA grabbed the resident's hands so she couldn't hit LPN #324 in the face. Within two to three minutes of LPN #324 and CNA #335 having control of the resident, the officer showed up. At that point the resident completely relaxed, and the officer then took over. Resident #41 told LPN #324 and CNA #335 the next day that she slipped out the smoking gate. The resident said she got out right when they first went out to smoke. CNA #335 stated she was leaving the unit as they were lining inside the hallway to come into the unit when she left for her break, and not everyone was in the building yet from the smoke break. The CNA hadn't noticed if Resident #41 had been in that line. CNA #335 stated Lord knows where she would have ended up if I hadn't seen her. Since the incident, the facility has alerted staff to be more vigilant with the doors of the unit, two staff members now monitor smoke breaks with one standing in front of the gate in the courtyard, and the timer on the one door got changed from 30 to 10 seconds.An interview with the Administrator via phone on 05/01/26 at 12:27 P.M. revealed she had unsubstantiated the allegation since the facility had found the resident pretty quickly and Resident #41 hadn't shown any injury or emotional distress from the incident. The Administrator verified Resident #41 snuck out the door from the unit to the hallway after coming back from a smoke break before the secure door was reset. Review of the facility document titled Smoking Headcount log on 05/01/26 at 1:44 PM with the Director of Nursing (DON) revealed the document had vertical columns for date, time, # ?R' out and #'R' in . On 04/18/26, there was no documentation for any of the smoke breaks that day, which included the 1:30 P.M. smoke break. The DON confirmed at the time of the review, there was no proof that the residents had been counted upon return from the 1:30 P.M. smoke break on 04/18/26.Review of the facility policy titled Smoking Policy, revised April 2024, (continued on next page)

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