

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Cedar Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 1136 Adair Avenue Zanesville, OH 43701	

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** 42015</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on observation, interview, record review and facility investigation review the facility failed to prevent Resident #20 from exiting the facility without staff assistance. This affected one resident (Resident #20) of three residents reviewed for accidents. The facility census was 80.</p> <p>Finding include:</p> <p>Review of the medical record for Resident #20 revealed an admitted on 06/09/23. Diagnosis included unspecified dementia, anxiety, and encephalopathy.</p> <p>Review of Resident #20's physician order dated 06/26/23 revealed the resident had a wanderguard (a magnetized fob that is placed on the wrist or ankle to alert staff when a resident is exiting an alarmed door) placed on her ankle and for placement to be checked every shift.</p> <p>Review of Resident #20's Care Plan revealed the resident was a risk for elopement related to impaired cognition, wandering, a history of attempting to leave the building, and decreased safety awareness. Interventions included to complete an elopement risk assessment quarterly, notify physician and family of behavior changes, and a wanderguard to her ankle.</p> <p>Review of Resident #20's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a severe cognitive impairment and had a wander/elopement alarm that she utilized daily.</p> <p>Review of Resident #20's elopement evaluation dated 04/22/24 revealed the resident was at risk for elopement due to having a history of elopement or attempted leaving the facility without informing staff.</p> <p>Review of Resident #20's progress note dated 05/07/24 revealed the nurse was on the east unit when another resident (Resident #48) yelled down the hall that Resident #20 was outside. The nurse immediately responded and noted the resident walking along the front parking lot. The resident was redirected back into the facility. No injuries were noted, and the resident denied any concerns at the time.</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: 366286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Cedar Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 1136 Adair Avenue Zanesville, OH 43701	
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 the facility investigation dated 05/07/24 revealed on 05/07/24 at 6:15 P.M. staff were notified that Resident #20 was in the parking lot. Staff members LPN #100 and State tested Nurses Aide (STNA) #101 responded and, with redirection, Resident #20 was brought back inside at 6:16 P.M. A head-to-toe assessment was completed on the resident with no injuries noted. All wanderguards were checked and determined to be working. Resident #20 was placed with a one-on-one supervision until 05/08/24 at 8:00 A.M. when a maintenance worker was able to remove the sensor from the door and replace it with a button (requiring the exiting person to press the button, located in the area between the two doors, to gain access outside and not automatically opened by a sensor). Review of LPN #100 and STNA #101 witness statements dated 05/07/24 revealed they heard another resident yell that Resident #20 got outside and they responded immediately redirecting her back inside. Review of STNA #102's witness statement dated 05/07/24 revealed she had let a family member out the front door and shut the door causing the alarm to turn red (indicating it was locked). Resident #20 was in the lobby sitting on the couch. STNA #102 noted Dietary Cook #103 was about to leave. STNA #102 stated she responded to a call light and when she came out LPN #100 ran outside because Resident #48 reported that Resident #20 got outside. Review of Dietary Cook (DC) #103's witness statement dated 05/07/24 revealed she went out the front door. She heard the door lock behind her. She reported she was out there for five minutes and saw Resident #20 with staff following her.</p> <p>Observations on 05/14/24, during the onsite survey, revealed the resident walked independently. Facility staff encouraged her to participate in activities and frequently interacted with her. The resident appeared confused at times. Observation of her head, neck, arms, legs, and ankles revealed no signs of injury and a wanderguard was observed on her left ankle.</p> <p>Interview on 05/14/24 at 12:25 P.M. with the Administrator revealed on 05/07/24 at 6:30 P.M. Resident #20 was able to exit the facility by following Dietary Cook #103. He stated to exit the facility you must enter a code into the front door which unlocks the door. He then stated that you walk through this door into a short breezeway where you must exit through another door. He continued the way the doors were set up, after DC #103 exited the first door by entering a code, walked through the breezeway and opened the second door, it happened to trigger the sensor causing the locked door to momentary unlock. He reported by activating the sensor it also deactivated the wanderguard for a brief minute. This allowed for Resident #20 to open the coded door without triggering her wanderguard. He stated he did not realize that the second door could trigger the sensor (the sensor is hung high on the wall situated directly in front of the coded door and is used to unlock the coded door when entering the facility). He continued that the resident was only outside for approximately one minute and brought back inside without any issues. She was found approximately 10 feet away from the front door in the parking lot, looking for her daughter's car. He reported the resident was assessed, notifications were made, the resident was placed on a one on one supervision, all wanderguards were assessed and noted to be working appropriately, and the sensor was removed on 05/08/24 at 8:00 A.M.</p> <p>Phone interview on 05/14/24 at 2:35 P.M. with STNA #101 revealed she was working with Resident #20 on 05/07/24 when she heard another resident yell that Resident #20 went outside. She responded right away with LPN # 100. She reported the resident was redirected inside, and she did not have any injuries.</p> <p>Attempts were made during the onsite investigation to reach DC #103 but no return call was provided.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Cedar Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 1136 Adair Avenue Zanesville, OH 43701	
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>The deficient practice was corrected on 05/08/24 when the facility implemented the following corrective actions:</p> <p>On 05/07/24 at 6:16 P.M. a head-to-toe assessment was completed on Resident #20 by LPN #100 and no injuries were noted.</p> <p>On 05/07/24 at 6:16 P.M. the Director of Nursing (DON) was notified of the incident by LPN #100.</p> <p>On 05/07/24 at 6:16 P.M. through 05/08/24 at 8:00 A.M. (when the front door sensor was replaced with a push button release) Resident #20 was placed on a one-on-one supervision.</p> <p>On 05/07/24 the DON checked all wanderguards against all doors to ensure they were functioning appropriately. The residents with wanderguards in place were identified as Resident #20, Resident #29, Resident #47, Resident #51.</p> <p>On 05/07/24 at 6:30 P.M. Resident #20's family and the Nurse Practitioner were notified of the incident by LPN #100.</p> <p>On 05/07/24 all residents received an elopement assessment. Resident #20's care plan was updated, and the elopement book was updated with the new care plan. This was completed by the DON.</p> <p>On 05/07/24 through 05/08/24 all staff were educated on the elopement policy by the DON.</p> <p>On 05/08/24 elopement drills were conducted on both shifts by the DON and no concerns were noted.</p> <p>On 05/08/24 a Quality Assurance and Performance Improvement (QAPI) meeting was held to discuss the incident and plan put in place. Members included the Medical Director, DON, Maintenance Director, and Administrator.</p> <p>On 05/08/24 at 8:00 A.M. the facility removed the sensor and replaced it with a push button to exit the facility.</p> <p>Wanderguard assessments will be completed weekly for four weeks to ensure proper functioning for all residents who have a wanderguard by the DON or designee. This will be done by ensuring the alarm system is functioning correctly with the wanderguards in place.</p> <p>No further elopements have occurred between 05/08/24 and 05/15/24.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00153835</p>		