

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/13/2025
NAME OF PROVIDER OR SUPPLIER  Concordia at Sumner		STREET ADDRESS, CITY, STATE, ZIP CODE  970 Sumner Parkway Copley, OH 44321	

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>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews, observations and interviews with staff the facility failed to prevent Resident #28 from eloping from the facility without staff knowledge. This affected one resident (Resident #28) of four residents reviewed for elopements. The census was 42. Findings include:Initial tour was conducted on 11/13/25 from 9:00 A.M. to 9:21 A.M. The facility was divided into two buildings ([NAME] and [NAME]) connected by a hallway. Each building was set up in a square formation with an enclosed courtyard. Each building could house 24 residents. Review of the medical record for the Resident #28 revealed an admission date of 04/27/23. Diagnoses included were dementia, dysphagia, paroxysmal atrial fibrillation and hypertension.Review of the plan of care dated 04/30/23 revealed the resident was at risk for elopement/wandering behavior due to cognitive impairment. Interventions included redirecting as needed and having a wanderguard bracelet (a bracelet worn by a resident which secured doors when near to prevent elopement) in place.Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/30/25, revealed the resident had impaired cognition. The assessment identified the resident to be independent with maneuvering a manual wheelchair over 150 feet. He had physical behaviors against self and others. Resident had no behaviors of wandering. Review of the elopement risk assessment dated [DATE] revealed the resident was at risk for elopement. Review of the nurses notes dated 11/08/25 and timed for 2:17 P.M. revealed Resident #28 was observed sitting in his wheelchair in the front parking lot by a visitor. The visitor brought him inside and notified a staff member. Wandergaurd was on his left ankle and was not working or sounding. Resident #28 was immediately given a new bracelet. Resident was given 1:1 supervision at that time by the nurse. Nurse manager, nurse practitioner were notified and a message was left for the guardian.Review of physician orders for November 2025 revealed resident was to wear wanderguard bracelet on right wrist. Resident #28 was identified as at risk for elopement on 06/19/24.Review of the elopement investigation dated 11/08/25 revealed three witness statements. Certified Nursing Assistant (CNA) #307 stated she was walking down the hall when a family member stopped her by the front door and told her Resident #28 was in the parking lot. CNA #307 brought him back in at approximately 12:00 P.M. CNA #301 stated she was doing care on another resident. When she was finished, the other CNA informed her a visitor saw Resident #28 in the parking lot and the wanderguard bracelet was not working. Licensed Practical Nurse (LPN) #205 was notified by CNA #307 she was told by a visitor Resident #28 was observed in the parking lot in his wheelchair. Resident #28 was brought inside. Wanderguard bracelet was on his left ankle but the alarm was not sounding. LPN #205 last saw him around 11:00 A.M.Interview on 11/13/25 at 9:30 A.M. with Administrator and Director of Nursing (DON) revealed a Self-Reported Incident was not completed based on Ohio Department of Health (ODH) criteria. Administrator sent an email to ODH on 11/08/25 reporting the incident and requesting additional guidance if needed. They suspected Resident #28 eloped through Door #1, the front door. He stated the cameras were down. Unrelated to this issue, Door #2 was not functioning properly, it had an alarm on it that had to be manually shut off. He stated no staff had to reset that alarm on 11/08/25 at the time of the elopement. The facility was supposed to be doing every 15-minute checks on Resident #28 prior to the elopement because of Door #2.Interview on 11/13/25 at 12:33 P.M. with CNA #301 revealed Resident #28 had a fall between 9:30 A.M. and 10:15 A.M. and was found in the doorway to the enclosed courtyard, and the resident had been with a nurse since the fall. CNA #301 and CNA #307 were getting residents ready for lunch when CNA #307 told her a visitor informed her Resident #28 was found in parking lot. CNA #301 stated she was unaware the wanderguard alarm was not working. She stated the nurse reached out to management about it and was told a different door was not working prior to this and staff were told to do fifteen-minute checks of the four residents who wore wanderguard bracelets until it was fixed. CNA #301 revealed none of them were informed about doing every 15-minute checks due to Door #2 not working. She stated they started to do 15 minute checks after Resident #28 eloped. CNA #301 stated they were busy the day Resident #28 eloped and revealed Resident #28's behaviors were normal on the day of elopement. Interview and review of documentation on 11/13/25 at 1:24 P.M. with Systems Administrator (IT) #500 revealed he checked the doors every week and showed weekly audits. The audit indicated Door #2, a side door, was not functioning. It had a note for an outside company coming to fix it on 11/14/25. According to the audit, Door #2 was functioning on 11/04/25. IT #500 stated there was a temporary alarm on this door that had to be manually turned off. He stated they suspected Resident #28 eloped from Door #1 the front door</p>		