STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366323	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayside Farm Inc	4557 Quick Rd Peninsula, OH 44264

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** 42013 Based on observation, record review, facility policy review and interview, the facility failed to ensure Resident #36's risk of elopement was properly and timely re-assessed, and failed to ensure comprehensive care planned interventions were updated and implemented to prevent Resident #36 from eloping from the facility. This affected one resident (#36) of three residents reviewed for wandering and elopement. The facility census was 92. Findings include: Review of Resident #36's medical record revealed an admitted [DATE] with diagnoses including schizoaffective disorder, bipolar type, type two diabetes mellitus with unspecified complications, paranoid personality disorder and anxiety. Review of Resident #36's care plan dated 04/26/24 included Resident #36 was at risk of elopement due to new admission, history of wandering and elopement, exit seeking and disease process. Resident #36's risk of leaving the facility unattended would be decreased through the next review on 11/08/24. Interventions included to identify patterns of wandering and was wandering purposeful, aimless or escapist; distract from wandering by offering diversions, structured activities, conversation and television. Further review of the care plan did not reveal interventions were added after 04/26/24. Review of Resident #36's Elopement and Wandering Risk assessment dated [DATE] revealed Resident #36 was at medium risk for elopement. Review of Resident #36's care plan dated 10/17/24 included declarations in guardianship would honored unless revoked by court and, or responsible party. Engage in ongoing advanced care planning with Resident #36 and guardian to discuss options. Interventions included to notify guardian of all medical changes. Review of Resident #36's medical record including assessments dated 08/11/24 through 03/19/25 did not reveal evidence Resident #36 had an Elopement and Wandering Risk assessment completed. (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	Review of Resident #36's progress notes revealed a late entry progress note dated 10/14/24 at 8:25 P.M. which revealed on 10/14/24 at 5:04 P.M. Licensed Practical Nurse (LPN) #200 was administering medications to the residents in the lower level common area and the fire alarm sounded and next she heard the lower-level exit door alarm sounding. LPN #200 saw Resident #36 running out of the door, he pulled the fire alarm and exited the building. LPN #200 used the walkie-talkie to alert staff that Resident #36 exited the building and was headed into the woods. Resident #36 was found, a head-to-toe assessment was completed, and Resident #36's physician and guardian were notified. Review of Resident #36's progress notes dated 10/15/25 at 11:28 A.M. revealed the guardian and Resident #36 agreed to a room move. Review of Resident #36's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was cognitively intact. The assessment revealed Resident #36 was independent for toileting, hygiene and dressing and required (staff) set-up or clean-up assistance with personal hygiene. Resident #36 was independent in his ability to walk at least 150 feet in a corridor or similar space. Review of the facility incident log dated 03/14/25 at 3:40 A.M. revealed Resident #36 had an elopement from the facility. Observation of facility camera footage dated 03/14/25 at 2:51 A.M. with the Administrator revealed Resident #36 resided on the north hall nursing unit on the main level of the facility. The Administrator stated Resident #36 knew the code for the stairwell and was allowed to use the stairwell or the elevator to go down to the lower level. Review of the camera footage at 2:51 A.M. of the lower level nursing unit revealed Resident #36 walked out of the northwest stairwell into the lower level hall and took a few steps toward the nurse's station. At 2:52 A.M. Resident #36 paused, looked around, dropped down to his hands and knees and crawled past the nurses station until he was about half way up the opposite hall. At the end of the hall was a door leading to the outside area and a fire alarm pull station on the wall by the door. When Resident #36 crawled by the nurse's station the nurse (RN #203) was in the nurse's station with her back to the desk and hall, she was tending to the medication cart and was not aware Resident #36 crawled by. The aide (Certified Nursing Assistant (CNA) #202) was not seen in the camera footage and the Administrator stated he did not know where she was. At 2:53 A.M. Resident #36 stood up, walked to the end of the hall by the door to the outside and the fire alarm pull area, stepped into a resident room doorway and stood there. At 3:19 A.M. CNA #202 was seen walking around by the nurses station. Review of the camera footage at 3:37 A.M. revealed Resident #36 stepped out of the resident room, laid on the ground because it appeared he saw the nurse and did not want to be detected. Resident #36 stood up and walked to the fire alarm pull area, tugged at the cover for a bit, then pulled the alarm cover up and off the alarm. At 3:39 A.M. RN #203 saw Resident #36 standing by the fire alarm area, tugging at the cover, she stood up, might have said something, and Resident #36 activated the fire alarm at 3:40 A.M. The door to the outside unlocked and Resident #36 opened the door and ran out of the facility. RN #203 ran and followed him outside and ran back in the building at 3:40 A. M. then ran to the double doors and went through them. The Administrator stated he asked Resident #36 what route he took to the gas station and Resident #36 stated he went through the woods and then by the schools. The Administrator asked Resident #36 why he left the facility and Resident #36 said he wanted to talk to cops. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Witness Statement dated 03/14/25 at 3:40 A.M. written by Licensed Practical Nurse (LPN) #205 revealed Resident #36 was agitated because he got caught trying to steal an aides back pack out of the nurse's station and was in his room listening to music. LPN #205 was in the nurse's station charting and Resident #36 left his room and went downstairs. The lower level aide (CNA #202) came up to the break room and right after that the fire alarm went off. Review of a Witness Statement dated 03/14/25 at 3:40 A.M. revealed Registered Nurse (RN) #203 was in a resident's room administering a pain medication and when she returned to the medication cart she noticed Resident #36 was at the end of the hall but she did not know what he was doing because an oxygen tank was on the counter and obstructed her view. RN #203 stated she stood up to tell Resident #36 he needed to return to his room and as she stood up Resident #36 pulled the fire alarm and escaped out of the now unlocked door. RN #203 stated she ran after him, shouting for him to come back, and she could not see where he ran. RN #203 returned to the building, ran up the stairs to alert the rest of the staff that Resident #36 ran off. RN #203 stated she ran outside along with the rest of the staff, but they could not find Resident #36. Review of a Witness Statement dated 03/14/25 at 3:40 A.M. written by Certified Nursing Assistant (CNA) #204 revealed Resident #36 was last seen in his room and was sitting on his bed. When CNA #204 heard the fire alarm he rushed directly to Resident #36's room since I knew he could do that and unfortunately he was not in his room. CNA #204 alerted his coworkers about Resident #36's absence in his room and they rushed outside to look for him. Review of a Witness Statement dated 03/14/25 at 3:45 A.M. written by Certified Nursing Assistant (CNA) #202 revealed she was on her break and did not witness Resident #36 leaving the facility. CNA #202 stated she became aware Resident #36 left the facility when the fire alarm sounded. Review of Resident #36's progress notes dated 03/14/25 at 9:06 A.M. revealed an interdisciplinary team (IDT) note stating on 03/14/25 at 3:40 A.M. the nurse observed Resident #36 pull the fire alarm and go through the now unlocked door. The nurse immediately went after him but could not see where he ran. The nurse ran back to inform the other staff members that Resident #36 was outdoors. All staff responded, the elopement protocol was immediately implemented and a search began. The Administrator, police and Resident #36's guardian were notified. At 8:35 A.M. the local police notified the Administrator that Resident #36 was located and was in their custody. Resident #36's physician and guardian were notified. Review of a facility Self-Reported Incident tracking number 258228 dated 03/14/25 at 11:46 A.M. included the Administrator was notified by nursing staff at 3:45 A.M. that Resident #36 was observed pulling the fire alarm and exiting the now unlocked door on the 300 hall (lower level). Staff followed Resident #36 outside but lost sight of him. Staff returned to the building and started the facility elopement protocol by notifying the Administrator, Resident #36's guardian and the local police. The facility staff continued ground searches until Resident #36 was located by the local Police at 8:35 A.M. The police returned Resident #36 to the facility and he was sent to the local hospital per physician orders for evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's progress note dated 03/14/25 at 12:37 P.M. revealed Resident #36 returned to the facility at 9:30 A.M. Vital signs were blood pressure 160/88, pulse 109, respirations 20, oxygen saturation was 96 percent on room air, and temperature was 98.1 Fahrenheit. Resident #36 was escorted to his room, one-to-one supervision was started, his medications were administered, and a skin assessment was completed with multiple scratches noted. Medical Director #201 gave orders to send Resident #36 to the local hospital for evaluation. Resident #36's guardian was aware. Resident #36's blood pressure was rechecked and was 132/80. Interview on 03/19/25 at 9:36 A.M. with the Director of Nursing (DON) revealed Resident #36 tried to elope from the facility in the past and had a guardian. Resident #36 hid by the door leading to the outside, waited for no staff to be around, pulled the fire alarm and ran out of the facility. The nurse (RN #203) saw Resident #36 pull the fire alarm and run out of the facility and ran after him, but lost track of him and came back into the building and started the elopement protocol. The DON stated the fire alarm releases egress and the doors open. The DON indicated the fire alarm signal was loud, staff responded and went to the doors to monitor them and make sure no other residents left the facility. The DON stated the police were involved and brought dogs to help find Resident #36, and a ground search was conducted until Resident #36 was found. Resident #36 was found at a gas station a couple miles away near busy roads at 8:35 A.M. The DON stated the temperature was about 40 degrees Fahrenheit and Resident #36 was wearing gloves, boots and long pants. The DON indicated on 03/14/25 at the time Resident #36 eloped from the facility there was one nurse and one aide working on the lower level. The DON stated the medication cart was located behind the nurse's station desk, Resident #36 crawled by the nurse's station and the nurse saw him towards the end of the hall. After Resident #36 eloped all the windows and doors were checked and staff was re-educated on the elopement policy. Observation on 03/19/25 at 10:00 A.M. revealed Resident #36 resided in the north nursing unit of the facility and it was on the main first floor level. There were stairwells and an elevator which were used to access the lower level nursing unit. The stairwells had a keypad located next to the door and required a code to be entered to be able to use the stairs to descend to the lower level. On the lower level a door was located at one end of the hall which led to the outside and near the door was a fire alarm pull station. Outside of the door was a small hill which led toward a barn and a fenced in area for horses and to the left of the door was a sidewalk leading towards an open field and a wooded area. Interview on 03/19/25 at 11:05 A.M. of CNA #202 revealed she was working on the lower level nursing unit on 03/14/25 when Resident #36 eloped from the facility. CNA #202 stated she did not know Resident #36 was in the lower level nursing unit and she told RN #203 she was taking a break and went to the main floor break room to make coffee. CNA #202 indicated during her break she heard the alarm, looked out into the hall and saw RN #203 running and RN #203 told her Resident #36 eloped from the facility. CNA #202 stated Resident #36 often came to the lower level but when he did come they directed him back upstairs because if they did not have eyes on him he would try to take other resident belongings or he tried to leave the facility. CNA #202 indicated Resident #36 used to live on the lower level and he was moved upstairs because he tried to leave the facility. CNA #202 revealed a prior incident when Resident #36 was found by the bushes and brought back right away. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/19/25 at 1:11 P.M. with LPN #206 revealed she worked on the unit Resident #36 resided on and stated the resident was still in the hospital and had not returned since his elopement on 03/14/25. LPN #206 stated Resident #36 played his music loudly, especially at night, was disruptive to the other residents, and took their belongings. LPN #206 stated Resident #36 was not supposed to go to the lower level without a staff member escorting him. LPN #206 indicated Resident #36 was very quick on his feet and very smart. LPN #206 stated the Administrator immediately changed the stairwell code if a resident on the main level had the code because none of them were supposed to have it, but they could ride the elevator to the lower level and it was easier to monitor who was going up and down. LPN #206 indicated Resident #36 was definitely an elopement risk, had been on every 15 minute checks in the past, saw a psychiatrist, has had medication changes and should not have the code to the stairwell. LPN #206 stated Resident #36 waited for his opportunity. Interview on 03/19/25 at 3:07 P.M. with the Administrator, the Director of Nursing (DON) and Interim DON (IDON) #207 revealed staff should monitor and redirect Resident #36 if they saw him go by doors to the outside. The DON stated when the facility had fire drills the staff would immediately make sure Resident #36 was in his room and everyone knew this. The DON stated she did not know if it was written as an intervention anywhere in Resident #36's medical record. The Administrator stated the main level was more secure because residents had to try harder to leave than if they resided on the lower level, and staff were always checking with Resident #36 to see how things were going. The Administrator stated changing the stairwell code and not allowing Resident #36 to use the stairwell would be difficult to enforce because Resident #36 would linger by the stairwell and see what the code was when others used it or another resident would give him the code. The DON stated hourly rounds were made to check on Resident #36 and other residents and if he was on the lower level he would be redirected back to his nursing unit. The Administrator stated they tried to make life here as enjoyable as possible without being overly restrictive. Interview on 03/19/25 at 4:33 P.M. with CNA #204 revealed he was working on 03/14/25 when Resident #36 eloped from the facility. CNA #204 stated most of the time Resident #36 was okay to take care of but sometimes he got agitated and shouted. On those occasions CNA #204 was able to calm him down. CNA #204 stated Resident #36 had tried to get out of the facility in the past and when there was a fire drill he checked on him right away. On 03/14/25 he checked on Resident #36 as soon as he heard the fire alarm, but Resident #36 was not in his room. Interview on 03/19/25 at 5:36 P.M. with the Administrator, DON, and IDON #207 revealed the stairwell code was not changed if a resident was at risk, but the resident was not provided the stairwell code. The DON and Administrator confirmed Resident #36 did not have an elopement assessment completed since 08/10/24 and his care plan was not updated with new interventions as noted above. Review of the facility undated policy titled Missing Resident and Elopement revealed it was the policy of the facility to provide a safe and secure environment for all residents. In the event of resident elopement, it was the policy of the facility to implement its policies and procedures immediately to locate the resident in a timely manner. This deficiency represents non-compliance investigated under Control Number OH00163709.