STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38523 Based on closed record review, facility policy review and interview, the facility failed to report an incident of neglect involving Resident #95 to the State Agency as required. This affected one resident (#95) of four residents reviewed for neglect. The facility census was 91. Findings include: Review of Resident #95's closed medical record revealed an admitted [DATE] with diagnoses including adult failure to thrive, malnutrition and metabolic encephalopathy. Review of a social service progress note, dated 12/19/24, revealed Resident #95 admitted to the facility for short term rehabilitation services after a recent hospitalization . She was a full code status (advance directives) and her discharge plan was to return to her private residence where she lived alone. The note indicated Resident #95 received support from her brother. Resident #95 used a cane and a walker at home. The note indicated Resident #95 was a questionable historian who seemed confused. Review of Resident #95's care plan, initiated on 12/23/24 revealed the resident was identified to be a falls/safety/risk/elopement risk. A listed goal included Resident #95 would remain free from injuries and falls. Care planned interventions included to encourage use of the call light, if unable to utilize call light nursing assistants would assess the resident every 30-60 minutes, instruct the resident on safety measures, and keep call light in reach. Review of Resident #95's Minimum Data Set (MDS) 5-day assessment, dated 12/24/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severely impaired cognition. Resident #95 required partial/moderate (staff) assistance for activities of daily living (ADLs). Resident #95's mood interview could not be conducted as the resident was rarely/never understood. The assessment indicated Resident #95 had no behaviors. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/31/24 at 9:20 A.M. with the Administrator, Corporate Regional Nurse #505, and Corporate Director of Clinical Services #508 revealed Resident #95 eloped from the facility and was found unresponsive on the morning of 12/24/24 outside the facility doors on a back patio. Corporate Regional Nurse #505 confirmed the staff working that night had not performed their routine, every 2-hour checks on Resident #95. The facility investigated the incident and implemented corrective action related to the incident of elopement following the incident; however, the facility did not report the incident to the State Agency (SA) as an incident of neglect that resulted in the resident's death. This was verified by administrative staff at the time of the interview. Attempts to reach Former Administrator #504 on 01/02/24 at 9:50 A.M. and 12:59 P.M. were unsuccessful. Review of the undated facility policy titled Abuse Prohibition revealed each resident has the right to be free from abuse and neglect. The policy defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. All allegations of abuse, neglect, and misappropriation of property are immediately reported, thoroughly investigated and appropriate actions taken. This deficiency represents noncompliance investigated under Complaint Number OH00161082 and Complaint Number OH00161073.

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(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 - Immediate jeopardy to resident health or safety 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** 38523 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, closed medical record review, review of the local police report, staff interviews, review of the National Weather Service forecast, review of the facility Elopement Policy and Procedure, review of Abuse, Neglect and Misappropriation Policy and Procedure, and review of camera footage, the facility failed to provide adequate supervision to prevent Resident #95, who had diagnoses of metabolic encephalopathy, malnutrition, and adult failure to thrive and severe cognitive impairment, from leaving the facility without staff knowledge. This resulted in Immediate Jeopardy and actual harm leading to death beginning on [DATE] at approximately 8:40 P.M. when Resident #95 was last seen inside the facility. On [DATE] at 9:30 P.M., [DATE] at 12:36 A.M. and [DATE] at approximately 4:00 A.M. staff identified Resident #95 was not in the facility but failed to take sufficient action to determine her whereabouts. On [DATE] at 6:09 A.M., Licensed Practical Nurse (LPN) #500 began phoning nursing management regarding Resident #95 missing from the facility. At 6:22 A.M., LPN #500 reached Registered Nurse (RN) #484, who was off-duty and off-site, via phone and informed her Resident #95 was missing. A code purple (facility code for an elopement) was called and a search of the facility and property began. RN #484 arrived at the facility at approximately 7:30 A.M. and assisted with search efforts. The local police department was then called, responded to the facility and assisted in search efforts. On [DATE] at approximately 8:10 A.M., RN #484 was informed a wheelchair was observed in the stairwell of the lower level. RN #484 observed the chair, continued up the stairs near where the wheelchair was found and opened the door which exited to the outside, where she met resistance. RN #484 observed Resident #95 lying on the patio outside the exit door to the facility. Resident #95 was observed cold to touch, wet, and without respirations or a heart rate. RN #484 screamed for help and initiated cardiopulmonary resuscitation (CPR). Additional staff responded to the area. Emergency Medical Services (EMS) was contacted, and Resident #95 was transported to a local hospital where she was unable to be resuscitated and was pronounced deceased on [DATE] at 8:57 A.M. On [DATE] at 11:14 A.M., the Administrator, Corporate Regional Director of Operations #507, and Corporate Director of Clinical Services #508 were notified Immediate Jeopardy began on [DATE] at 8:40 P.M. when the facility failed to provide adequate supervision to prevent Resident #95 from eloping. Between [DATE] at 8:40 P.M. and [DATE] at 8:10 A.M. the facility failed to have adequate and effective systems in place to ensure the resident's safety and supervisory needs were met. During this time period, facility staff failed to recognize the resident had exited the facility unsupervised and was missing from the facility. On [DATE] at 8:10 A.M. Resident #95 was found lying on the patio outside the exit door to the facility. Resident #95 was observed cold to touch, wet, and without respirations or a heart rate. RN #484 screamed for help and initiated cardiopulmonary resuscitation (CPR). Additional staff responded to the area. Emergency Medical Services (EMS) was contacted, and Resident #95 was transported to a local hospital where she was unable to be resuscitated and was pronounced deceased on [DATE] at 8:57 A.M. due to environmental exposure. The Immediate Jeopardy was removed on [DATE] and the deficiency corrected on [DATE] when the facility implemented the following corrective actions: (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 6:22 A.M., LPN #500 phoned RN #484 and informed her Resident #95 was missing and attempts to reach the resident's brother were unsuccessful. RN #484 provided instructions to activate a code purple. RN #484 notified Certified Nurse Practitioner (CNP) #502. RN #484 arrived at the facility at 7:18 A.M. On [DATE] at approximately 7:25 A.M., the local police department was notified Resident #95 was missing. Officer #506 responded and collected information and staff statements. On [DATE] at approximately 7:45 A.M., the facility remained in a code purple and continued to search for Resident #95. On [DATE] at approximately 8:10 A.M., Housekeeping Staff #485 informed RN #484 of a wheelchair he observed in a lower-level stairwell. Housekeeping Staff #485 escorted RN #484 to the wheelchair. RN #484 identified the chair as Resident #95's, proceeded up the stairs, and opened the exit door (to the outside) at the top of the stairs. RN #484 identified Resident #95 was lying outside of the facility door and yelled for help. Resident #95 was unresponsive, and CPR was initiated and continued until EMS arrived and transported Resident #95 to a local hospital where she was pronounced deceased . On [DATE], the facility's elopement policy was reviewed by Corporate Regional Nurse #505. No updates or revisions were made. On [DATE], Corporate Regional Nurse #505 re-educated the Administrator and Director of Nursing (DON) on the facility's elopement policy and procedures including assessment, identification, monitoring, and managing the elopement policy. On [DATE] at 8:30 A.M., the Administrator began education with all staff on the elopement policy and procedure, including door alarms and prompt response. Education was additionally provided on abuse, neglect and misappropriation. Nursing staff members received further education on nurse-to-nurse responsibilities regarding census. The education was completed on [DATE] by 5:00 P.M. On [DATE] at 9:00 A.M., Corporate Regional Nurse #505, Corporate Director of Operations #507, Corporate Director of Clinical Services #508, and the Former Administrator #504 walked the building and checked all doors to ensure the doors alarmed and worked properly. On [DATE] at 9:15 A.M. a head count of all residents was completed by LPN #438. All residents were accounted for except for Resident #95. On [DATE] at 9:10 A.M. a contracted door alarm company was contacted to check doors, change door keypad codes, and discuss options to enhance the sounding of the door alarms. The door alarm company installed six additional remote sounders in different locations of the facility, including inside the door at the top of the stairs Resident #95 used to exit the facility. These sounders were installed on [DATE] by 6:00 P.M. On [DATE] all residents residing in the facility were assessed by RN #379 and RN #407. No residents were identified to have any injuries or adverse effects. The resident assessments were completed on [DATE] by 2:30 P.M. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] all residents were re-assessed for elopement risk by LPN Unit Manager (UM) #434. The assessments were completed by 3:00 P.M. The facility identified zero in-house residents at risk for elopement. Ongoing audits would be completed by the DON or designee upon admission, re-admission, quarterly, with significant changes, and as needed. On [DATE], LPN #438 verified all elopement risk assessments were completed with no residents at risks. No care plan revisions related to elopement were required for in-house residents. This was completed on [DATE] by 5:00 P.M. On [DATE] at 2:00 P.M., an ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held. In attendance were Former Administrator #504, the DON, ADON #411, Maintenance Supervisor #381, Social Service Designee (SSD) #447, LPN #438, Human Resources (HR) Staff #601, Business Office Manager (BOM) #404, Corporate Regional Nurse #505, Corporate Director of Clinical Services #508, Corporate Director of Operations #507. Medical Director (MD) #503 attended via phone. During the meeting, the corrective action plan for Resident #95's elopement was presented by the Administrator and approved by the interdisciplinary team (IDT). On [DATE], the facility implemented random and unannounced elopement drills to be performed three times weekly for four weeks, monthly on all shifts for four months, then monthly on rotating shifts. The elopement drills were coordinated by the Administrator or designee. The results of the drills would be reviewed by the IDT in monthly QAPI meetings. Ongoing audits were implemented to ensure staff hears and responds to alarms timely and appropriately three times weekly for four weeks. The results of the audits would be reviewed by the IDT in monthly QAPI meetings. Ongoing audits were implemented to ensure that with each change of nurse shift, a head count was performed and verified with census records. The results of the audits would be reviewed by the DON or designee daily for 30 days. The results of the audits would be reviewed by the IDT in monthly QAPI meetings. On [DATE], all exterior doors added a door alarm that required alarm de-activation to be turned off with a manual key entry. All doors with alarms were noted to be functioning properly. Findings include: Review of the closed medical record for Resident #95 revealed an admitted [DATE] with medical diagnoses including metabolic encephalopathy, malnutrition, and adult failure to thrive. Resident #95 was transported to a local hospital where she was pronounced deceased on [DATE]. Review of the most recent elopement assessment dated [DATE] revealed the assessment did not identify Resident #95 to be at risk for elopement. The assessment noted the resident was cognitively impaired with poor decision-making skills and confusion. Resident #95 was noted to be a recent admission (within the last 30 days) and not accepting of the situation. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a social service progress note, dated [DATE], revealed Resident #95 admitted to the facility for short term rehabilitation services after a recent hospitalization . She was a full code status (advance directives) and her discharge plan was to return to her private residence where she lived alone. The note indicated Resident #95 received support from her brother. Resident #95 used a cane and a walker at home. The note indicated Resident #95 was a questionable historian who seemed confused. Review of Resident #95's care plan, initiated on [DATE] revealed the resident was identified to be a falls/safety/risk/elopement risk. A listed goal included Resident #95 would remain free from injuries and falls. Care planned interventions included to encourage use of the call light, if unable to utilize call light nursing assistants would assess the resident every ,d+[DATE] minutes, instruct the resident on safety measures, and keep call light in reach. Review of Resident #95's Minimum Data Set (MDS) 5-day assessment, dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. Resident #95 required partial/moderate (staff) assistance for activities of daily living (ADLs). Resident #95's mood interview could not be conducted as the resident was rarely/never understood. The assessment indicated Resident #95 had no behaviors. Review of the National Weather Service forecast at www.weather.gov revealed the weather in the Cleveland area on [DATE] revealed a high temperature of 41 degrees Fahrenheit (F) and a low of 20 degrees F. The forecast for [DATE] and [DATE] called for rain on-and-off. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a police report dated [DATE] revealed a call was placed at 7:27 A.M. in regard to a resident of the facility that had not been seen since [DATE] at 8:40 P.M. Officer #506 arrived on site at the facility at 7:32 A.M. and met with facility staff. The report noted RN #423 began her assigned nursing shift on [DATE] at 7:00 P.M. and completed her assigned check on Resident #95 at approximately 8:40 P.M. At approximately 9:00 P.M., RN #423 was re-assigned to another unit, and LPN #500 assumed care (for this resident). LPN #500 was noted in the report as having completed her first check on Resident #95 at approximately 9:30 P.M. LPN #500 noted Resident #95 was not in her room and assumed the resident had left the facility with her brother, as she had previously left the faciity on a prior date for a few hours. LPN #500 stated she checked the visitors log, but noted no visitors had come inside the facility to visit Resident #95. No further action was taken until [DATE] at approximately 12:36 A.M., LPN #500 attempted to call Resident #95's brother multiple times without success. The report noted LPN #500 stated multiple times that she was a new nurse and was unsure what to do after that. On [DATE] at approximately 6:30 A.M., LPN #500 contacted an off-duty nurse, RN #484 about Resident #95's disappearance. Following the phone call, a code purple was called, after which Resident #95 was still not found. LPN #500 was instructed by RN #484 to complete a thorough search both inside and of the perimeter outside of the building. While awaiting administration in the lobby, Resident #95's brother returned a phone call to LPN #500 and provided the phone to the officer. Resident #95's brother did not know where Resident #95 was and stated he had not picked her up. The brother reported to the officer he visited the resident on [DATE] at approximately 5:30 P.M. and the resident stated she wanted out of the facility. The brother provided a prior address where the resident could be, or stated there was a chance the resident remained on the property and was hiding from the nurses. The report indicated a short time later, multiple screams were heard, and the officer ran in the direction of the screams. Nurses escorted the officer outside to the north side patio of the building, outside the activity room exit, where Resident #95 was observed lying on her back in the corner of the patio. Resident #95 was unresponsive, her eyes and mouth wide open. Resident #95 was cold to the touch. The officer called for dispatch to send Emergency Medical Services (EMS). While waiting for EMS to arrive, nurses began to perform CPR on Resident #95. Resident #95 was placed on a stretcher and transported to a local hospital where she was pronounced deceased on [DATE] at 8:57 A.M. Review of a progress note dated [DATE] at 6:45 A.M., authored by LPN #500, revealed upon the start of her shift she had checked on Resident #95, who was not in her room. The note indicated a thorough check of the nursing unit was completed. LPN #500 checked Resident #95's electronic medical record and LOA in notes verified. At 12:36 A.M., LPN #500 noted the resident had not returned to the facility and LPN #500 attempted to call Resident #95's brother at least 15 times with no answer. At 6:09 A.M., LPN #500 began to call an unnamed Unit Manager without success. At 6:22 A.M., LPN #500 phoned RN #484 and informed her Resident #95 had not returned to the facility. Review of the facility investigation into Resident #95's elopement revealed the following witness statements following the incident: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. LPN #500 provided a written statement on [DATE] at 9:00 A.M. The statement revealed LPN #500 arrived to work on [DATE] at approximately 9:15 P.M. and took over the lower level nursing assignment from RN #423. She indicated the nurse had written out shift change report and needed to finish passing resident medications. LPN #500 first walked down the hall to check on the residents. LPN #500 recalled looking into Resident #95's room and saw the resident was missing at 9:27 P.M. After she checked the notes to see if there was a LOA for the resident, there was a prior note indicating the resident was LOA. The statement indicated after midnight ([DATE]) at 12:36 A.M. LPN #500 attempted to contact Resident #95's brother, and later at 6:22 A.M. she called RN #484. Resident #95 was later found on the patio balcony near the activities room and the resident was taken [off facility grounds] by EMS. b. RN #423's undated witness statement revealed she was Resident #95's nurse on [DATE] from 7:20 P.M. until approximately 9:45 P.M. RN #423 administered Resident #95 her evening medication at 7:45 P.M. At that time, Resident #95 was seated in her wheelchair beside the nurse's station and had no signs of anxiety or agitation. Around 8:30 P.M., RN #423 received information from the facility scheduler of a change of assignment to the upper level of the facility and another nurse was coming in to take over her assignment. RN #423 recalled the oncoming nurse arrived at the facility on [DATE] at approximately 9:45 P.M., she gave her the keys to the [medication] cart and gave LPN #500 report before heading to the upper level for the remainder of her shift. RN #423 stated she did not know or hear anything about Resident #94 until [DATE] at approximately 6:00 A.M. when the lower-level nurse reported the resident was not in her room since 10:30 P. M. c. LPN #429 was interviewed on [DATE] by phone by HR Staff #601. LPN #429 recalled she was the nurse assigned to cart 1 of the lower level. LPN #429 revealed she clocked in [on [DATE]] at approximately 10:45 P. M. and was unfamiliar with Resident #95. LPN #429 recalled that [on [DATE]] at approximately 6:20 A.M., she was informed the resident was missing. d. Certified Nursing Assistant (CNA) #501 was interviewed on [DATE] by HR Staff #601. CNA #501 arrived at the facility [on [DATE]] at approximately 9:00 P.M. CNA #501 recalled he looked into Resident #95's room for the first time on his shift [on [DATE]] between 12:00 A.M. and 1:00 A.M. but never went inside the resident's room and assumed she was sleeping. CNA #501 stated it was after 4:00 A.M. when he inside Resident #95's room for the first time on his shift and he assumed she was gone based on the condition of the resident's room; the resident's bed was unmade, and linen and trash was on the floor. CNA #501 stated he meant to ask LPN #500, but it slipped his mind. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Root Cause Analysis (RCA) dated [DATE] revealed the incident involved a resident (Resident #95) being found unresponsive outside of the facility, on the patio outside the activity room door. A 5 Whys was reviewed and indicated the resident had gone up the stairs unattended and out the exterior door. Staff did not respond to alarm going off on the first floor into the stairwell appropriately, did not check the area and perform a headcount, nor did staff complete routine checks. The RCA listed LPN #500 assumed Resident #95 was on LOA, CNA #501 stated he did not see the resident on [DATE] at 4:00 A.M. and forgot to tell his nurse. CNA #501 additionally had stated he did not see the resident his whole shift. No staff admitted to turning off the alarm, and the facility cameras did not show this area. LPN #500 had received an order from the provider for Resident #95 to go on LOA visits with her brother, and assumed the resident was out on an LOA. The RCA concluded there was ineffective shift-to-shift report, a lack of urgency around code purple with a failure to identify a missing resident versus an assumed LOA, lack of validation of frequent checks and rounding, and a failure to respond appropriately to the door alarms with an immediate head count and checking of the surrounding area. The RCA action plan and monitoring referenced the facility's abatement plan. Interview on [DATE] at 9:20 A.M. with the Administrator, Corporate Regional Nurse #505, and Corporate Director of Clinical Services #508 revealed Resident #95 had not been identified as an elopement risk upon admission to the facility, but did elope from the facility and was found unresponsive on the morning of [DATE] outside the facility doors on a back patio. Corporate Regional Nurse #505 confirmed the staff working that night had not performed their routine, every 2-hour checks on Resident #95. The facility investigated the incident and implemented corrective action following the incident. Interview on [DATE] at 1:49 P.M. with Corporate Regional Nurse #505 confirmed the facility had an alarm to the lower-level stairwell door. Corporate Regional Nurse #505 confirmed the door had to have been alarming at the time Resident #95 exited; however, no staff members working recalled or admitted de-activating an alarm between [DATE] at 9:00 P.M. and [DATE] at 8:00 A.M. All staff in the building who worked between [DATE] at 7:00 P.M. and [DATE] at 7:00 A.M. were interviewed and none reported hearing any door alarm going off during their shift, nor had any staff reported turning off or deactivating any sounding alarm during their shift. The two staff members assigned to care for Resident #95 on the night of [DATE], LPN #500 and CNA #501, were terminated following this incident. Interview and observation on [DATE] at 1:54 P.M. of the facility with Corporate Regional Nurse #505 revealed Resident #95 resided on the lower level of the facility. The location Resident #95's wheelchair was found at the base of the stairs was not visible from the small window of the door to the stairwell. At the top of the stairs, a one-way swing gate was present, and two doors were noted on the second-floor landing. One door with a keypad alarm was locked and had a key code (to enter the main/second level) and one door exited to the outside back patio. Corporate Regional Nurse #505 stated the exit door to the back patio was unlocked for safety. The door alarm had the capability to alarm, but the key was stored in the alarm and turned to the off position on the date Resident #95 eloped from the facility. Corporate Regional Nurse #505 confirmed following the incident, the door alarm company added a louder-sounding alarm requiring a manual key to de-activate. The key was removed from the door alarm and was held by administrative and nursing staff. If the alarm was activated, administrative or nursing staff would respond with the key, deactivate the alarm, and would be responsible for ensuring all residents were accounted for. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 3:48 P.M. with RN #484 revealed she received a call from LPN #500 on [DATE] at approximately 6:20 A.M. RN #484 stated she was unsure why LPN #500 phoned her but said she had tried to call other department leaders without success. LPN #500 told her Resident #95 was missing, she advised LPN #500 to call a code purple, to check the building and the outside perimeter of the building and that she would be on her way into the facility. RN #484 estimated she arrived at the facility on [DATE] at approximately 7:15 A.M. and upon arrival LPN #500 and LPN #429 informed her they had checked the building and perimeter, and Resident #95 remained missing. RN #484 instructed them to phone the police, who responded a few minutes later at approximately 7:30 A.M. During this time, staff continued to search for Resident #95, and RN #484 and Officer #506 waited for Former Administrator #504 at the front door to update her. A short time later, RN #484 was informed by Housekeeping Staff #485 that he located a wheelchair in the lower-level stairwell. Housekeeping Staff #485 escorted RN #484 to the wheelchair. RN #484 identified the chair as Resident #95's, proceeded up the stairs, and opened the exit door (to the outside) at the top of the stairs. RN #484 identified Resident #95 was lying outside of the facility door and yelled for help. Resident #95 was soaking wet, as it had rained all night. Resident #95 was unresponsive, and CPR was initiated and continued until EMS arrived and transported Resident #95 to a local hospital where she was pronounced deceased . Review of the police report addendum dated [DATE] revealed Officer #509 visited the facility that day to see the room Resident #95 had resided in and see the route she traveled to get outside the facility. Officer #509 was accompanied by Corporate Director of Operations #507. The report noted across Resident #95's former room was a door that led to a stairwell. The door to the stairwell had a keypad and a horizontal push bar to open the door. Once the push bar was pressed, a faint audible alarm does sound. If the push bar was pressed and held for 15 seconds, the door automatically opens without the code. At the top of the stairwell, the door to the right was locked with a keypad and led to the interior of the main floor. If the door handle was held for 15 seconds, the door would open. The door to the left was the door Resident #95 exited out of, which lead to an exterior patio area. The door does not have an alarm or keypad when opened, was not locked, and could be opened without a code and without waiting for 15 seconds like the other doors did. The police report addendum noted on [DATE], Officer #509 typed up paperwork for criminal charges related to this incident for an unnamed individual. The charges included Involuntary Manslaughter and Gross Patient Neglect. The report noted the paperwork was signed by a local judge and returned to the officer. No further information or addendum was available at the time of the on-site investigation. Attempts to reach Former Administrator #504 on [DATE] at 9:50 A.M. and 12:59 P.M. were unsuccessful. A telephone interview was attempted on [DATE] at 9:52 A.M. with LPN #500 but was unsuccessful. Telephone interview on [DATE] at 10:54 A.M. with CNA #501 revealed he had been told (on [DATE]) by an unnamed staff member Resident #95 was out on a LOA. CNA #501 recalled he went about his duties, answered call lights and assisted other residents. CNA #501 stated he did not work with Resident #95 often. When he entered the room later in the shift, Resident #95 was not in her room. CNA #501 stated he assumed she was not in the building. CNA #501 stated he went home at the conclusion of his shift on [DATE] at 7:00 A.M. CNA #501 stated he never heard any alarm, nor had to enter any codes to de-activate any door alarms during his shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	01/10/2025

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on [DATE] at 2:00 P.M. with Director of IT #610 revealed the facility had both interior and exterior cameras that covered the facility common areas, the front door, the back service hall, the front parking lot, and the generator area near the back patio. Director of IT #610 pulled up camera footage from [DATE] to [DATE] and there was no evidence or video of Resident #95 exiting the facility. Director of IT #610 stated the facility's cameras were not infrared, and once it becomes dark outside, the video footage appeared all dark. The area where Resident #95 was located on the back patio was not visible from any camera angle. The only evidence of Resident #95 on the facility's video footage was when she was on a gurney being removed from the back patio to be transported to a local hospital by the EMS providers. At that time, Resident #95 was observed wearing grey pants and a long-sleeved top. A telephone interview was attempted on [DATE] at 1:11 P.M. with Resident #95's brother and was unsuccessful. An interview on [DATE] at 1:20 P.M. with Corporate Director of Clinical Services #508 revealed the facility was informed Resident #95's preliminary cause of death was environmental exposure and hypothermia. Resident #95's official death certificate remained pending at the time of the on-site investigation. Review of the undated facility policy titled Abuse Prohibition revealed each resident has the right to be free from abuse and neglect. The policy defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. All allegations of abuse, neglect, and misappropriation of property are immediately reported, thoroughly investigated and appropriate actions taken. Review of the facility policy titled Elopement revised ,d+[DATE] revealed a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. This situation represents a risk to the resident's health and safety. If a resident is missing from the facility, the Administrator and Director of Nursing will be notified immediately. The physician and responsible party will be notified. The nurse or designee will initiate a full house head count of the residents. A staff member will announce code purple over the intercom system to alert the staff that a search will begin for the resident. Once the announcement has been made, staff will report to the nurse's station and await further instruction from the Administrator, DON, or charge nurse. A thorough search of the inside of the facility and outside grounds of the facility will be conducted. If the resident is not located after the staff has searched the internal and external grounds, the local police department will be notified. Following the incident, a detailed investigation into the circumstances surrounding the incident will be completed by the Administrator and Director of Nursing. The Interdisciplinary Team (IDT) will meet following an elopement. Cases of elopement will have correction action and tracking by the Quality Assurance committee. This deficiency represents noncompliance investigated under Complaint Number OH00161082 and Complaint Number OH00161073.