STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366491	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strongsville Healthcare and Rehabilitation	18936 Pearl Road Strongsville, OH 44136

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** 37096 Based on interview, record review, review of facility video footage, review of the Ohio Department of Health (ODH) Certification and Licensure System (CALS) and review of the facility policy, the facility failed to ensure an allegation of potential neglect was reported to the State Survey Agency as required. This affected one (Resident #37) of six residents reviewed for neglect. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including dementia, chronic kidney disease Stage IV, depression, and post traumatic stress disorder (PTSD). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 had severe cognitive impairment. Review of a care plan dated 09/03/24 revealed Resident #37 was an elopement/wander risk related to impaired safety awareness. Interventions included distracting the resident from wandering by offering pleasant diversions, structured activities, food conversation, television, or books. The care plan additionally instructed staff to provide structured activities including toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Review of a police report dated 11/24/23 at 12:20 A.M. revealed a call was received from a concerned citizen that an elderly confused male was found sitting on the curb of the apron in front of a business. The citizen stated she would stand by in a white jeep with her flashers on until the police arrived. The police arrived on 11/24/24 at 12:30 A.M. and found the elderly male confused and had bleeding to his left hand. Officer #575 provided first aid and called for an ambulance. The elderly male was identified as Resident #37. The resident told police he lived in [NAME], Wisconsin and believed he was still there. Resident #37 stated he was out for a walk and fell . Resident #37 was sent by squad to the emergency room (ER) for further evaluation. Dispatch reached out to several nursing homes in the area and verified the nursing facility where Resident #37 resided. On 11/24/24 at 12:50 A.M. Resident #37's daughter was notified Resident #37 was in the ER. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366491	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER: Strongsville Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 18936 Pearl Road Strongsville, OH 44136	

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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	Review of a progress note dated 11/24/24 at 1:13 A.M. revealed another nurse received a phone call stating a male resident (later identified to be Resident #37) was found outside and taken to the ER. A head count was initiated, and all doors were checked to ensure doors and alarms were working properly. The ER called and reported the resident (#37) was okay and received imaging which resulted in negative findings. On 12/02/24 at 4:20 P.M. review of video footage with the Administrator revealed the video was a copy of a video taken on a computer screen. There was no date, but the time stamp read 11:07 P.M. The Administrator revealed the original video had a date of 11/23/24 and was no longer available. The video was viewed partially from a computer monitor and then from the Administrator's cell phone to get a clearer picture. In the video, Resident #37 was viewed standing in the lobby in front of the first set of doors with his right hand by the keypad located to the right of the sliding door. The lobby door opened (by a visiting female from the outside) and Resident #37 walked through the lobby door and stood in the vestibule between the entrance to the inside lobby and the outside main door for several seconds. A visiting female was then seen watching Resident #37 exit the vestibule through the outside door of the building. The visiting female walks through the lobby door turns around and was seen looking out of the doors, the lobby door was still open. The visiting female punched in a code and the lobby doors closed. The visiting female proceeds several feet through the lobby, pauses and turns one more time to look out the door of the lobby and proceeded to walk into the building. Review of the ODH CALS website revealed no Self-Reported Incident (SRI) of potential neglect had been reported regarding Resident #37's elopement from the facility. Interview on 12/03/24 at 9:00 A.M. with the Administrator stated she did not complete a SRI report to the State Survey Agency. The Administrator stated she received guidance from corporate stating elopements are not reportable. Review of the policy Abuse, Prohibition revised October 2022 revealed in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is make, if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures. This deficiency represents an incidental finding while investigating Complaint Number OH00160218.

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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** 37096 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, medical record review, review of local police report, resident, family, and staff interviews, local police detective interview, review of the National Weather Service forecast, review of the facility Elopement Policy and Procedure, review of camera footage, the facility failed to provide adequate supervision to prevent Resident #37, who had a diagnosis of dementia, post- traumatic stress disorder (PTSD) and severe cognitive impairment, from leaving the facility without staff knowledge. This resulted in Immediate Jeopardy and the potential for serious harm, injury, or death when Resident #37 was seen (by camera footage) on 11/23/24 at 11:07 P.M. standing inside the facility in front of the main door when a visiting family member entered from outside, punched in the door code and let Resident #37 out of the building without notifying staff. The resident's whereabouts remained unknown until 11/24/24 at 12:20 A.M. when a concerned citizen called the local police department after finding a confused male (later identified as Resident #37) sitting on the curb of a five-lane, heavily traveled street with speeds of 25 miles per hour (mph) to 35 mph approximately 0.6 miles from the facility. On 11/24/24 at 12:30 A.M. the police arrived and found Resident #37 confused with an abrasion to his left hand due to a fall. The squad transported Resident #37 to the emergency room (ER) for further evaluation. On 11/24/24 at 12:50 A.M. Licensed Practical Nurse (LPN) #423 received a call from the local police department stating Resident #37 was transported to the ER. The resident was missing from the facility for approximately one hour and 45 minutes without the knowledge of staff. The ambient air temperature outside on 11/23/24 was between 43 and 47 degrees Fahrenheit (F). This affected one resident (#37) of five residents reviewed for elopement. The facility identified 20 residents, #9, #19, #27, #37, #41, #44, #47, #49, #50, #52, #58, #59, #62, #63, #74, #75, #76, #83, #85, #90, who were at risk for elopement. The facility census was 89. On 12/03/24 at 1:30 P.M., the Administrator, Director of Nursing (DON), and Regional Director of Clinical Services (RDCS) #300 were notified Immediate Jeopardy began on 11/23/24 at 11:07 P.M. when the facility failed to provide adequate supervision to prevent resident elopement. Resident #37 was seen at the front door standing by the keypad when another resident's family member punched in the code and let Resident #37 out of the building and did not notify staff. A staff member reported hearing the door alarm sound, but did not respond as the staff member assumed the alarm was activated by staff member retrieving food. The Immediate Jeopardy was removed and deficiency corrected on 11/25/24 when the facility implemented the following corrective actions: On 11/24/24 at 12:43 A.M. the facility was alerted by the local police department Resident #37 was missing from the facility On 11/24/24 at 12:45 A.M. the door alarms were checked by LPN #500. On 11/24/24 at 1:00 A.M. RDCS #300 reviewed the facility elopement policy with no changes being made to the policy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/24/24 at 1:00 A.M. the Administrator and DON were re-educated on the facility elopement policy by RDCS #300. On 11/24/24 at 3:11 A.M., upon return from the local ER, Resident #37 was placed on 1:1 supervision with Certified Nursing Assistant (CNA) #581. On 11/24/24 at 3:14 A.M., Resident #37 was assessed by the DON upon his return from the local ER. On 11/24/24 at 3:30 A.M., Resident #37's care plan was updated by Registered Nurse (RN) Minimum Data Set (MDS) Coordinator #350. The update included the addition of 1:1 supervision. On 11/24/24 at 11:30 A.M. Resident #37's 1:1 supervision was discontinued, and the resident was transferred to the facility secured memory care unit. Elopement risk assessments were completed on all 89 residents who resided in the facility. This was completed on 11/24/24 at 6:00 A.M. by RN Unit Manager #524. The assessments noted 20 residents were identified at high risk for elopement. All residents at high risk of elopement resided on the secured memory care unit. Subsequent elopement assessments would be completed on a quarterly and as-needed basis by the nursing leadership team. The Administrator re-educated all staff on 11/24/24 at 10:07 A.M. on the facility's elopement policy and procedure. Residents at high risk of elopement were listed in an elopement binder kept at the front desk. The binder was updated on 11/24/24. The binder included the resident's demographics, including a photograph. The elopement binder would be reviewed 5 times weekly and updated as needed by the Administrator or designee. The front door entrance code was changed on 11/24/24 by Maintenance Director #499. The facility implemented a plan for the door code to be changed weekly for six months, then as needed to address family members having the access codes. Resident #37's daughter and Visiting Family Member #375 were re-educated on the facility's elopement policy, visitation, and door access on 11/24/24 by the Administrator. An elopement drill was completed on 11/24/24 at approximately 1:00 A.M. This was coordinated by Director #499. The facility implemented a plan for ongoing elopement drills to be completed to verify staffs understanding and implementation of the facility elopement policy on alternate shifts monthly for six months, then quarterly thereafter. This would be completed by Maintenance Director #499 and overseen by the Administrator. On 11/25/24 at 9:00 A.M., signage was placed at the front entrance for families, visitors, and residents stating, Visiting Hours are 8am-8pm. Doors are locked in off-hours to ensure the safety of our residents. Call [PHONE NUMBER] for after-hour assistance. Questions may be directed to the Administrator. This was completed by the Administrator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/25/24 at 9:30 A.M, an ad hoc Quality Assessment and Performance Improvement (QAPI) meeting was held. The Administrator presented the QAPI Team with investigation and all findings for discussion and review. Discussion included an action plan from the (elopement) incident involving Resident #37. Staff in attendance included the Administrator, DON, RN Unit Manager #524, RN MDS Coordinator #350, Social Service Designee (SSD) #710, Therapy Director #715, Activity Director #720, Maintenance Director #499, Housekeeping/Laundry Director #730, Food Service Director #735, Medical Director #765, Human Resources Director #755, Business Office Manager (BOM) #740, Admissions Coordinator #745, Pharmacy Consultant #760, and Scheduler #750. The facility implemented a plan for ongoing audits to monitor elopement risk to be completed on each unit and include a random sample of 3-5 residents weekly for four weeks, then randomly thereafter. The audits would include monitoring for residents who were exhibiting signs or symptoms which could be indicative of an increased elopement risk such as residents wandering aimlessly, with cognitive impairments, behavior patterns, packed belongings, statements of wanting to leave the facility, and/or staying near an exit door as well as auditing door codes and staff response time for door alarms. The audits would be completed by the Administrator, DON, or designee. The results of the audits would be reviewed in QAPI. The facility implemented a plan for all new employees to receive education on the facility's elopement policy upon hire during orientation by HR Director #755 or designee, then annually and as needed thereafter. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including dementia, chronic kidney disease Stage IV, depression, and PTSD. Review of the most recent elopement assessment dated [DATE] revealed the assessment did not identify the resident to be at risk for elopement. A care plan dated 09/03/24 revealed Resident #37 was an elopement/wander risk related to impaired safety awareness. Interventions included distracting the resident from wandering by offering pleasant diversions, structured activities, food conversation, television, or books. The care plan additionally instructed staff to provide structured activities including toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. Resident #37 required supervision with eating, toileting and transfers. The assessment also noted the resident required set-up assistance with walking 50 feet. Review of the National Weather Service forecast at www.weather.gov revealed the weather in the Cleveland area on 11/23/24 included a high temperature of 47 degrees Fahrenheit (F) and low of 43 degrees F. (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 police report dated 11/24/23 at 12:20 A.M. revealed a call was received from a concerned citizen that an elderly confused male was found sitting on the curb of the apron in front of a business. The citizen stated she would stand by in a white jeep with her flashers on until the police arrived. The police arrived on 11/24/24 at 12:30 A.M. and found the elderly male confused and had bleeding to his left hand. Officer #575 provided first aid and called for an ambulance. The elderly male was identified as Resident #37. The resident told police he lived in [NAME], Wisconsin and believed he was still there. Resident #37 stated he was out for a walk and fell . Resident #37 was sent by squad to the ER for further evaluation. Dispatch reached out to several nursing homes in the area and verified the nursing facility where Resident #37 resided. On 11/24/24 at 12:50 A.M. Resident #37's daughter was notified Resident #37 was in the ER. Review of the hospital discharge summary dated 10/24/24 at 2:52 A.M. revealed Resident #37 had imaging completed including computed tomography (CT) scan of the head, cervical spine, and an x-ray of the left hand. No acute findings were seen. Resident #37 had no complaints of neck pain. There was no evidence of a traumatic injury to the head, however there was an abrasion to his left hand which was cleaned at the ER. Review of a progress note dated 11/24/24 at 1:13 A.M. revealed another nurse received a phone call stating a male resident (later identified to be Resident #37) was found outside and taken to the ER. A head count was initiated, and all doors were checked to ensure doors and alarms were working properly. The ER called and reported the resident (#37) was okay and received imaging which resulted in negative findings. On 12/02/24 at 4:20 P.M. review of video footage with the Administrator revealed the video was a copy of a video taken on a computer screen. There was no date, but the time stamp read 11:07 P.M. The Administrator revealed the original video had a date of 11/23/24 and was no longer available. The video was viewed partially from a computer monitor and then from the Administrator's cell phone to get a clearer picture. In the video, Resident #37 was viewed standing in the lobby in front of the first set of doors with his right hand by the keypad located to the right of the sliding door. The lobby door opened (by a visiting female from the outside) and Resident #37 walked through the lobby door and stood in the vestibule between the entrance to the inside lobby and the outside main door for several seconds. A visiting female was then seen watching Resident #37 exit the vestibule through the outside door of the building. The visiting female walks through the lobby door turns around and was seen looking out of the doors, the lobby door was still open. The visiting female punched in a code and the lobby doors closed. The visiting female proceeds several feet through the lobby, pauses and turns one more time to look out the door of the lobby and proceeded to walk into the building. An attempted interview on 12/03/24 at 9:29 A.M. with Resident #37 revealed the resident stated it was a secret that he had left the facility. Resident #37 believed it happened in [NAME], Wisconsin. The resident then appeared to be agitated and ended the interview. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 12/03/24 at 11:59 A.M. with Certified Nursing Assistant (CNA) #581 revealed on 11/23/24 she heard a door alarm sounding for a short period, then it went silent. CNA #581 revealed she did not respond to the alarm and reported she figured it was somebody getting food delivered. She stated she was unaware Resident #37 was missing until the facility received calls from Resident #37's daughter and the police. At 12:57 A.M. she completed a head count. CNA #581 stated she was assigned to provide one on one supervision to Resident #37 when he got back from the ER. Resident #37 was extremely tired and did not mention any information about the incident. CNA #581 assisted the resident to change his clothes, and then the resident went to bed. Resident #37 was wearing a hat fleece jacket socks and house shoes, and his hand was bandaged up. Interview on 12/02/24 at 12:20 P.M. with Resident #37's Power of Attorney (POA) #580 revealed she received a call from the police on 11/24/24 at 12:42 A.M. stating her father was found approximately a half mile down the street sitting on the curb and he did not have his rollator walker with him. Resident #37 told her he fell three times after he exited the facility. During the interview, POA #580 revealed she was extremely upset that someone let her father out of the facility. POA #580 stated her father often woke up at night due to PTSD and would call her. She would then tell him to go back to sleep. She believed her father awoke and could not find staff and started wandering down the hall to the lobby door and started banging on the door. She reported that while Resident #37 was out of the building, he had on his slippers and a fleece zippered jacket. Interview on 12/03/24 at 2:06 P.M. with CNA #316 revealed he was assigned to Resident #37 on 11/23/24, the night of the elopement. The CNA revealed the last time he had seen the resident, prior to the elopement was between 9:30 P.M. and 10:00 P.M. The resident was in his room, fully dressed. CNA #316 reported he knew Resident #37 to frequently sleep in his clothes. Resident #37 was lying in bed watching television. CNA #316 stated he had been providing care to other residents, and at approximately at 12:00 A.M. he was notified by another unnamed CNA that Resident #37 was missing from the facility. A head count was initiated. Resident #37 was not in his room at that time. CNA #316 viewed the camera footage and Resident #37 appeared to be pushing the keypad when a visitor came up to the front door, entered a code, opened the door and entered the facility, talked to Resident #37 and then the door closed with Resident #37 exiting the facility. Interview on 12/03/24 at 3:56 P.M. with LPN #500 revealed she was assigned to the memory care and west unit on 11/23/24, the night Resident #37 eloped. Resident #37 resided on the west unit. LPN #500 stated she was in the memory care unit when the elopement occurred. CNA # 316 was the only CNA assigned to the west unit. LPN #500 did not see Resident #37 until he came back from the emergency room and at that time, she assessed Resident #37. Resident #37 was placed on one-on-one supervision with CNA #581 following the incident. Interview on 12/03/24 at 4:06 P.M. with LPN #426 revealed she administered Resident #37 his medications on 11/23/24 at 8:45 P.M. LPN #426 stated she had last seen Resident #37 on 11/23/24 walking around the hall with other residents after dinner. Interview on 12/04/24 at 8:20 A.M. with Visiting Family Member (VFM) #375 revealed on 11/23/24 Resident #37 was standing at the door when she entered the building (after punching in a code). The VFM revealed Resident #37 stated he was an employee and wanted to leave. VFM #375 stated it was not her right to question or keep the person in the facility due to being an employee who worked in the facility. After letting Resident #37 out of the building she stated she punched in the code to close the lobby door. She reported the code to the door was common knowledge. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 12/04/24 at 10:24 A.M. with the DON revealed on 11/23/24 the nurse was contacted by police and the Resident #37's daughter. After the notification, staff completed a head count and checked all doors to ensure proper function. The DON reviewed the camera footage and interviewed staff. Resident #37 was seen on camera going out the front door (on the video). The resident was evaluated in ER and upon return was placed on 1:1 supervision with a staff member. The next day Resident #37 was moved to the facility secured unit. Through her investigation, it was determined that staff did not report hearing the lobby door alarming. However, following the incident the facility conducted a Quality Assurance Performance Improvement (QAPI) meeting, placed a sign at the entrance of new visiting hours and all staff were re-educated. Interview on 12/05/24 at 7:05 A.M. with Officer #575 revealed on 11/23/24 he arrived on the seen and found an elderly man who was confused and who had an abrasion to the hand that was bleeding. The man stated he was from [NAME], Wisconsin. Officer #575 stated he provided first aid and called the squad. Dispatch began calling nursing homes in the area. Officer #575 verified the elderly man was Resident #37 and resided at this facility. Officer #575 revealed at the time of the incident Resident #37 was wearing a sweater and pants and should have had a warmer jacket. He stated the weather was approximately 40 degrees F. Interview on 12/05/24 at 1:00 P.M. with LPN #423 revealed on 11/23/24 she received a call from Resident #37's POA who was frantic and stated You guy did not know he was gone?. LPN #423 stated at the time she was talking to Resident #37's POA the police called. Staff then verified Resident #37 was missing and initiated a search and a head count. LPN #423 revealed she viewed the video and saw Resident #37 was trying to unlock the door from the top and push the keypad. LPN #423 stated she was in a room providing care to another resident and did not hear any alarm at the time Resident #37 eloped. Interview on 12/09/24 at 11:30 A.M. with a concerned citizen (Citizen #582), revealed she was driving down the road with her family and found a male (identified to be Resident #37) sitting in the middle of an apron, close to the street. The area was not well lit. She stated she initially drove past the resident before she turned around and entered the parking area through another entrance. Citizen #582 activated her hazard lights and called the police. Resident #37 tried getting up and fell . Citizen #582 stayed with the resident until the police arrived. Review of the facility's policy titled Elopement, revised October 2022 revealed the purpose of the policy was to identify a resident's risk for elopement, prevent a resident from exiting the facility without the knowledge of the staff and to delineate the reporting process if an elopement occurs. This deficiency represents non-compliance investigated under Master Complaint Number OH00160219 and Complaint Number OH00160218.