STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365729	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRAEVIEW MANOR	**20611 EUCLID AVE EUCLID, OH 44117**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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.** Based on record review and interview, the facility failed to report the elopment of a resident as a suspected case of neglect to the Ohio Department of Health. This affected one (Resident #45) of five residents reviewed for wandering and elopement. The facility census was 44 residents. Findings include: Interview with the Administrator and Registered Nures (RN) #901 on 06/22/2020 at 9:37 A.M. revealed they were investigating a suspected elopement event involving Resident #45. The resident had a Brief Interview for Mental Status score of 10 (indicating moderate cognitive impairment) and had been missing since 06/17/2020. He wore a wanderguard device while admitted to the facility. The facility did not know how Resident #45 got out of the building. Review of the State of Ohio Certification and Licensure System (CALS) website on 06/22/2020 at 10:17 A.M. revealed no evidence the facility reported the suspected elopement event on 06/17/2020 or any time after. Interview with the Administrator on 06/22/2020 at 4:56 P.M. confirmed the facility did not report the suspected elopement to the Ohio Department of Health CALS reporting website. This deficiency substantiates Complaint Number OH 464.
F 0689 **Level of harm -** Immediate jeopardy **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** Based on observation, interview, review of the medical record, facility incident report, police report, and the facility elopement and neglect policies, the facility failed to provide appropriate supervision of one cognitively impaired resident (Resident #45), who was at high risk for elopement and dependent on multiple inhaler medications for chronic breathing issues from leaving the facility without staff knowledge on [DATE]. This resulted in Immediate Jeopardy when Resident #45 could not be found in the facility on [DATE]. Searches both inside and outside of the buildings could not locate the resident. The likelihood of actual harm, serious injury or death has occurred as Resident #45's location has been unknown to the facility, family, and police since the time he was last seen on [DATE] at approximately 3:05 P.M. This affected one of five residents reviewed for elopement risk. The facility has identified four residents currently in the facility who were at high risk for elopement. The census was 44 residents. On [DATE] at 4:09 P.M., the surveyor informed the Administrator and Registered Nurse (RN) #901 that a situation of Immediate Jeopardy was identified which began on [DATE] at 5:00 P.M. when Resident #45 who was at risk for elopement and exhibited an intent to leave the facility and had a Wandergauard in place, (a device that causes the door to alarm upon exit), could not be found inside or outside of the facility, and his whereabouts continue to remain unknown. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following measures: On [DATE] at 5:00 PM, Licensed Practical Nurse (LPN) #401, LPN #404, LPN #407, State tested Nursing Assistant (STNA) #402, STNA #403, STNA #405, and STNA #406 searched the entire building and Resident #45 was not located. On [DATE] at 5:00 P.M., LPN #401, notified the Administrator, the Director of Nursing (DON), the resident's physician (Physician #501), the Medical Director, and local police that Resident #45 was missing. The Administrator, DON, and local police immediately went to the facility for further investigation. On [DATE] at 5:00 P.M., LPN #401, LPN #404, LPN #407, STNA #402, STNA #403, STNA #405, STNA #406, the DON, and Social Service Designee (SSD) #408 initiated an extensive search of the surrounding area within a 1 mile radius of the facility, including area businesses, Euclid Avenue, and local parks. Resident #45 was not located. On [DATE] at 6:00 P.M., the Administrator interviewed 16 staff to determine when Resident #45 was last seen,which was at 3:00 P.M. The staff interviewed included 3 Registered Nurses (RN), 3 LPNs, 8 STNAs, one Housekeeper, and one Activity/Social Service staff. On [DATE] at 6:00 P.M., Police Officer #502 began searching local hospitals, shelters, bus lines, and the resident's previous known address. Resident #45 was not located. On [DATE] at 6:00 P.M., the DON and Administrator conducted a head count of all residents in the facility and confirmed all residents, other than Resident #45, were in the facility. On [DATE] at 6:30 P.M., SSD #408 interviewed 20 residents to determine when Resident #45 was last seen. One resident reported seeing Resident #45 earlier in the lounge but was unable to remember the time he was in the lounge. On [DATE] at 7:00 P.M., the DON checked all secured doors to ensure that they were locked and alarmed. All doors were locked and functioning properly. On [DATE] at 7:00 P.M., the DON began checking the placement and functioning of the remaining Wanderguard bracelets worn by four residents. All bracelets were functioning properly. On [DATE] at 8:00 P.M., the DON ensured all residents at risk for elopement had current pictures on file, which were also included with their medical record face sheet in the elopement binder located at the front desk. The surveyor observed this binder in use on [DATE]. On [DATE] at 8:00 P.M., the DON checked the care plan and Kardex of all residents at risk for elopement, and reviewed elopement interventions. All residents at risk for elopement had appropriate interventions in place. On [DATE] beginning at 10:00 P.M., all facility staff were re-educated by the DON, Administrator, and RN #201 on the facility's elopement policy and exit seeking behaviors. All staff education was completed on [DATE] at 3:00 P.M. On [DATE] at 11:00 P.M., Registered Nurse (RN) #201 contacted six local hospitals and provided them with Resident #45's identifying information. The hospitals did not have Resident #45 in their care. On [DATE] at 10:00 A.M., the DON completed elopement evaluations for all residents to determine if any residents who were not at risk for elopement had a changed status. No new residents were identified as being at risk for elopement. On [DATE] at 10:00 A.M., Maintenance Staff #409 and Maintenance Staff #410 checked the secured doors for functioning, and all windows for proper opening according to life safety code regulations. All secured doors and windows were found to be functioning properly. On [DATE] at 11:00 A.M., the local police notified the facility that Resident #45 was not found at the apartment of his emergency contact family member. On [DATE] at 8:00 P.M., RN #901 checked all Wanderguard bracelets to ensure they were not expired and reviewed all Wanderguard physician orders [REDACTED]. The bracelets were not expired, and all orders were complete and accurate. On [DATE] at 5:00 P.M., the facility temporarily relocated those residents at risk for wandering to a secured unit in order to check the Wanderguard system. These residents were returned to their original rooms after this system check was completed, which was observed by the surveyor on [DATE]. On [DATE] at 3:00 P.M., Maintenance Staff #409 ensured that all alarmed egress doors will alarm continuously if the door is opened and the alarm can only be turned off manually by staff. On [DATE] at 3:00 P.M., the therapy department was instructed by the Administrator to ensure the therapy gym was never left unattended without being securely locked to ensure no residents were able to enter without a staff member present. On [DATE], the DON or designee began conducting a random audit of residents with Wanderguard bracelets orders to ensure the Wanderguard bracelets were in place and functioning properly. This audit will continue weekly for four weeks. On [DATE], Maintenance Staff #409 began conducting a random audit of the secured doors to ensure appropriate functioning. This audit will continue weekly for four weeks. On [DATE] from 8:26 A.M. to 8:44

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) A.M., interviews with two LPNs, two STNAs, and the receptionist revealed they were knowledgeable of the facility elopement procedures and the actions to be taken if elopement is suspected. On [DATE] at 8:38 A.M., interview with Physical Therapist #605 revealed they were reminded to follow their usual procedure to keep the gym door locked when physical therapy staff was not in the room. Although the Immediate Jeopardy was removed on [DATE], the deficiency remained at a Severity Level 2 (no actual harm with the potential for minimal harm that is not Immediate Jeopardy) as the facility was in the process of auditing the functioning of alarm doors and their Wanderguard system, as well as the care of residents identified at a high risk for elopement. Findings include: Review of Resident #45's medical record revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. His hospital discharge record dated [DATE] noted he had dementia and impaired decision-making ability. There was a care plan for elopement risk that was added to his care plan on [DATE]. He had a physician's orders [REDACTED]. His last full Minimum Data Set 2.0 (MDS) assessment dated [DATE] revealed he had a Brief Interview for Mental Status (BIMS) score of 10 (indicating moderately impaired cognition) and he required no physical assistance from staff for locomotion off the unit. He used a walker for mobility and did not have steady balance walking, however, he was able to stabilize without staff assistance. Review of Resident #45's progress notes revealed he attempted to exit the facility unattended on [DATE] and [DATE]. On both occasions he was redirected without leaving the facility. A progress note written by LPN #401 on [DATE] at 5:00 P.M. documented the nurse was informed that Resident #45 was not in his room. A subsequent progress note written by LPN #401 on [DATE] at 5:05 P.M. said a thorough search was conducted and the resident was not found. The police, physician, and resident's family were informed. Review of the police report for Resident #45's elopement revealed the local police department was contacted on [DATE] at 6:31 P.M. They found the resident had taken a hat and jacket but had left his walker in the facility. The police checked his former apartment but were unable to gain entry. The police also searched nearby areas and called the resident's emergency contact family member, however, were unsuccessful in finding the resident. Review of the facility's incident log for the last three months revealed an elopement event for Resident #45 on [DATE]. However, there were no other elopement events documented on the incident log. Review of the facility's elopement investigation for Resident #45 revealed documentation they searched the grounds, facility, and neighborhood for the resident without success (documented as completed on [DATE]). They did a headcount of the residents and notified the police, family, and physician of the elopement. The facility verified secured doors were locked and alarming. Elopement evaluations were done for all residents, and residents wearing Wanderguard devices were checked to ensure they were in place. The facility did broad elopement inservices for staff. Review of witness statements for the elopement investigation for Resident #45 revealed the last time staff members saw the resident in the facility was at approximately 3:05 P.M. on [DATE]. No witness saw him leave or knew how he got out of the facility. STNA #402's witness statement identified that she noticed Resident #45 was not in his room at 5:00 P.M. that day and notified the nurse she could not find him. Review of Resident #45's physician orders [REDACTED]. There was no evidence Resident #45 had received any medications since [DATE]. Observation on [DATE] at 8:28 A.M. revealed room [ROOM NUMBER] was marked with Resident #45's name, and he was not in the room. On 06//,[DATE] at 9:03 A.M., interview with RN #201 revealed Resident #45 could not be found on [DATE]. RN #201 said she was his caregiver that day shift, but the resident disappeared in the evening. RN #201 state the resident had cognitive impairment and a history of wandering and had independent mobility with his walker. RN #201 did not know where he was now. Interview with the Administrator and RN #901 on [DATE] at 9:37 A.M. revealed they were investigating a suspected elopement event involving Resident #45 who had a Brief Interview for Mental Status (BIMS) score of 10 (indicating moderate cognitive impairment) and had been missing since [DATE]. They indicated he wore a Wanderguard device while admitted to the facility. They did not know how he got out of the building. The facility provided no evidence of submitting a self reported incident to the State Agency. A tour of the facility on [DATE] at 10:30 A.M. revealed two exit doors had functioning Wanderguard locks; two doors were unlocked and alarmed when opened for approximately 15 seconds; two doors were unlocked and alarmed when opened until the door closed again; and two were locked by interior twist-locks which could be undone, however these were located in the therapy gym. Interview with Speech Therapist #601 at the time of this tour revealed therapy staff locked access to the gym whenever they were not present in the gym. Interview with the Administrator on [DATE] at 4:56 P.M. revealed the police were notified on the day of the elopement. The Administrator said the facility had no functioning security cameras which could have detected Resident #45's exit. The Administrator also verified that they did not report the suspected elopement to the State Agency. Interview with the emergency family contact of Resident #45 on [DATE] at 5:40 P.M. revealed she was his stepdaughter, and the facility called to inform her of the elopement on [DATE] at approximately 7:00 P.M. She did not know how Resident #45 got out of the facility. As far as she knew Resident #45 was still missing. Interview with Detective #302 on [DATE] at 8:13 A.M. revealed the facility informed the police on [DATE] at approximately 8:15 P.M. of Resident #45's suspected elopement. The police searched the exterior of the building and reached out to the media, contacted family, and alerted hospitals. Resident #45 was considered a missing person, and the police had no insight where he might have gone or where he might be now. Interview with LPN #401 on [DATE] at 9:31 A.M. revealed she was the nurse assigned to Resident #45 the evening he disappeared ([DATE]). She had a complicated new admission at 3:30 P.M. that day which occupied her attention early in the shift. At approximately 5:00 P.M. that day an aide informed her Resident #45 could not be found, and LPN #401 initiated a search and contacted the management team. LPN #401 indicated she knew Resident #45 had a history of [REDACTED]. However, she did not hear a door alarm in the timeframe Resident #45 went missing. Interview with the facility Medical Director on [DATE] at 9:48 A.M. revealed he was not personally familiar with Resident #45. He said he was called on the day of the elopement and was informed of the situation. The Medical Director indicated when residents are at high elopement risk, staff are expected to provide appropriate monitoring to their needs. The Medical Director stated he met with facility management on [DATE] to review needs and methods to prevent further elopement. On [DATE] at 9:54 A.M. and 4:36 P.M., the surveyor called State tested Nursing Aide #402 (Resident #45's caregiver aide on the second shift of [DATE]) and left a message requesting her to call back. The calls were not returned in the timeframe of the survey. Interviews with five staff members (LPN #404, LPN #202, STNA #602, STNA #603, and Receptionist #604) on [DATE] from 8:26 A.M. to 8:44 A.M. revealed they were recently educated on elopement procedures by the facility and were familiar with proper actions to take if suspected. Interview with Physical Therapist #605 on [DATE] at 8:38 A.M. revealed the facility had contacted the therapy department and reminded them to keep the gym door locked when they were not present, however he said this was already their standard procedure. A tour of the facility on [DATE] at 9:11 A.M. revealed the two doors with Wanderguard alarms still functioned appropriately, and the four alarmed exit doors had their alarms modified to go indefinitely until staff disabled them with a key. The gym was unlocked, however occupied by therapy staff. All four residents wearing Wanderguard devices (Residents #30, #12, #8, and #5) had them in place on their ankles. The facility had an elopement binder available at the front desk with pictures and descriptions of all residents at high risk for elopement. On [DATE] at 9:39 A.M., interview with the Administrator revealed Resident #45 was still missing at this time. There was no observation of Resident #45 in the facility. On [DATE] at 3:00 P.M., interview with the Administrator revealed the facility still had no knowledge or updates as to the whereabouts of Resident #45. Review of the facility's elopement policy (undated) revealed that when an employee discovered a resident was missing from the facility, they were to initiate a search, notify staff and authority officials as necessary, complete a head-count of residents, initiate an extensive search of the surrounding area, and notify local public transportation, shelters, churches, and bars as relevant. Review of the facility's abuse policies (undated) revealed it defined neglect as a failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. Suspected neglect was to be promptly reported to management and investigated. The administrator was to provide a written report of abuse investigations to the state survey and certification agency within five working days of the reported incident. This deficiency substantiates Complaint Number OH 464.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to prevent a significant medication error for Resident #43 when she took another resident's medications. This affected one (Resident #43) of five residents reviewed for medication administration. The facility census was 44 residents. Findings include: Review of the facility's investigation of a medication error event dated 06/17/2020 revealed Resident #43 picked up another resident's (Resident #36) medication cup and took those medications while the nurse was in a resident's room. The nurse notified the physician and the resident's daughter. The facility re-educated the nurse on appropriate medication pass. Interviews with Licensed Practical Nurse (LPN) #202 on 06/22/2020 at 9:29 A.M. and on 06/25/2020 at 8:28 A.M. revealed she was Resident #43's nurse on 06/17/2020 and brought Resident #36's morning medications with her when she administered Resident #43's medications in her room. The nurse

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) administered the medications meant for Resident #43, then turned around to wash her hands and while her back was turned Resident #43 took all but two of Resident #36's pills. The nurse reported the event and monitored Resident #43's vital signs. Resident #43's blood pressure went low (she was on antihypertensive medications and had also taken Resident #36's antihypertensive medications) so the physician ordered her to be sent to the hospital. The resident's vital signs improved while the resident was being sent out, however, the resident stayed overnight at the hospital and was readmitted to the facility the next day. Review of Resident #43's medical record revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She had regularly-scheduled morning medications including [MEDICATION NAME] and [MEDICATION NAME]-[MEDICATION NAME] (both anti-hypertensive medications). A progress note on 06/17/2020 at 12:11 P.M. revealed she picked up another resident's medication cup and took the medications. A note the same day at 1:50 P.M. revealed she was sent to the hospital for a blood pressure of 82/43 and a heart rate of 41, and while leaving the facility her blood pressure increased to 116/60 and her heartrate was 54. Her hospital record revealed she was not fully alert and oriented, and that on arrival to the emergency room her blood pressure was 109/53 and her heart rate was 62. She was diagnosed with [REDACTED]. Review of Resident #36's medical record revealed her regularly-scheduled morning medications on 06/17/2020 included [MEDICATION NAME] (an anti-hypertensive), [MEDICATION NAME] (an anti-anxiety medication with a possible side effect of [MEDICAL CONDITION]), and [MEDICATION NAME] (a diuretic used to treat high blood pressure). Interview with Resident #43 on 06/22/2020 at 10:55 A.M. revealed she was unaware of taking incorrect medication or of being hospitalized while staying at the facility. Review of the facility's oral medication policy (undated) revealed the policy did not clarify whether medications could be drawn ahead of time, however, it did provide a process for drawing medications from storage at the time of administration. This deficiency substantiates Complaint Number OH 464.