STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365644	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINCHESTER CARE & REHABILITATION	36 LEHMAN DR CANAL WINCHESTER, OH 43110

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** Based on record review, review of a facility investigation and police report and interview with Resident #16, staff and the police deputy, the facility failed to ensure Resident #16, who was cognitively impaired and high risk for elopement was provided adequate supervision to prevent the resident from leaving the facility without staff knowledge. This affected one resident (#16) of ten residents identified to be at risk for elopement who did not reside on the facility secured care unit. Findings include: Review of Resident #16's medical record revealed and admission date of [DATE] with [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. Review of a wander/elopement assessment completed on [DATE] revealed the resident was assessed to be at high risk for elopement. Review of the care plan, dated [DATE] revealed Resident #16 was at high risk for elopement. Interventions included if the resident was missing from the facility to follow elopement protocol, notify physician and family and document. The resident was also noted to have a wanderguard device band in place to alert staff of attempts to exit the facility (via the facility front door). Review of the Minimum Data Set Assessment (MDS) 3.0 quarterly assessment, dated 04/20/2020 revealed the resident exhibited wandering behavior on one to three days of the seven day assessment reference period. The resident required staff supervision/set up for transfers, walking in room, corridor, locomotion on and off unit, toilet use, personal care and was assessed to be independent with eating. A Brief Interview for Mental Status (BIMS) assessment revealed the resident exhibited moderate cognitive impairment with a score of 12. Review of a progress note, dated 0[DATE]3/2020 at 10:03 A.M. revealed Resident #16 was observed by staff exiting out the back door. Staff immediately followed the resident and were able to verbally redirect him back into facility. The resident was assessed with [REDACTED]. Review of a progress note, dated 05/16/2020 at 4:06 P.M. documented Resident #16 went on an unauthorized leave of absence at 1:45 P.M. The note indicated the Director of Nursing (DON) was notified as well as the primary care physician and sheriff's department. The note indicated the returned from the unauthorized leave of absence at 3:00 P.M. with the sheriff's department. The resident was assessed to have no injuries and his vital signs were documented to be within normal limits. The note revealed 15 minute checks initiated, the resident was educated on unauthorized leave of absence and verbalized understanding. A progress note, dated 05/16/2020 at 4:31 P.M. revealed the resident was asked safety questions. The resident stated he did not know how to get back to the facility, he did not know how to call the police and he was aware he was lost. The resident could recall he was brought home by the sheriff and was able to tell the nurse how he got out and showed her where he walked through the neighborhood. He stated he just wanted to take and walk and get some air. The resident stated he was tired of being inside. The note indicated the resident was educated on asking to sit outside and leave of absence. A progress note, dated 05/18/2020 at 9:45 A.M. revealed the social worker re-assessed Resident #16 and he was assessed to have a BIMS score of 9, which continued to reflect moderate cognitive impairment. The resident was able to recognize staff and his room. He was challenged in recall as to why he left the building. The resident continued to struggle with long term memory. Additional record review revealed documentation of every 15 minute checks being completed for the resident since 01/2020. The last entry completed on 05/16/20 was documented at 1:45 P.M. which coincided with the progress note which indicated the resident went on an unauthorized leave of absence on this date at 1:45 P.M. Review of police report documentation revealed an incident dated 05/16/2020 which indicated the sheriff's department was dispatched for a missing person at 2:26 P.M. and arrived at the facility at 2:38 P.M. Resident #16 was identified to be missing from the facility and the sheriff's department was told by staff the resident had left on foot and was last seen in the area of West Waterloo Street. The staff said they searched the building. Licensed Practical Nurse (LPN) #3 revealed someone, possibly a guest, had seen the resident walking on West Waterloo Street. LPN #3 revealed they sent staff out to try to find the resident and called the sheriff at that time. She stated the resident was wearing a security bracelet and none of the (facility door)alarms had gone off. She believed that when he was at the nurse's station he might have gone outside with some of the residents who were smokers who go out the back door. A description of the resident was given to the deputy and two other deputies later found the resident at 3:01 P.M. at the corner of North High Street and Pfeifer Drive and returned to the facility. At the time the resident was located he told police he had been gone for hours and he was lost and thirsty and just wanted to go back to the nursing home. The deputy had been told by staff the resident was last seen at 1:45 P.M. as he was on 15 minute checks and by 2:00 P.M. he was not in the facility. Review of the facility investigation revealed LPN #4 was told State tested Nursing Assistant (STNA) #5 who was not working at the time of the incident, had seen Resident #16 walking on foot on Waterloo Street towards the facility from Walmart Crossing. The LPN stated she got in her car to try to find the resident but was unable to find him. She stated she returned to the facility and the supervisor called the sheriff. A statement from LPN #6 revealed it was reported to her by a STNA that they couldn't find Resident #16. He was last seen on 05/16/20 at 1:45 P.M. and at 2:00 P.M. staff were not able to find him. The DON and primary care physician were notified and resident was returned to the facility at 3:00 P.M. by the sheriff department. Updated wander/elopement assessments completed on 05/18/2020 and 05/20/2020 revealed Resident #16 remained at risk for elopement Interview with the DON on 05/20/2020 at 3:33 P.M. revealed Resident #16 told staff he went out the back door (on 05/16/20). Resident #16 reported Resident #100 had let him out. The DON stated she interviewed Resident #100, who denied letting the resident out and indicated Resident #100 was not to have the code to get out the back door but was aware this resident had gotten the door code in the past and would go out this door on his own. An attempt to interview Resident #100 on 05/21/2020 at 8:19 A.M. was unsuccessful as the resident refused to be interviewed. On 05/21/2020 at 8:19 A.M. during a telephone interview with Resident #16, the resident was asked about the incident when he left the faciity on [DATE]. The resident first stated he didn't remember anything. When asked specifically if he knew how to leave the facility, he stated he left through the back door, you just put in the code. When asked if he knew the code, he replied no. The resident denied there being any type of alarm on the door and stated no one was around him when he left. The resident then stated he had gotten lost but then was brought back to the facility after 45 minutes or an hour by the sheriff. During a follow up telephone interview with the DON and Regional Director of Clinical Operations Registered Nurse (RN) #2 on 05/21/2020 at 10:15 A.M. the DON stated they would change the code on the back door every time someone gets access to it and monthly. She then stated the facility did not have any type of policy regarding the security of this door and/or changing the key code. RN #2 revealed the code should be changed as needed. A telephone interview with Nurse Practitioner (NP) #13 on 05/21/2020 from 11:31 A.M. to 12:00 P.M. revealed she had known Resident #16 since he was admitted in December 2019. The resident had been admitted from a psychiatric hospital via an emergency admission by the police. He had been confused and disoriented with weight loss and not taking medications for about five months. The resident had a [DIAGNOSES REDACTED]. The NP revealed the resident did not have the capacity for decision making and the physician wanted to do a competency evaluation on him but this has not been completed as of this time due to the Covid-19 situation. When

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

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.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) asked if she felt it was safe for the resident to be out of the facility independently in the community without supervision, she stated he was alert and he could walk (independently) but doesn't remember where he is supposed to be and he would not remember how to get back or how to get food. She stated she wasn't sure how he got out of the facility (on 05/16/20) and didn't feel he would remember a code if he was given the code to door. During a telephone interview on 05/21/2020 at 2:31 P.M. with LPN #12, the LPN revealed she was at work when STNA #5 who was off duty came into the facility and stated she was driving down the road and saw Resident #16 walking down the street. She stated she and the STNA got in my car and went to look for him. We were unable to find him and returned to the facility and I notified the supervisor. During a telephone interview on 05/21/2020 at 2:37 P.M. with STNA #5, the STNA revealed she was off work on 05/16/20 when she was going to the Dairy Queen and saw Resident #16 walking down the street. She stated her cell phone was not working and she had her children with her so she couldn't stop or call anyone. She stated she drove to the facility and got LPN #12 and then they went to look for him. We were unable to find him at that time so we went back to the facility. During a telephone interview with Maintenance Director #7 on 05/21/2020 at 2:51 P.M. the maintenance director revealed the alarm code on the key pad at the back door was changed as needed. The MD revealed the code had last been changed on 04/29/20. The facility did not maintain any type of record as to when the door code was changed or why it was changed. During a telephone interview on 05/21/2020 at 3:08 P.M. with LPN #3, the LPN revealed a deputy brought Resident #16 back to the facility on [DATE] and reported the resident had been about a mile from the facility. During a telephone interview on 05/26/2020 at 9:50 A.M. with Deputy #10, the deputy revealed he had talked to the supervisor, LPN #3 when he arrived to the facility for a report of a missing person. He stated he remained at the facility while two other deputies went out looking for the resident (Resident #16). He stated he received a call from the deputies that they had found the resident and brought him back to the facility uninjured at 3:01 P.M. During the interview, Deputy #10 revealed LPN #3 had told him the resident's security bracelet (wanderguard) was supposed to go off and it did not. She stated she reset the door and the alarm never went off. He stated he told her the battery was probably dead and she stated she would look at it. This deficiency substantiates Complaint Number OH 718.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, review of Centers for Disease Control (CDC) guidelines for mask use and care and staff interview the facility failed to develop an infection control policy and procedure to address resident mask/facial covering use and care and failed to ensure resident facial masks were properly stored and laundered to decrease the risk of spreading infection. This affected one resident (#60) randomly observed and had to potential to affect all residents who wore facial masks. However, the facility did not have a record or know how many or which residents had facial masks at the time of the onsite survey. The facility census was 134. Findings include: On 05/26/20 at 12:10 P.M. Resident #60 was observed exiting his room. At the time of the observation, the resident was not wearing any type of facial mask/covering. Registered Nurse (RN) #2 who also observed the resident exiting his room asked the resident to put on his mask. The resident proceeded to obtain a paper mask from his pant pocket. Observation of the mask revealed it was soiled on the inside of the mask with an orange substance. RN #2 then asked the resident to put on his cloth mask since the paper one was soiled. The resident obtained a cloth mask from the same pocket as the soiled disposable one. The cloth mask was black in color and the integrity and cleanliness of this mask could not be determined. Additional observations at this time, on 05/26/20 at 12:10 P.M. revealed five additional random residents were observed in the halls wearing cloth masks. During an interview on 05/26/2020 at 12:30 P.M. with Corporate Regional Director of Clinical Operations Registered Nurse (RN) #2, the RN was asked how the facility ensured the cloth masks being used by the residents were being properly stored and how they were cleaned. In addition, the RN was asked if the facility had a policy related to this. RN #2 revealed the facility did not have any type of policy related to this but followed the CDC guidelines. She stated masks were to be stored in a brown paper bag when not in use. RN #2 also revealed the facility recommended masks to be cleaned/laundered when they were visibly soiled. The RN was unable to provide evidence the masks were being cleaned on a routine basis and/or who monitored them to ensure they were not being used by residents when visibly soiled. The RN revealed there were some residents who used cloth masks and some who used paper masks. However, the facility was unable to provide a list of which residents had/used masks and the type of mask they had. During an interview on 05/26/2020 at 12:35 P.M. with State tested Nursing Assistant (STNA) #14, the STNA revealed she did not know what the facility policy was for laundering resident face masks. She stated she had never laundered any of the resident's masks. An interview on 05/26/2020 at 12:45 P.M. with the Maintenance Director revealed he had recently taken over for the laundry housekeeping supervisor as he was terminated. He stated he recommended resident masks be hand washed by the nursing assistant staff but didn't have a policy on how to do this, who was to do this or how often it was to be done. Review of the CDC guidelines revealed cloth face masks should be washed after each use in the washing machine and dried in the dryer on the highest heat setting and allowed to completely dry or washed by hand using a bleach solution and allowed to dry completely. To wash, the CDC recommenced the bleach solution be five tablespoons household bleach per gallon of room temperature water or four teaspoons of bleach per quart of room temperature water. The guidelines revealed to soak for five minutes, rinse thoroughly with cool or room temperature water.