STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. BUILDING _____ B. WING _____	09/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCIOTO COMMUNITY	433 OBETZ ROAD COLUMBUS, OH 43207

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 0559 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility room change policy and staff interviews the facility failed to ensure immediate notification of the family when resident #60's room was changed. This affected one resident (Resident #60) of four residents reviewed for room changes. The facility census was 83. Findings include: Review of Resident #60's medical record identified admission to the facility occurred on 11/07/19, from the facility's attached assisted living. Resident #60 resided in the facility's nursing home secure, locked unit until he was moved on 06/01/20 to the Capri hallway. Resident #60 had medical [DIAGNOSES REDACTED]. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 07/10/20, revealed the resident had impaired cognition. The assessment identified behaviors of wandering. The resident was independent for ambulation with the use of a walker. Interview on 09/02/20 at 10:11 A.M. with Registered Nurse (RN) #250 revealed Resident #60 moved from the secured unit to the Capri hallway on 06/01/20. Interview on 09/02/20 at 10:30 A.M. with Administrator revealed when there was a room change the Social Service Director #400 notified the family of the room change. She stated during the time when they had a lot of COVID positive cases, a resident with a fever was immediately moved to another room, and sometimes the notifications were made after rather than prior to the move. She reported housekeeping and maintenance were responsible for moving the residents. Review of the nurse's notes dated 06/26/20 at 3:21 P.M., revealed Resident #60's son was notified of the room change. Further review of nurse's notes revealed no other room change notifications were completed prior to 06/26/20. Interview on 09/03/20 at 5:00 P.M. with Social Service Director #400 verified Resident #60 was moved on 06/01/20 and the resident's son was notified on 06/26/20. Review of the facility policy titled Notice of room or roommate change, dated 11/2016 revealed prior to the room transfer, the resident his or her roommate (if any) and the resident's representative will be provided with information concerning the decision to make the room transfer. Documentation of the room transfer, and reason is recorded in the resident's medical record. This deficiency substantiates Complaint Number OH 427.
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 observation, medical record review, review of facility elopement investigation, review of wander-guard manufactures instructions and staff interviews the facility failed to ensure adequate supervision to prevent elopement from the facility for one of four residents (Resident #60) identified as a high risk for elopement. The facility also failed to ensure wander-guard bands were changed prior to expiration. This affected one of four residents reviewed for risk of elopement. The facility census was 83. Findings include: Review of Resident #60's medical record identified admission to the facility occurred on [DATE], from the facility's attached Assisted Living facility (AL). Resident #60 resided in the facility's secure, locked unit until he was moved on [DATE] on the Capri hallway. Resident #60 had medical [DIAGNOSES REDACTED]. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the resident had cognition issues. The assessment identified the resident had behaviors of wandering and was independent for ambulation with the use of a walker. Review of the wandering risk assessment dated [DATE] revealed the resident was at high risk for elopement and had no elopement attempts in the past three months. Review of Resident #60's physician orders [REDACTED]. Check placement and function every shift. The order did not include the serial number or when the device expired. Review confirmed the facility staff checked the placement and functioning twice a day and documented on the Treatment Administration Record (TAR). Review of the nurses notes dated [DATE] (Wednesday) at 9:17 A.M. identified nursing staff heard the courtyard alarm sound. An aide went to turn off the alarm and see why it was going off. Resident #60 had gotten out of the unit and made it to the attached AL unit. According to AL staff, Resident #60 was outside standing next to the facility's bus. When the nurse asked the resident what he was doing he stated, I am going to my doctor's appointment. The notes identified Resident #60 refused to go back into the facility with the nurse and was taken for a ride in the bus, then back to the facility where he then went back inside the building. The notes identified the staff would do more frequent checks on Resident #60. A physician order [REDACTED]. Interview with State tested Nurse Aide (STNA) #250 occurred on [DATE] at 9:01 A.M. The interview identified she was working on [DATE] at 9:17 A.M. when a door alarm was sounding as she was passing breakfast trays. STNA #250 identified it was the door leading from the Capri unit to the enclosed courtyard, then onto the AL. STNA #250 identified she looked in the courtyard and did not see anyone so she turned the alarm off. STNA #250 identified shortly after was when the AL staff notified her that Resident #60 was over on their unit. STNA #250 confirmed Resident #60 was ambulatory and confused at times. STNA #250 identified she had never known him to go through any doors. Interview with the Assisted Living Activities Director (AD) #300 occurred on [DATE] at 9:28 A.M. The interview identified she was coming to work on [DATE] and had clocked in and was heading to the front lobby to have her temperature checked. The interview identified she saw Resident #60 inside the front lobby heading out the AL main door and she went to check on him. AD #300 confirmed Resident #60 stated he had a physician appointment and was heading towards the facility transportation van. AD #300 identified she told Resident #60 they had to get the keys and he walked back into the facility with her. Another staff person decided to take him in the van around the parking lot, because he was upset and thought he had a physician appointment. AD #300 identified when they returned he went back over to the nursing home side without incident. Review of the facility records identified Resident #60 was placed on 1:1 direct supervision on [DATE] upon returning to the nursing home through that day until all staff were educated not to turn the alarm off without verifying why it went off, which was completed on [DATE] in the afternoon. Resident #60's record identified no issues from [DATE] through [DATE] at 7:43 A.M. Review of the nursing notes dated [DATE] at 7:43 A.M. revealed Patient eloped outside the building and found at AL entrance door. Licensed Practical Nurse (LPN) #200 and LPN #210 responded to the sounding alarm at the AL and observed Resident #60 on camera, outside pulling on the double doors trying to come inside the main entrance to the AL. The notes identified Resident #60 was unable to tell the nurse how he was able to get outside. LPN #210 noted Resident #60's wander guard wasn't working and he replaced it with a new one. LPN #210 identified Resident #60 had no injuries, vital signs were within normal limes and Resident #60 was placed on continuous 1:1 staff supervision. A telephone interview was completed with LPN #200 on [DATE] at 8:17 A.M. LPN #200 confirmed she was working the night shift from 7:00 P.M. through 7:00 A.M. on [DATE]. LPN #200 identified she received a phone call from a Resident Assistant (RA) on the assisted living side of the building that a person was trying to get into the main door. The RA said the person was able to identify himself as Resident #60 and was able to provide a correct room number. LPN #200 identified when she received the

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) call she was heading from her area to the assisted living side of the building and heard the door alarm sounding. LPN #200 identified LPN #210 who was working on the Capri unit, where Resident #60 lived was also heading to the door alarm area. The interview identified they believed the resident went out the side door of the Tuscany unit, which was a few feet from the front door that he was entering. The interview identified Resident #60 was unharmed and came into the facility without issues. LPN #200 confirmed she did provide LPN #210 with a new wander-guard band for Resident #60 after they determined his was expired. A telephone interview was completed with LPN #210 on [DATE] at 12:02 P.M. The interview confirmed he was working the night of [DATE]. The interview confirmed around 6:20 A.M. he heard an alarm going off and was heading the nursing station to determine where. The interview identified the nursing station had a panel that identified which door was alarming. The interview confirmed the Tuscany door was sounding. LPN #210 identified about that time he was met by LPN #200 who said Resident #60 was outside by the assisted living main door. LPN #200 confirmed a staff person from the AL was bringing Resident #60 back into the building. LPN #200 identified he had seen Resident #60 no more than ,[DATE] minutes prior to this incident in the TV room with his walker. LPN #210 confirmed upon looking at Resident #60's wander-guard it was determined to been working, but had expired on [DATE]. LPN #210 confirmed he placed a new wander-guard on Resident #60 and implemented 1:1 supervision. Observation and interview with Maintenance Director (MD) #220 occurred on [DATE] at 12:44 P.M. MD #220 confirmed the facility had video cameras at some of the exits of the building. The interview identified they had video of Resident #60 coming back into the building, however, did not have video of him leaving. MD #220 showed the surveyor the video which was dated [DATE] at 5:22 A.M., at which time Resident #60 was observed outside walking up to the assisted living main entry door. Resident #60 was observed with a walker, fully dressed and wearing a face mask. Resident #60 could be observed trying to open the door at that time, but the camera did not show him actually enter the building. MD #220 said the AL side of the building did not have alarms but all the exit doors in the nursing home side had alarms. The interview confirmed he checked and documented their functioning weekly. The interview confirmed on [DATE] he was notified Resident #60 eloped from the building and checked all the nursing home exit doors, but did not document those door checks. MD #220 confirmed all the doors were working properly when tested on [DATE]. MD #220 identified he was never told where Resident #60 had gotten out of the building. Review of the facilities elopement investigation dated [DATE] at 6:37 A.M. identified Pt was found outside the building at Assisted Living entrance door by a Resident Assistant. Interview with the facility Administrator and Director of Nursing (DON) occurred on [DATE] at 12:40 P.M. The interview confirmed on [DATE] the facility replaced all residents' wander-guards and updated the physician orders [REDACTED]. The interview confirmed Resident #60's wander-guard he was wearing on [DATE] had expired on [DATE]. The interview identified the video tape was noted to be exactly an hour off and so they determined Resident #60 actually arrived at the AL main door on [DATE] at 6:22 A.M. Review of the wander-guard manufacture's instructions identified the transmitter was a small device placed on the ankle or wrist of the patient that sends a signal to the receiver. The transmitters were available in a wide variety of life expectancies i.e.; one year, one and half, two and three years. The instructions identified they should be tested weekly. This deficiency substantiates Complaint Number OH 427.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, review of facility infection control policies and staff interviews the facility failed to ensure visitor screening was completed for two surveyors of eleven people including nine staff observed entering the building. This had the potential to affect all residents in the facility, however, they currently had no COVID positive residents. The facility census was 83. Findings include: Observation of the facility occurred on 09/02/20 at 7:30 A.M. by two surveyors. Upon going to the main entrance the doors they were locked, with a button to push to enter. An unknown facility staff person used a remote buzzer to allow entry into the facility. Upon entering the facility no staff came to the front of the building to conduct a screening. After waiting approximately five minutes, one surveyor went to the back nursing station and identified themselves as surveyors. The staff instructed the surveyors to go to the conference room. Upon entering the conference room Physical Therapist (PT) #500 arrived and handed each surveyor a form, but did not go over any of the questions. The form was very difficult to read. At that time the surveyors attempted to go over the questionnaire about COVID exposure and symptoms and took each others temperature using thermometers in the room. Interview with Housekeeping Supervisor #310 occurred on 09/02/20 at 8:25 A.M. The interview identified the front desk clerk #530 was responsible for completing the surveillance of persons entering the facility (including the questionnaire, temperatures and ensuring hand sanitizer was used) upon entering the building. Interview with front desk clerk #530 occurred on 09/02/20 at 7:56 A.M. The interview confirmed the questionnaire she used was very difficult to read and one could not make out what some of the questions were. The interview confirmed she needed to find the master copy to be able to read all of the questions. Interview with the facility Director of Nursing (DON) and Administrator occurred on 09/03/20 at 12:40 P.M. The interview confirmed the facility staff should complete the surveillance of anyone immediately upon entering the facility. The interview identified the current form being used was not readable to complete the surveillance of people entering the building. Review of the COVID-19: Screening Checklist-for visitors and staff, identified all individuals entering the building must be asked the following questions: has this individual washed their hand or used Alcohol-based hand rub (ABHR), ask the individual if they have any of the following respiratory symptoms, check temperatures and asked if they have worked in a facility with recognized COVID-19 cases.