STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366100	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF CENTERVILLE	1001 ALEX BELL ROAD CENTERVILLE, OH 45459

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 **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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of the National Weather Forecast, review of the facility's investigation, observations, staff interviews and review of facility's policy on Missing Person Locator, the facility failed to provide adequate supervision to ensure a cognitively impaired resident, assessed to be at high risk for elopement from the facility and with exit seeking behaviors, did not elope from the facility. This resulted in Immediate Jeopardy when Resident #63 was placed at risk for serious harm and injury when the resident eloped from the facility without staff knowledge and exited a door near a steep hill and near a busy four-lane road. The resident was missing for two hours before being found outside the facility lying face down on the sidewalk in hot weather. This affected one (#63) of four residents (#07, #12, #21 and #63) reviewed for elopement. The facility identified 07 current residents (#07, #12, #21, #22, #35, #45 and #79) to be at risk for elopement. The facility census was 93. On 07/28/20 at 2:30 P.M., the Administrator was notified that Immediate Jeopardy began on 07/17/20 at 5:15 P.M. when Resident #63 exited the secured memory care unit through a stairwell door activating the door alarm, which State tested Nursing Assistant (STNA) #70 turned off without initiating a resident search. The resident then exited another door to the outside, which malfunctioned and did not alarm as it should have. Resident #63 was found on the sidewalk outside the facility lying face down two hours later. The ambient air temperature outside was 91 degrees Fahrenheit on 07/17/20. The resident was placed at potential risk of falling down a steep hill which was near the door the resident exited and/or being hit by a vehicle due to the facility resided on a four-lane road. At the time of discovery, Resident #63 was found to have physical injuries, including an abrasion to her forehead, measuring three centimeters (cm.) in length by three cm. in width, an abrasion to her right knee measuring 7.5 cm. by 7.5 cm. and a skin tear to her left elbow measuring 1.5 cm. by one cm. The Immediate Jeopardy was removed and the deficient practice corrected on 07/23/20 when the facility implemented the following corrective actions: On 07/17/20 at 7:25 P.M. Resident #63 was assessed by Licensed Practical Nurse (LPN) #21. The LPN found new injuries on the resident to her forehead, an abrasion to her right knee and a skin tear to her left elbow. On 07/17/20 at 7:50 P.M., the Administrator notified the Medical Director of the incident and actions taken. On 07/17/20 at 8:00 P.M., Resident #63 was placed continuous one-to-one staff supervision. The resident will remain on one-to-one supervision indefinitely for the resident's protection. On 07/17/20 at 9:00 P.M., Environmental Service Director #88 completed all door audits to ensure all exterior doors met safety regulations. All other facility doors were functioning correctly. The exterior door from the stairwell to the outside from the dementia unit did not alarm at the nurse's station. At 9:30 P.M., Environmental Service Director fixed the door for it to alarm at the nurse's station when opened without a door code. On 07/17/20 at 9:30 P.M., the Administrator verified all facility doors were functioning. On 07/17/20 at 9:45 P.M., the Administrator began all staff education on the facility's policy on Missing Patient and door alarm responses. On 07/17/20 at 10:30 P.M., all eight residents with secure care bracelets (a bracelet type device worn to alert staff of unauthorized exits through doors equipped with an alarming system) were validated for placement and functioning by LPN #21. On 07/17/20 at 11:00 P.M., the Administrator reviewed and updated the facility's Center Watch Binders and Boards. The Center Watch Binders and Boards provide identification information for the residents at risk for elopement. On 07/17/20 at 11:16 P.M., the facility began an investigation into Resident #63's elopement from the facility. On 07/18/20, the Director of Nursing (DON) reviewed and updated care plans as necessary for the eight residents with exit seeking behaviors (Resident #07, #12, #21, #22, #35, #45, #63 and #79). On 07/18/20, missing patient and door alarm drills were initiated two times per day for five days by the Department Managers, Nursing Managers and/or Nursing Supervisor. On 07/20/20, Unit Manager #7 reviewed the residents with exit seeking behaviors utilizing the Exit Seeking Quality Assurance and Performance (QAPI) Audit Tool. On 07/22/20 at 4:30 P.M., all 140 staff members were educated on the facility's policy on Missing Patient and door alarm responses. On 07/23/20, the missing patient and door alarm drills were completed two times per day for five days by the Department Managers, Nursing Managers and/or Nursing Supervisors. On 07/27/20, the medical records for Resident #07, #12 and #21, identified at risk for elopement, were reviewed with appropriate assessments and plans of care in place. There were no other identified elopement events. On 07/27/20 at 1:25 P.M., observations of the doors on the dementia unit revealed all four doors alarmed when opened without a door code. Staff were observed to respond quickly to the door alarms. Interviews on 07/27/20 with LPN #21, Registered Nurse (RN) #72, RN #7, STNA #49, #38 and #53 revealed the staff had knowledge of proper procedures for resident elopement, and what to do if a door alarms. Findings include: Review of Resident #63's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the exit seeking risk assessment, dated 05/19/20, revealed Resident #63 was at a high risk for elopement. Review of the physician's orders [REDACTED]. Resident #63 resided on a secure unit to maintain safety. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/06/20, revealed the resident had severe cognitive deficits and had exit seeking behaviors. The resident also required supervision with locomotion on the unit and limited assistance with locomotion off the unit. Review of the nursing note, dated 07/17/20 at 6:45 P.M., documented LPN #21 was notified by STNA#49 that Resident #63 was not observed in her room, bathroom or the dining room when she went to assist the resident with eating. Unit Manager #7 was notified. The resident was last seen at 4:00 P.M. lying on her bed. A head count was conducted, and the facility was searched. Resident #63 was observed outside the facility laying on the ground at 7:20 P.M. Resident #63 was assessed for injuries. Neurological checks were initiated. Resident #63 was found to have physical injuries, including an abrasion to her forehead, measuring three centimeters (cm.) in length by three cm. in width, an abrasion to her right knee measuring 7.5 cm. by 7.5 cm. and a skin tear to her left elbow measuring 1.5 cm. by one cm. Review of the National Weather Service Report for the evening of 07/17/20 revealed the outside temperature was 91 degrees F. Review of the facility's investigation, dated 07/17/20, revealed Resident #63 exited the building undetected. STNA #70 reported the door alarm to the door leading to a stairwell was alarmed at an unknown time on 07/17/20. When she heard the door alarm, STNA #70 checked the landing, which lead to a stairwell and another door which lead to the outside, and she saw no residents on the landing or down the first stairwell. STNA #70 stated she returned to her work duties without checking further down the stairs or outside the second door. On 07/17/20 at 6:45 P.M., STNA #49 was picking up resident meal trays. STNA #49 noted Resident #63's tray was untouched. STNA #49 went to the resident's room she checked in the bathroom, hall and dining room for the resident. STNA #49 could not locate Resident #63 on the unit and then reported this to LPN #21. LPN #21 notified Unit Manager #7 and a head count and a facility search were initiated. Interview on 07/27/20 at 10:00 A.M. with the Administrator revealed Resident #63 left the facility through the stairwell door. The stair well door sounded, and STNA #70 responded. STNA #70 looked down the steps and when no residents were seen, STNA #70 reset the door and returned to her

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) duties. STNA #70 never looked outside. The Administrator verified the facility's policy was not followed. The Administrator noted the staff should have did a head count to make sure all residents were accounted for. Observations of Resident #63 on 07/27/20 at 1:30 P.M. revealed she was lying on her bed watching television. An STNA was sitting in the room with her. Resident #63 did not verbalize when spoken too. Interview with Unit Manager #7 on 07/27/20 at 1:50 P.M. revealed the resident walks very fast around the unit. Resident #63 walks up to the doors and looks out without opening them. Interview with RN #72 on 07/27/20 at 2:00 P.M. revealed she saw the resident outside on the ground lying on her stomach from a window when they were conducting the whole facility search. RN #72 assessed the resident for injury and brought her back inside for further assessment. Interview with STNA #49 on 07/27/20 at 2:10 P.M. revealed she was assisting the residents with their evening meal. She noted Resident #63 had not eaten and she went to find the resident. Resident #63 was not in her room or bathroom. This alarmed STNA #49 and she began looking in other resident rooms. STNA #49 reported to LPN #21 she could not locate the resident. Interview with the Maintenance Supervisor (MS) #88 on 07/27/20 at 3:00 P.M. revealed the door to the stairwell alarmed, however, the door to the outside did not alarm. He verified the door to the outside should have alarmed. He noted the door has a plug in the ceiling that came loose and broke the connection to the outside door causing it to malfunction, which allowed Resident#63 to leave the facility without staff knowledge. Interview with the Administrator via telephone on 07/28/20 at 10:00 A.M. revealed the facility cameras recorded Resident #63 went out the stairwell door at 5:15 P.M. on 07/17/20. The recording revealed STNA #70 responded at 5:16 P.M. STNA #70 opened the door and looked down the steps and reset the door and returned to work. Interview with LPN #21 on 07/28/20 at 9:00 A.M. revealed STNA #49 reported the resident missing. LPN #21 noted STNA #70 did not report the door alarm to her when it went off at 5:15 P.M. on 07/17/20. Interview with STNA #70 on 07/29/20 at 10:00 A.M. revealed she responded to the door alarm but could not remember the time. She stated only the stair well door was alarming. STNA #70 stated she opened the door and looked down the steps and saw no one. She thought it was a staff member who did not reset the door, so she returned to her work duties. Review of the facility's policy on Missing Person Locator, dated 04/2009, revealed if an employee discovered a sounding door alarm, the staff are to conduct an internal search of the immediate area. The staff should perform a face to face head count. If a resident is found missing, a more thorough search shall ensue. This is an incidental finding during the course of the complaint investigation.