STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365315	A. BUILDING _____ B. WING _____	08/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAPITAL CITY GARDENS REHABILITATION AND NURSING CE	920 THURBER DRIVE WEST COLUMBUS, OH 43215

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** Based on medical record review, review of a facility investigation, review of a police incident report, review of a facility Self-Reported Incident (SRI), observation of a facility video, review of a weather report, observations, interviews with staff and a family member and review of the facilities elopement policy and procedure, the facility failed to provide adequate supervision to prevent the elopement of a resident who was assessed as being cognitively impaired and at risk for elopement. This resulted in Immediate Jeopardy and serious injury when one resident (#01) eloped from the facility, without staff knowledge, and was missing for approximately six hours. When the resident was finally located, he was admitted to the hospital for evaluation related to a [MEDICAL CONDITION] spine second vertebra (L2) and of the right olecranon (elbow). This affected one (#01) of three residents reviewed for risk of elopement. The facility identified two residents at high risk for elopement. The facility census was 93. On 08/19/20 at 3:39 P.M., the Administrator and Director of Nursing (DON) were notified that Immediate Jeopardy began on 08/14/20 at 9:42 P.M. when Resident #01 exited the unit through a side door used for smokers. State tested Nursing Assistant (STNA) #70 let Resident #01 outside while residents were smoking but failed to tell STNA #71 the resident was outside. Resident #01 then exited through a gate to the sidewalk on a corner street behind the facility. Approximately six hours later, Resident #01 was located outside, down a cement pathway, that leads to a side door of the building next door. Resident #01 was found lying on his side after falling in front of the door. The cement pathway was approximately four feet wide and 65 feet long with a declining slope of approximately 25 percent (%) and its use was for a ramp for wheelchairs. Resident #01 was assessed and found to have an abrasion to his right forearm (elbow area). Resident #01 was transferred and admitted to the hospital for evaluation related to a fracture of L2 and of the right elbow. The Immediate Jeopardy was removed on 08/15/20 when the facility implemented the following correction actions: On 08/15/20 at 3:15 P.M., Resident #01 was located and was transferred to the hospital for evaluation and treatment. On 8/15/20 at 2:30 A.M., the DON or the designee began all staff in-service training regarding resident elopement risks/smoking area. The staff training included providing a list of residents who were identified as smokers and the elopement book was reviewed. The in-service training was completed on 08/15/20. On 08/15/20, STNAs #70 and #71 were disciplined for failing to provide Resident #01 adequate supervision resulting in an elopement. On 08/15/20, the DON or designee completed a whole house audit to identify residents at risk for elopement and identify residents who smoke for staff reference. On 08/15/20 at 7:30 A.M., the DON initiated smoking audits to ensure only those residents who smoked are in the courtyard and that all who are in the courtyard return inside following smoke breaks. The audits will be completed by the DON or designee and will be completed twice weekly for four weeks then monthly thereafter. On 08/15/2020, the Maintenance Supervisor installed chime alarms to both gates in the outside courtyard to alert staff of anyone trying to come in or go out of the courtyard. On 08/17/20 at 7:00 A.M. and 1:30 P.M., the DON or designee completed all staff in-service training to provide reinforced education regarding elopement and smoking supervision. On 08/18/20 at 4:00 P.M., the Maintenance Supervisor removed/replaced the gate with a permanent fence in the outside courtyard located outside Unit A's exit door. The fence will limit only one exit/entrance from outside of the facility. On 08/19/20, review of the medical records for two (#02 and #03) additional residents, reviewed for elopement, revealed no concerns. Observation of Resident #02 and #03 on 08/19/20, revealed elopement interventions were in place. Observation on 08/19/20 at 11:00 A.M. of the facility exit doors revealed they were automatically locked, and a key fob was used by staff to unlock the doors. Observation of the facility gate leading into the Unit A exit into the courtyard revealed a chime alarm had been placed. Additional observations on 08/19/20 at 4:00 P.M. of the facility fence where the gate used to be revealed the facility had put in a permanent piece of fence and had removed the gate. On 08/19/20 and 08/20/20, an interview with Registered Nurse (RN) #50 and STNA #71 confirmed they received in-service training regarding supervision and the facility policy to prevent elopements. RN #50 and STNA #71 were knowledgeable regarding the facilities policy to prevent elopements. Although the Immediate Jeopardy was removed on 08/15/20, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: Review of Resident #01's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #01 was transferred and admitted to the hospital on [DATE]. Review of Resident #01's quarterly Minimum Data Set (MDS) assessment, dated 05/21/20, revealed the resident had impaired cognition with a brief interview for mental status (BIMS) of five out of 15. The assessment identified the resident to have behaviors of wandering (saying he wanted to go to work or home). Resident #01 required supervision while in his wheelchair, and extensive one to two person assist for toileting. The MDS documented Resident #01 rarely did use his walker. Review of the plan of care dated 05/26/20 revealed Resident #01 was at risk for elopement/wandering behavior related to a history of attempts to leave the facility unattended, impaired safety and disoriented to place. Interventions included provide structured activities: toileting, walking inside and outside, reorientation strategies. Identify pattern of wandering, divert as needed and intervene as appropriate. Review of the elopement risk assessments dated 06/26/20 revealed Resident #01 scored a six (scores of 10 or higher indicate at risk) and wanderguard was in place. On 08/10/20, the elopement risk assessment revealed Resident #01 scored a 13 and wanderguard was discontinued due to the facility being on lock down during the pandemic and stating thus not warranted at this time. Review of Resident #01's physician orders [REDACTED]. Further record review revealed Resident #01 was not identified as a resident who smoked. Review of the nurse notes dated 08/15/20 at 4:23 A.M. revealed the DON was notified at midnight, Resident #01 was not in his room or the facility. RN #50 stated she looked for Resident #01 as she last saw him on 08/14/20 at 9:30 P.M. walking up the unit hall with a walker. So around 11:30 P.M., she went to check on him in his room and noted Resident #01 was not in bed or his room. Code Amber was called and staff searched the facility and outside perimeter. The DON responded by coming into facility. The facility and perimeter was searched again with no success. Emergency services was contacted as was Resident #01's son. The Columbus Police Department (CPD) arrived and took description along with what Resident #01 was wearing which was grey sweatpants, black t-shirt, and white shoes. Resident #01 was ambulating with a walker. CPD searched the facility twice and searched the perimeter. Cameras were reviewed with CPD and detectives. CPD officer arrived back at the facility after the search and stated Resident #01 was found by the canine dog at a church behind the facility and he had fallen. The DON went with the officer and assessed the resident. Resident #01 was responsive, laughing, and joking. Resident #01 stated that he had gotten off work and was heading home. Resident #01 had sustained a laceration to the right forearm, unable to measure due to awaiting Emergency Management Team (EMT), but the DON stated she cleansed the area with normal saline, patted the area dry, and wrapped it in kerlix. Resident #01 was assisted to a wheelchair with staff to get off of the ground. No other

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) injuries were noted and no complaints of pain were voiced by the resident. CPD and the DON sat with resident until the paramedics and the son arrived. Neurological (neuro) checks were performed with no adverse reactions noted. EMT's arrived and took Resident #01 to the local hospital for evaluation and treatment. Review of the facilities elopement investigation dated 08/18/20 revealed on 08/14/20 at 9:42 P.M. Resident #01, while utilizing his walker, was let out Unit A door and allowed into an outside courtyard where resident's smoke by STNA #70. STNA #71 was outside supervising the smokers and did not realize STNA #70 had let Resident #01 outside. STNA #70 allowed Resident #01 to exit the facility assuming he was a smoker. On 08/14/20 at 11:30 P.M., RN #50 noted Resident #01 was not in his room when she went to look for him. An Amber alert was initiated immediately, and staff responded to the page. Resident #01 was not found after a search of the entire facility and outside perimeter. On 08/15/10 at 12:00 A.M. the DON was notified and responded by coming into the facility to perform a further search without success. On 08/15/20 at 12:30 A.M., emergency responders were contacted by the DON and Resident #01's son was notified by RN #50. On 08/15/20 at 12:40 A.M., police arrived, and a thorough search was conducted throughout the facility without the resident being observed. On 08/15/20 at 2:00 A.M. the detective arrived and another search of the outside perimeter/facility inside was completed without success. On 08/15/20 at 3:15 A.M., police notified the DON that Resident #01 was observed on a pathway behind the facility lying on the ground. The DON responded and assessed the resident with noted laceration to right forearm and left hand. Resident #01 was assisted into a wheelchair, that was brought from facility. Resident #01 was laughing and in good spirits. The son was notified and EMT contacted by the police department. On 08/15/20 at 3:30 A.M., the EMT's arrived and Resident #01 was taken to the local hospital per request of the resident's son. Review of the police incident report dated 08/15/20 revealed the police department received a call of a resident identified as Resident #01. The police incident report documented Resident #01 was last seen on 08/14/20 at 9:30 P.M. Resident #01 was last seen wearing white/blue t-shirt and jeans. Caller from the facility stated staff searched the entire building and could not find Resident #01. Search completed on 08/15/20 at 3:39 A.M. and Resident #01 was sent to local hospital. Review of Resident #01's hospital medical record revealed on 08/15/20 the resident presented to the emergency room after a fall. Resident #01 lives at a nursing facility and reportedly escaped and fell down a hill. Resident #01 was awake, alert, has dementia and is an unreliable historian. Resident #01 had abrasions on his forearm and head. During the evaluation Resident #01 complained of pain, unclear specifically where but includes bilateral knee, abdominal, and right arm pain. Resident #01 was found to have a fracture of L2 and of the right elbow and would have an orthopedic (ortho) evaluation. On 08/16/20, Resident #01 was evaluated by ortho who determined the resident could be discharged from the hospital without surgical intervention. On 08/16/20, Resident #01 was discharged to a family members home. Review of a facility SRI dated 08/18/20 titled Neglect/Mistreatment Abuse revealed an incident of possible neglect occurred 08/14/20 at 9:42 P.M. Further review of the SRI revealed Resident #01 was let outside to an outside courtyard where other residents were smoking and another STNA was assisting with smoking. Resident #01 then made it out of courtyard gate. Staff were immediately in-serviced on communication as STNA who was out with other residents was unaware of Resident #01 being let out into the courtyard. Both STNA's (#70 and #71) involved received disciplinary action. Staff education was implemented immediately. Smoking list was provided to staff of those residents that can go out and smoke. Resident #01's son and physician were made aware. The SRI was unsubstantiated regarding neglect. Interview with STNA #70 on 08/18/20 at 4:00 P.M. and again on 08/19/20 at 11:00 A.M. was attempted but the staff did not return the phone call. On 08/19/20 at 4:00 P.M. an interview with the DON revealed Resident #01 was found outside following his elopement on 08/15/20 and was down a pathway. Further observations with the DON of the pathway where Resident #01 was found revealed the pathway leads to a side door of the building next door to the facility and is not on the facilities premise. The DON stated Resident #01 was found lying on his side after falling in front of the door to the building next door. The observations revealed there is a cement pathway that is approximately four feet wide and 65 feet long with a declining slope of approximately 25%. This pathway is used by the building next door as a ramp for wheelchairs. The observations revealed there was no lighting down the cement pathway. The DON stated through their investigation, Resident #01 left the facility unsupervised on 08/14/20 at approximately 9:42 P.M. out the Unit A exit door into the courtyard and at the time the resident was ambulating with his walker. The DON confirmed when Resident #01 was found on 08/15/20, he was without his walker and he had left his walker along the pathway. Interview on 08/19/20 at 7:10 P.M. with RN #50 revealed she had last seen Resident #01 on 08/14/20 at 9:30 P.M. when he was walking down the hall. RN #50 stated on 08/14/20 at 11:30 P.M. she went to administer Resident #01's medication and noticed he was not in his bed or room. RN #50 stated she immediately started an Amber Alert and staff started searching for the resident. RN #50 revealed on 08/15/20 at 12:00 A.M. the staff had not located Resident #01, so she notified the DON. Interview on 08/19/20 at 1:00 P.M. with Resident #01's family member revealed he was notified by the nurse on 08/15/20 at 1:30 A.M. that Resident #01 was missing from the nursing home. Resident #01's family member stated he went to the facility and helped search for the resident. Resident #01's family member also stated he did not know what would have happened if the police canine dog had not located the resident. Resident #01's family member stated the resident was located down an unlit pathway, that was lined with overgrown shrubs and no handrails. Resident #01's family member stated the resident was found at the bottom of this pathway (ramp) curled up. Resident #01's family member stated the resident did not smoke and should have never been let out the door. Observation with the Administrator on 08/19/20 at 2:00 P.M. of a facility video from a camera located near the Unit A exit door revealed the video was dated 08/14/20 at 9:42 P.M. In the video, STNA #70 was leaning against the wall in front of Unit A exit door. Resident #01's back was observed to the camera, but it appeared Resident #01 spoke to STNA #70. STNA #70 then opened the Unit A exit door and let Resident #01 out into the courtyard. Resident #01 was wearing a dark t-shirt, grey sweatpants and exited the Unit A exit doors with a walker. Interview on 08/20/20 at 7:00 P.M. with STNA #71 revealed he does a head count when residents go out to smoke and another head count when letting them back inside after smoking. STNA #71 stated both head counts were the same on 08/14/20. STNA #71 stated he was not aware STNA #70 had let Resident #01 out into the courtyard. STNA #71 stated the facility policy is to not allow dementia residents outside with the smokers. Review of the Columbus Weather Underground Report revealed on 08/14/20 the sunset was at 8:24 P.M. Further review of the weather report revealed on 08/15/20 at 12:51 A.M., the outside temperature was 60 degrees Fahrenheit (F), at 1:51 A.M., the outside temperature was 61 degrees F and at 2:51 A.M., the outside temperature was 59 degrees F. Review of facility policy titled Elopement, dated 12/2007 and amended on 08/10/2020, revealed the facility will continue to assess for risk of elopement/wandering upon admission, quarterly, and with any signs and symptoms of risk. This deficiency substantiates Complaint Number OH 073.