STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365839	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLUMBUS ALZHEIMER'S CARE CTR	700 JASONWAY AVENUE COLUMBUS, OH 43214

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 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 the hospital history and physical, review of the hospital speech language pathology notes, surveyor observation, review of the facility census roster, interviews with facility staff, review of emails with the facility, review of the facility's elopement investigation, and review of the facility's policy on elopement, 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 a history of attempting to leave the facility, did not elope from the facility. This resulted in Immediate Jeopardy when Resident #01 left the facility without staff knowledge and was found by an off-duty facility employee at a gas station 0.7 miles from the facility, having crossed a heavily traveled seven lane road in order to reach the gas station. This affected one (#01) of four residents (#01, #04, #06, and #08) reviewed for elopement. The facility identified two current residents (#01and #04) to be at risk for elopement. The facility census was 75. On 07/16/20 at 1:49 P.M., the Administrator was notified that Immediate Jeopardy began on 07/14/20 at 7:10 A.M. when Resident #01 was discovered by off-duty State tested Nurse Aide (STNA) #201 at a gas station near a busy intersection roughly 0.7 miles from the facility and located on the opposite side of the street. The gas station was located at an intersection with seven lanes of traffic and a speed limit of 40 miles per hour. Resident #01 had exited the facility through an unsecured window in the resident lounge into an enclosed courtyard and exited the courtyard via an unsecured and unalarmed gate. Resident #01 was hospitalized prior to admission to the facility after having been found wandering away from his home and identified as exhibiting exit seeking behavior in the facility. Resident #01 had not been observed by staff for approximately one hour prior to being found at the gas station by STNA #201. The Immediate Jeopardy was removed on 07/22/20 when the facility implemented the following corrective actions: On 07/14/20 at 7:20 A.M., Resident #01 was returned to the facility and placed on one-on-one continuous staff observation. On 07/14/20 at 7:20 A.M., Maintenance Director #204 initiated safety checks on all windows and doors on the Skilled Unit. The Skilled Unit resident lounge window was secured with new five-inch bolts which extended into the wooden window frame. On 07/14/20 at 7:30 A.M., Unit Manager #205 completed a skin assessment on Resident #01 and no injuries were identified. On 07/14/20, the facility began an investigation into Resident #01's elopement from the facility. On 07/14/20 at 8:00 A.M., the Administrator and Unit Manager #205 began education with all staff regarding elopement policies and protocols. On 07/14/20 at 8:00 A.M., the Administrator and Unit Manager #205 began education on Resident #01's care plan to all staff who work with the resident. On 07/14/20 at 8:30 A.M., Maintenance Director #204 completed installation of new five-inch bolts on all windows in the Skilled Unit. The bolts were driven into the wooden window framing and prevented the windows from opening more than three and one-half inches. At 11:00 A.M., Maintenance Director #204 completed installation of the new bolts in all windows on the Program Unit, as well as in facility common areas. On 07/14/20 at 9:30 A.M., the facility Quality Assessment Performance Improvement (QAPI) committee met to review Resident #01's elopement. On 07/14/20, Maintenance Director #204 began daily visual checks of all windows and doors in the facility to ensure they remained secured. This continued through 07/22/20. On 07/15/20 at 8:00 A.M., the Director of Nursing (DON) audited the Profile Form Notebooks for accuracy and updates were completed. The Profile Form Notebooks provide identification information for the residents at risk for elopement. On 07/15/20 at 10:00 A.M., Resident #01 was assessed by the neurologist. The neurologist ordered changes to Resident #01's medications. Observation of room windows on 07/15/20 ending at 10:54 A.M. revealed the windows in resident Rooms #120, #124, #129, #130, #131, #133, #136, #137, #140, and #141 were secured with longer bolts. On 07/15/20 at 11:00 A.M., Maintenance Director #204 finished installing the new bolts on all office windows. On 07/16/20 at 10:00 A.M., the DON, Unit Manager #205, and Unit Manager #250 completed audits of all resident elopement assessments and care plans. On 07/17/20 at 3:00 P.M., the Administrator and Unit Manager #205 completed education to all staff on the facility elopement policies/protocols and on Resident #01's care plan for all staff who work on the Skilled Unit. On 07/20/20 at 3:00 P.M., every 15-minute checks were initiated on the resident lounge areas. At this time, Unit Manager #205 began educating nursing staff on the 15-minute checks for safety of resident lounge area. On 07/21/20 at 4:00 P.M., Maintenance Director #204 installed a temporary alarm on the courtyard exit gate. The alarm is audible on the Skilled Unit, which is closest to the courtyard gate. The facility has made arrangements for a permanent alarm to be installed that is audible throughout the building. On 07/22/20 at 1:00 P.M., the Administrator began educating staff on duty on the Skilled Unit on the audible alarm located on the courtyard exit gate. Education was in person and via the telephone. The facility will continue to educate each staff member not already educated, prior to their shift until the permanent alarm is installed and an all staff in-service can be conducted. The medical records for Resident #04 identified as the only other resident at risk for elopement, and for Resident #06 and Resident #08 were reviewed with appropriate assessments and plans of care in place. There were no other identified elopement events. Although the Immediate Jeopardy was removed on 07/22/20 at 3:00 P.M., the facility remained out of compliance at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings Include: Review of the medical record for Resident #01 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the hospital history and physical dated, 06/23/20, documented Resident #01 was admitted to the hospital on [DATE] after being found wandering at a gas station. Review of the hospital Speech Language Pathologist (SLP) note, dated 07/01/20, identified Resident #01 may take unsafe actions to address his needs independently. The note documented Resident #01 would benefit from one-on-one supervision due to impulsivity and poor safety awareness. Review of the nursing admission assessment, dated 07/10/20, revealed Resident #01 was able to understand others and make himself understood. Resident #01 was at risk for elopement and wandering; however, his wandering did not place him at significant risk of getting to a potentially dangerous place such as outside the facility. Resident #01 required supervision or touch assistance with walking 150 feet in a corridor or similar space. Review of the baseline care plan, dated 07/10/20, revealed Resident #01 had behaviors of wandering and exit seeking. The baseline care plan revealed Resident #01 was at risk for elopement and wandering. Interventions included the resident to be on a secure unit and the resident was allowed to have his door closed. The baseline care plan indicated Resident #01 had mild cognitive deficits and was independent with walking, transfers, bed mobility, and locomotion. Review of the elopement risk assessment, dated 7/10/20, revealed Resident #01 was not disoriented, was aware of his surroundings, had unsafe decision making capabilities, was exit seeking, had attempted to leave his home, was easily re-directed when wandering/exit seeking, was ambulatory, had a [DIAGNOSES REDACTED]. The interventions on the 7/10/20 elopement assessment included completion of a Profile Form and the resident was to reside on a secured unit. Review of the nurses' note, dated 07/10/20, revealed Resident #01 was alert to self. Review of the nurses' note dated 07/11/20 revealed as soon as Resident #01 wakes up he begins pacing up and down 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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) unit looking for an exit, asking staff to let him out or call him a cab. Resident #01 was not able to follow instructions and could not be reassured. Review of the nurses' note dated 07/13/20 revealed Resident #01 continued to be exit seeking and restless. A second nurses' note dated 07/13/20 revealed Resident #01 was pacing up and down the unit and was exit seeking. Review of Certified Nurse Practitioner (CNP) #200's note, dated 07/13/20, revealed staff had reported Resident #01 was pacing and was exit seeking. Resident #01 was oriented times one and was confused. On 07/13/20, CNP #200 ordered the [MEDICAL CONDITION] medication [MEDICATION NAME] 250 milligrams by mouth, two times a day, for restlessness. Review of the Situation Background Assessment Recommendation (SBAR) communication form, dated 07/14/20, revealed Resident #01 was noted to be outside of the facility on 07/14/20. The resident was brought back to the facility and an assessment was completed. No injuries were noted. Upon notification to CNP #200 of the event, she recommended Resident #01 be placed on one-on-one staff supervision. Review of the elopement assessment, dated 07/14/20, revealed Resident #01 was no longer aware of his surroundings and had attempted to leave the facility. This was identified as a change from the last assessment. A new intervention identified Resident #01 was placed on direct one-on-one staff supervision. Review of Resident #01's baseline care plan revealed a new intervention was added on 07/14/20 to include a one-on-one staff supervision. Review of the facility investigation into Resident #01's elopement revealed on 07/14/20 at 6:00 A.M., while completing rounds, STNA #202 observed Resident #01 come out of his room and ambulate independently down the hallway. On 07/14/20 at 6:10 A.M., Licensed Practical Nurse (LPN) #203 was with Resident #01 for several minutes completing an assessment of him. After the assessment, LPN #203 went down the other hall on the unit while Resident #01 remained in the hallway. On 07/14/20 at 7:10 A.M., STNA #201 arrived at a gas station down the street from the facility and observed Resident #01 on the gas station property. At 7:15 A.M., STNA #201 called the facility charge nurse and reported Resident #01 was at the gas station. The nurse notified the Unit Manager and the Administrator. The Administrator and Unit Manager immediately went to the gas station, which was found to be 0.7 miles from the facility and drove Resident #01 back to the facility. On 07/14/20 at 7:20 A.M., Resident #01 returned to the facility and was placed on one-on-one staff supervision at all times. During an interview on 07/15/20 at 8:50 A.M., the Administrator and DON revealed the entire facility is a secured facility. The interview revealed Resident #01 was admitted to the facility due to his wandering behaviors while at home. The Administrator revealed Resident #01 exited the facility via the window in the resident lounge area on 07/14/20. The windows in the facility have bolts in place to prevent them from opening more than approximately three and one-half inches; however, Resident #01 removed the bolts from the resident lounge window, knocked the window screen out, and exited the facility. During the interview, the Administrator stated STNA #201 had clocked out after her shift ended at 7:00 A.M. on 07/14/20 and was on her way home from the facility when she stopped at the gas station and observed Resident #01. Observations of the Skilled Unit on 07/15/20 between 8:55 A.M. and 9:33 A.M. revealed the resident lounge was located next to the nurses' station and had one window that exited to an enclosed courtyard area. The resident lounge window was secured with bolts to prevent the window raising greater than approximately three and one-half inches. Observation on 07/15/20 at 9:16 A.M. revealed Resident #01 was lying in bed. A staff member was observed to be seated in a chair near the bed. During an interview on 07/15/20 at 9:16 A.M., Maintenance Director #204 revealed when he checked the resident lounge area window after Resident #01 was discovered to have left the facility, he found both of the bolts had been removed from the window frame, allowing the window to open all the way. Maintenance Director #204 revealed he also discovered room [ROOM NUMBER] and room [ROOM NUMBER] each had one bolt removed from the window frames. Review of the facility census revealed room [ROOM NUMBER] was occupied by Resident #01 and room [ROOM NUMBER] was vacant. During an interview on 07/15/20 at 10:10 A.M., Maintenance Director #204 revealed the window bolts in use on all the windows prior to Resident #01's elopement only went through the frame of the window and were not secured to any wall structure. The bolts were only three inches in length and rested into an air pocket between the aluminum window framing and the structural wooden window studs. Maintenance Director #204 stated the window bolts could have possibly been loosened by consistently being hit when residents attempted to open the window beyond the three and one-half inch gap. Maintenance Director #204 stated on 07/14/20 he replaced all the three-inch bolts with five-inch bolts that are secured into the structural wooden window studs. During an interview on 07/15/20 at 11:47 A.M., the Administrator verified facility staff were not aware Resident #01 was missing and had eloped until they received a call from STNA #201 on 07/14/20 at 7:15 A.M. stating she was with Resident #01 at a gas station. The Administrator also verified the facility staff were aware Resident #01 exhibited exit seeking behaviors at home. During an interview on 07/15/20 at 2:37 P.M., the DON stated when a resident was at risk for elopement, resident specific interventions are to be put into place. The DON revealed the interventions in place for Resident #01's elopement risk included the secured unit and a Profile Form. During an interview on 07/15/20 at 3:57 P.M., STNA #201 revealed she was on her way home from work on 07/14/20 when she stopped to get gas at the gas station and noticed Resident #01. She stated Resident #01 was wearing a short-sleeved shirt, shorts, and shoes when she saw him. She stated she approached him, and he told her he had left the facility, did not tell the facility he left, and did not want to go back to the facility. STNA #201 stated she called the facility staff to notify them Resident #01 was at the gas station and she stayed with Resident #01 until facility staff arrived to pick him up. Review of e-mail correspondence with the Administrator, dated 07/15/20 at 4:38 P.M. and 4:48 P.M., revealed when Maintenance Director #204 observed the resident lounge window on 07/14/20, the bolts preventing the window from opening greater than three and one-half inches were removed. One of the bolts was found on the ground while the other was found on the windowsill. During an interview on 07/16/20 at 8:01 A.M., LPN #203 stated she saw Resident #01 pacing up and down the hallway on 07/14/20 between 5:00 A.M. and 6:00 A.M. She took Resident #01's blood sugar around 6:00 A.M. and then went to the other side of the unit. She gave report to the on-coming nurse around 7:00 A.M. LPN #203 stated she did not see Resident #01 after 6:00 A.M. She stated she had never observed Resident #01 messing with the windows prior to 07/14/20; however, she had heard of other staff who saw him trying to open the windows on the unit. She had not heard of him trying to remove the bolts of the window. LPN #203 did verify Resident #01 was known to exhibit exit seeking behaviors. During an interview on 07/20/20 at 8:23 A.M., the Administrator stated the resident lounge window that had been tampered with opens to an enclosed outside area. There is a gate in the enclosed outside area Resident #01 had to go through to leave the facility property. The Administrator stated the gate is neither locked nor alarmed. During an interview on 07/20/20 at 9:45 A.M., Unit Manager #205 revealed she arrived to work on 07/14/20 between 6:00 A.M. to 6:30 A.M. Unit Manager #205 indicated she had no knowledge Resident #01 had left the building when she arrived at the facility. She was made aware Resident #01 had eloped a little after 7:00 A.M. During an interview on 07/20/20 at 12:08 P.M., Registered Nurse (RN) #206 stated LPN #203 gave her report on 07/14/20 at 7:00 A.M. At that time, she was unaware of Resident #01 having left the facility. She stated once she became aware of Resident #01 having left the facility, she observed the resident lounge window and it was closed but looked like it had been manipulated. Review of e-mail correspondence with the Administrator, dated 07/20/20 at 12:15 P.M., revealed the gate to the enclosed courtyard outside the resident lounge window was closed when Maintenance Director #204 observed it on 07/14/20 after being notified Resident #01 had left the facility property. Review of the undated facility policy titled Elopements and Wandering Residents revealed the facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Residents will be assessed for risk of elopement and unsafe wandering upon admission and during their stay by the interdisciplinary team. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. Charge nurses and Unit Managers will monitor the implementation of interventions, response to interventions, and document accordingly. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to staff. This deficiency substantiated Complaint Number OH 091.