STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365798	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COURTYARD AT SEASONS	7100 DEARWESTER DRIVE CINCINNATI, OH 45236

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a facility self-reported incident (SRI), interviews with staff and residents representative and review of facility policy, the facility failed to notify the resident's representative of a new order for a Wander Guard bracelet (monitoring bracelet which triggers an audible alarm when a resident attempts to exit the facility without supervision). This affected one (#30) of three residents sampled for elopement risk. The census was 35. Findings include: Review of the record for Resident #30 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED].#30 dated 07/01/20 revealed resident was cognitively impaired, was coded as negative for the presence of wandering behaviors, used a walker for mobility, and required supervision and set up help for locomotion on and off the unit. Review of elopement risk assessment for Resident #30 dated 06/26/20 revealed resident was not determined to be at risk for elopement. Review of facility SRI report initiated on 08/20/20 and finalized on 08/25/20 revealed the facility investigated and substantiated an allegation of neglect in which Resident #30 exited the facility on 08/20/20 at approximately 6:26 A.M. without staff supervision. Further review of the report revealed the facility placed a Wander Guard bracelet to the resident's right ankle on 08/25/20 to prevent future elopement incidents. Review of the care plan for Resident #30 initiated 08/25/20 revealed the resident was an elopement risk/wanderer related to disorientation to place, history of attempts to leave facility unattended, and impaired safety awareness. Interventions included the following: identify pattern of wandering and intervene as appropriate, apply Wander Guard to right ankle, staff to check for placement and function of Wander Guard to right ankle every shift. Review of August 2020 physician orders for Resident #30 revealed an order dated 08/25/20 for resident to wear a Wander Guard bracelet and for nursing staff to check the placement and functioning of the bracelet every shift. Review of the August 2020 Medication Administration Record [REDACTED]. Review of the nurse progress notes for Resident #30 dated 08/25/20 through 08/31/20 revealed the notes did not contain documentation regarding resident representative notification of the order for Wander Guard bracelet placement. Interview on 08/31/20 at 11:01 A.M. with Resident #30 Representative confirmed the facility did not notify her of the order for resident to have a Wander Guard place. Resident #30's Representative confirmed she had a patio window visit with resident on 08/29/20 and noted he had a bracelet of some type to his right ankle which she perceived to be some type of safety monitoring device. Resident #30's Representative further confirmed she was going to call the facility and ask about the ankle bracelet. Interview on 08/31/20 at 2:53 P.M. with the Director of Nursing (DON) confirmed the facility had no documentation indicating Resident #30's representative was notified of the order for Wander Guard placement. Review of the facility policy titled Use of Wander Guard dated 02/27/19 revealed if a resident was determined to be at risk for elopement the use of a Wander Guard bracelet was recommended. Further review of the policy revealed the progress notes would include documentation of the facility's discussion of the use of Wander Guard device and would include documentation of discussion with the resident's representative regarding agreement or refusal of the device. This deficiency is based on incidental findings discovered during the course of this complaint investigation.
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 medical record review, review of a facility self-reported incident (SRI), observation, staff interview, and review of facility policy, the facility failed to ensure the alarms on the exit doors were sufficiently loud and effective in summoning staff assistance when residents exited the facility without supervision. Also, the facility failed to implement their elopement policy by reassessing a residents for elopement risk following an elopement incident. This affected one (#30) of three residents reviewed for elopements. The census was 35. Findings include: Review of record for Resident #30 revealed an admission date of [DATE] of [MEDICAL CONDITION]. Review of Minimum Data Set (MDS) for Resident #30 dated 07/01/20 revealed resident was cognitively impaired and required limited assistance of one staff with activities of daily living and was coded as negative for the presence of wandering behaviors. Review of the elopement risk assessment for Resident #30 dated 06/26/20 revealed resident was not determined to be at risk for elopement. Further record review revealed there was no other elopement risk assessment after 06/26/20. Review of the nurse progress notes for Resident #30 dated 08/20/20 timed at 7:00 A.M. revealed resident was assessed for a fall without injury, vital signs were noted to be within normal limits, and resident's attending physician and representative were notified. The medical record review revealed there was no documentation regarding Resident #30 eloping. Review of the August 2020 physician orders [REDACTED]. Review of August 2020 physician orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Further review of the care plan for Resident #30 initiated 08/25/20 revealed the resident was an elopement risk/wanderer related to disorientation to place, history of attempts to leave facility unattended, and impaired safety awareness. Interventions included the following: identify pattern of wandering and intervene as appropriate, apply Wander Guard to right ankle, staff to check for placement and function of Wander Guard to right ankle every shift. Review of a facility SRI form initiated 08/20/20 and completed 08/25/20 revealed the facility investigated and substantiated an allegation of neglect regarding Resident #30. Further review of the report revealed Resident #30 exited the 40 Hall door unsupervised using a walker at approximately 6:26 A.M. and was found lying on the ground outside the facility at approximately 6:35 A.M. by a staff member. The report revealed after investigation the facility determined the door alarm to the door where Resident #30 had exited the building was in working order, yet the volume of the alarm was of insufficient level to alert staff and be easily distinguished as a door alarm. The report also noted the door alarm only sounded when door was opened and silenced when the door closed. Observation on 08/27/20 at 9:22 A.M. of the 40 Hall exit door with the Administrator revealed the door alarm was functioning and in working order, but the alarm silenced immediately upon closure of the door. Interview on 08/27/20 at 9:22 A.M. with the Administrator confirmed Resident #30 had exited the building unsupervised on 08/20/20 at approximately 6:26 A.M. through the 40 Hall exit door. Administrator further confirmed facility had taken the following actions after the incident on 08/20/20: turned up the volume on the alarms to the 20 Hall and 40 Hall exit doors, initiated more frequent checks on Resident #30, re-educated staff on the abuse and elopement policies, placed a Wander Guard bracelet on Resident #30, made plans to order new door alarms which would sound continuously until they were turned off by staff for the 20 Hall and 40 Hall doors. Interview on 08/31/20 at 10:41 A.M. with Housekeeper #100 confirmed she found Resident #30 lying outside the facility on the ground with his walker on 08/20/20 at approximately 6:40 A.M. when she arrived on the campus for work. Housekeeper #100 further confirmed Resident #30 was not injured and was in no visible distress and was

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) lying in the grassy area close to the 40 hall exit door. Housekeeper #100 stated Resident #30 said he was looking for his car and she notified the nursing staff who came outside to assist the resident. Interview on 08/31/20 at 10:52 A.M. with Maintenance Director (MD) #400 confirmed he was not present in the facility when Resident #30 exited through the 40 Hall door on 08/20/20. MD #400 confirmed the door alarm did not sound loudly enough for staff to hear it and the door alarm stops sounding once the door is closed. He also confirmed the door alarms to the 40 Hall and 20 Hall were being replaced on 08/31/20 with an alarm which continues to sound until staff turn it off with a key. Interview on 08/31/20 at 2:53 P.M. with the Director of Nursing (DON) confirmed the facility did not update Resident #30's elopement risk assessment following his elopement on 08/20/20 and confirmed the most recent elopement risk assessment completed for Resident #30 was done on 06/26/20. Interview on 08/31/20 at 3:41 P.M. with Licensed Practical Nurse (LPN) #500 confirmed on 08/20/20 at approximately 6:45 A.M. Housekeeper #100 notified her Resident #30 was lying outside on the grass outside the 40 Hall exit door. LPN #500 confirmed she assisted resident back into the facility, assessed him for injuries with none noted, and notified the DON, the attending physician, and Resident #30's representative of the elopement and fall. LPN #500 further confirmed the last time she saw Resident #30 prior to the fall/elopement was sometime on 08/20/20 between 5:00 A.M. and 6:00 A.M. during her medication pass. LPN #500 confirmed Resident #30 did not receive any medications from her on 08/20/20, and he was in his room and was not exit-seeking when she observed him. LPN #500 confirmed she did not hear the alarm sound and was not aware Resident #30 had exited the building. Review of facility policy titled Elopement Review dated 09/22/18 revealed the facility would prevent elopement by reviewing resident risk factors and implementing any effective interventions to diminish exit seeking behavior and would be assessed using the elopement risk assessment in the facility's electronic medical record on admission, quarterly, and with any change in condition to determine the resident's potential to exit from the facility. This deficiency substantiates Complaint Number OH 288.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of medication information from Medscape and review of facility policy, the facility failed to ensure residents were free from unnecessary medications when as needed orders for antipsychotic and antianxiety medications were not limited to 14 days. This affected two (#14 and #19) of three residents sampled for medication review. The census was 35. Findings include: 1. Review of the medical record for Resident #14 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #14 dated 07/17/20 revealed resident was cognitively impaired, was totally dependent on the assistance of two staff for activities of daily living and was coded as negative for the presence of behaviors and for the administration of an antipsychotic. The [DIAGNOSES REDACTED].#14 initiated 07/04/20 revealed it did not contain documentation regarding behavioral concerns for the resident. Review of nurse progress note for Resident #14 dated 08/10/20 revealed resident was increasingly irritated and stated multiple times he needed to find his dog and wife, kept [MEDICATION NAME] at staff walking by, and attempted to open doors and stand up after staff asked him to sit down. Review of physician's order for Resident #14 dated 08/13/20 revealed an order for [REDACTED]. There was no stop date or duration included with the order. Review of the August 2020 MAR for Resident #14 revealed resident received [MEDICATION NAME] for anxiety and restlessness with effect on the following dates: 08/13/20, 08/14/20, 08/15/20, 08/17/20, 08/18/20, 08/19/20, 08/21/20, 08/22/20, 08/23/20, 08/24/20, 08/27/20, 08/29/20 and 08/31/20. Review of the behavior monitoring sheet for Resident #14 revealed staff were to monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, [MEDICAL CONDITION], aggression, refusing care. Staff were to document Y for any of the above observed and N if monitored and none of the above was observed. If YES staff would complete a progress note indicating findings. Further review of sheet revealed it was marked Y on 08/13/20 and 08/14/20 but was marked N the rest of the dates. Interview on 08/31/20 at 2:53 P.M. with the DON confirmed the Resident #14 was ordered [MEDICATION NAME] as needed on 08/13/20 and the order extended beyond 14 days without a stop date. 2. Review of the medical record for Resident #19 an admission date of [DATE] with diagnoses which included anxiety disorder and major [MEDICAL CONDITION]. Review of the MDS for Resident #19 dated 08/01/20 revealed resident was cognitively intact and was coded as negative for the presence of behavioral symptoms. Further review of the MDS revealed the resident received an antipsychotic one time during the seven-day assessment period and the resident had no [DIAGNOSES REDACTED].#19 dated 07/21/20 revealed the resident was at risk for potential side effect problems related to antipsychotic medication usage. Interventions included the following: monitor for dizziness, sedation, unsteady gait, monitor for abnormal involuntary movements and report any abnormal movements to the physician, monitor for adverse cardiovascular effects including the development or worsening heart failure, shortness of breath, [MEDICAL CONDITION], orthostatic [MEDICAL CONDITION], falls, and/or [MEDICAL CONDITION] episodes. Review of the physician orders for Resident #19 revealed an order dated 07/21/20 for resident to receive [MEDICATION NAME] one mg by mouth as needed for restlessness and two mg to be given as needed for severe restlessness. Further review of the order revealed it did not include a stop date and was to be used until the end of the resident's life as resident was under hospice services. Review of the July MAR and August MAR for Resident #19 revealed resident received [MEDICATION NAME] one mg on 07/27/20 for restlessness. Interview on 08/31/20 at 2:53 P.M. with the DON confirmed resident was ordered [MEDICATION NAME] as needed on 07/20/20 and the order extended beyond 14 days. Review of medication information from Medscape revealed [MEDICATION NAME] is an antipsychotic medication used to treat [MEDICAL CONDITIONS] and [MEDICAL CONDITION] Disorder. [MEDICATION NAME] is an antianxiety medication used for anxiety disorders, short-term treatment of [REDACTED]. Review of the facility policy titled Antipsychotic Medication dated 04/11/19 revealed antipsychotic medications would only be used to treat specific medical conditions such as [MEDICAL CONDITION] and [MEDICAL CONDITION] and for severe symptoms causing the individual inconsolable or persistent distress and a significant decline in function and should not be used for symptoms such as anxiety, restlessness, unsociability, uncooperativeness, and verbal expressions and behavior that do not represent a danger to the resident or others. Further review of the policy revealed as needed anti-psychotic medication orders should not be extended beyond 14 days. This deficiency substantiates Complaint Number OH 288.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a facility self-reported incident (SRI), staff interview, and review of facility policy the facility failed to ensure an elopement incident was documented in the resident's medical record in accordance with the facility policy. This affected one (#30) of three residents reviewed for elopements. The census was 35. Findings include: Review of the record for Resident #30 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED].#30 dated 07/01/20 revealed resident was cognitively impaired, was coded as negative for the presence of wandering behaviors, used a walker for mobility, and required supervision and set up help for locomotion on and off the unit. Review of the elopement risk assessment for Resident #30 dated 06/26/20 revealed resident was not determined to be at risk for elopement. Further record review revealed there was no other elopement risk assessment after 06/26/20. Review of the nurse progress notes for Resident #30 dated 08/20/20 timed at 7:00 A.M. revealed resident was assessed for a fall without injury, vital signs were noted to be within normal limits, and resident's attending physician and representative were notified. The medical record review revealed there was no documentation regarding Resident #30 eloping. Review of the August 2020 physician orders [REDACTED]. Review of August 2020 physician orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Further review of the care plan for Resident #30 initiated 08/25/20 revealed the resident was an elopement risk/wanderer related to disorientation to place, history of attempts to leave facility unattended, and impaired safety awareness. Interventions included the following: identify pattern of wandering and intervene as appropriate, apply Wander Guard to

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) right ankle, staff to check for placement and function of Wander Guard to right ankle every shift. Review of facility SRI report initiated on 08/20/20 and finalized on 08/25/20 revealed the facility investigated and substantiated an allegation of neglect in which Resident #30 exited the facility on 08/20/20 at approximately 6:26 A.M. without staff supervision. Interview on 08/31/20 at 2:53 P.M. with the Director of Nursing (DON) confirmed Resident #30's medical record did not include an account of resident's elopement on 08/20/20 and she was planning to have the nurse working at the time of the resident's elopement make a late entry in the medical record. Interview on 08/31/20 at 3:41 P.M. with Licensed Practical Nurse (LPN) #500 confirmed on 08/20/20 at approximately 6:45 A.M. Housekeeper #100 notified her Resident #30 was lying outside on the grass outside the 40 Hall exit door. LPN #500 confirmed she assisted resident back into the facility, assessed him for injuries with none noted, and notified the DON, the attending physician, and Resident #30's representative of the elopement and fall. LPN #500 further confirmed she did not hear the alarm sound and was not aware Resident #30 had exited the building and she had not documented an account of Resident #30's elopement in the resident's medical record and she planned to make a late entry. Review of the policy titled Missing Resident dated 02/27/19 revealed the facility would document any incidents of missing residents in the resident's medical record. This deficiency is based on incidental findings discovered during the course of this complaint investigation.
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, staff interview, review of facility policy, and review of online resources from the Centers for Disease Control (CDC) and the Ohio Department of Health (ODH), revealed two randomly observed facility staff (Server #600 and Physical Therapist (PT) #700) failed to wear appropriate facemask's inside the facility to potentially prevent the spread of Coronavirus Disease 2019 (COVID-19). This had the potential to affect all the residents in the facility. The census was 35. Findings include: 1. Observation on 08/27/20 at 8:49 A.M. of Server #600 who was serving as the screener for visitors and staff at the front entrance revealed employee was wearing a cloth face covering. Further observation revealed a box of surgical masks was available on the screening table for anyone who needed a mask. Interview on 08/27/20 at 8:50 A.M. with Server #600 confirmed she was offered a surgical mask by the facility, but she preferred to wear the cloth face covering which she had brought from home. Interview on 08/31/20 at 2:53 P.M. with the Director of Nursing (DON) confirmed staff were expected to wear N-95 or surgical masks at all times within the facility. Review of online resource from the CDC (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html) revealed the following information regarding cloth face coverings versus surgical facemask's and N-95 respirators: cloth face coverings are not considered PPE, cloth face coverings are not considered an appropriate substitute for PPE, health care workers should wear surgical masks or respirators (like N95 respirators) in the workplace to protect the wearer. 2. Observation on 08/27/20 at 9:10 A.M. revealed PT #700 was seated and working at desk in the therapy gym facing the open door of the gym and was not wearing a facemask. Further observation revealed Physical Therapy Assistant (PTA) # 800 was working in the therapy gym at the same time and was wearing an N-95 facemask. Interview on 08/27/20 at 9:12 A.M. with PT #700 confirmed she was working in the therapy gym facing the open door. PT #700 further confirmed she took her mask off for a moment when she was having a discussion with her manager and had not put the mask back on. Interview on 08/31/20 at 2:53 P.M. with the DON confirmed staff are expected to wear facemask's while working inside the facility in work and/or resident areas. Review of facility policy titled outbreak management dated 02/20/20 revealed facility would implement infection control measures necessary for outbreak management including personal protective equipment (PPE) training. Further review of the policy revealed the facility would instruct staff on how the disease is transmitted, any specific precautions needed and the use of masks by the staff would be in accordance with the type of outbreak and infection control recommendations. Review of facility document undated titled How to Take a Mask Break revealed if staff needed to remove mask to do so during break time and away from the potential for contact and outdoors was preferred location. Review of an online resource from the CDC (https://www.cdc.gov/Coronavirus/2019-ncov/hcp/long-term-care-strategies.html) revealed the following guidance regarding facemask's: ensure all healthcare care personnel (HCP) wear a facemask for source control while in the facility. Review of ODH public health order dated 07/23/20 revealed all individuals in the state of Ohio should wear a face covering in indoor locations that were not private residences. Further review of the order revealed a face covering was not required in an office for an individual working alone provided the office was an enclosed space. Review of the CDC website (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html) revealed social distancing should be practiced in combination with other everyday preventive actions to reduce the spread of COVID-19, including wearing masks, and wearing a mask was not a substitute for social distancing