STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365324	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELDEN VILLAGE HEALTHCARE	5005 HIGBEE AVENUE NW CANTON, OH 44718

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record and policy review, the facility failed to ensure all allegations including neglect were reported immediately to the Ohio Department of Health. This affected one (Resident #1) of three residents reviewed for elopement risk. Findings include: Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1 resided on the secured dementia unit until he was discharged to the hospital on [DATE] following a fall and did not return to the facility. On 05/31/20 at 7:20 P.M. Resident #1 left the facility unattended and was found along side a busy four lane road by the police who returned him to the facility on [DATE] at 8:15 P.M. Interview with the Administrator on 07/06/20 at 7:30 A.M. revealed he did not report the incident to the Ohio Department of Health because the facility self implemented a plan of correction. Review of the facility's July 2017 abuse investigation and reporting policy revealed 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves suspicion of a crime, abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. 3. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record and policy review, the facility failed to assess Resident #1's skin wounds upon admission and when the skin wounds reopened. This affected one (Resident #1) of three residents reviewed for skin wounds. The facility census was 81. Findings include: Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the admission summary dated 04/25/20 at 3:17 P.M. indicated Resident #1 refused a skin assessment. On 04/27/20 at 12:27 P.M. the skin/wound note indicated Resident #1 had a burn on his back, an open lesion to the right side of his face, and an open lesion to the right corner of his eye. Review of the admission comprehensive assessment (MDS 3.0) dated 05/01/20 section M skin conditions indicated Resident #1 had open [MEDICAL CONDITION] other than ulcers, rashes or cuts and burns. The assessment indicated Resident #1 did not have skin tears upon admission. Review of the nurse aide bath/shower report dated 04/27/20 indicated he had open areas to his right forearm and the top of his left wrist. The report was not signed by a nurse and there was no further documentation of the areas including type, location, size or description. Review of subsequent skin/wound notes dated 04/29/20, 05/06/20, 05/13/20, 05/20/20 and 05/27/20 revealed lack of assessment of the right forearm and left wrist area. Review of the incident/investigation revealed on 05/31/20 at 7:20 P.M. Resident #1 successfully eloped from the facility. Review of the witness statement authored by Registered Nurse (RN) #99 dated 05/31/20 indicated Resident #1 reopened skin tears on his right forearm and a laceration on his left wrist. There was no description, size, number or measurement of these areas. On 06/01/20 at 1:41 P.M. the Director of Nursing (DON) authored a late entry for 05/31/20 into a progress note about the incident. The DON noted the resident had no injuries. The skin/wound note dated 06/03/20 at 3:01 P.M. continued to identify the open [MEDICAL CONDITION] to the right side of Resident #1's face and eye area. On 06/10/20 at 2:37 P.M. the skin/wound note indicated the right forearm abrasion was resolved. Review of the care plan related to skin tears/potential for skin tear on the right arm related to aging and fragile skin was not developed until 06/23/20. The interventions included encouraging good nutrition, treatment, keep the skin clean and dry, monitor/document, location, size and treatment of [REDACTED].M. verified the nurse aide bath/shower report was not signed by a nurse, the areas were not assessed by a nurse to identify the type of open areas, location, size or description, there was no further nursing assessment of the areas on going and no assessment of the areas upon his return on 05/31/20 or thereafter. Review of the skin assessment and documentation policy and procedure dated 12/01/18 indicated to complete a skin grid-other skin problems when an area other than pressure was identified such as rash, skin tear, burn, cut, abrasion, excoriation, open lesion, surgical wound or bruise. Be sure to note if the impairment was present upon admission. The procedure indicated to measure each area one time per week and as needed for any changes in the wound. Record the measurements and descriptions on the skin grid. Keep the grids in the treatment book until the area resolves. Note any new physician orders [REDACTED].
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 non-compliance that was subsequently corrected prior to this survey. Based on observation, staff interview, medical record review, review of the facility investigation and review of the Elopement Policy, the facility failed to provide adequate supervision for one cognitively impaired resident (Resident #1) to prevent elopement from the facility. This resulted in Immediate Jeopardy when Resident #1 who was at risk for elopement, voiced and exhibited exit seeking behaviors and resided in the secured dementia unit, left the facility unknown to staff. Resident #1 was at risk for serious harm, impairment or death as he walked along a heavily trafficked four lane road and was found by a police officer who returned him to the facility. This affected one (Resident #1) of three residents reviewed for exit seeking behaviors. The facility identified eight additional residents (Residents #2, #3, #4, #5, #6, #7, #8 and #9) who were ambulatory or independently mobile and assessed as being at risk for wandering and elopement or exhibited exit seeking behaviors. On 07/07/20 at 1:55 P.M. the Administrator and the Director of Nursing (DON) were notified Immediate Jeopardy began on 05/31/20 at 7:20 P.M. when Resident #1 left the facility without staff knowledge. Resident #1 was last seen in the building on 05/31/20 at 7:00 P.M. before exiting through an alarmed door, into a secured

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) courtyard where he scaled a six- foot fence using his wheeled walker. The local police were notified and at 8:15 P.M. found Resident #1 walking along a busy four lane road. Review of the police report revealed the resident was approximately 0.7 miles from the facility. There was a tear in his blue jeans and he had several small open scratches to his arms and a small cut on his head. The resident asked the officer to take him home so he could see his wife and feed his dog. The Immediate Jeopardy was removed and corrected on 06/02/20 at 5:30 P.M. when the facility implemented the following corrective actions: On 05/31/20 at 8:15 P.M. Resident #1 was returned to the facility by local police. Assessment revealed the resident reopened old skin tears on the top of his left wrist and had a small laceration on his right forearm. Review of the nurse aide bath/shower report dated 04/27/20 indicated he had open areas to his right forearm and the top of his left wrist upon admission to the facility. The resident was provided one to one direct supervision and monitored for further elopement behaviors. On 05/31/20 at 8:00 P.M. the Administrator educated staff currently working on the importance of checking alarms and elopement policies. On 05/31/20 at 8:30 P.M. the Administrator tested all 15 doors that have the alert system. Three of the 15 were located in the secured unit. The gate and the patio doors were also tested . All of the door alarms were determined to be functional. On 05/31/20 at 9:00 P.M. the DON began assessments on all cognitively impaired residents in the facility to determine if they were at risk for elopement or had a change in condition. Care plans were updated and new interventions were implemented as needed. On 06/01/20 at 10:00 A.M. the elopement book was updated by the Administrator to include adding Resident #1. The elopement book included a picture of the resident and their face sheet for staff and law enforcement to aid in search if a resident was missing. On 06/02/20 at 9:00 A.M. physician orders [REDACTED].#1 through #9) who were identified as at risk for elopement by the DON to ensure appropriate interventions were in place. On 06/02/20 at 5:30 P.M. the Administrator and DON and Human Resource Director (HRD) #94 completed education with all 70 staff on supervision of residents, elopement policy, missing persons, and responding to door alarms. This was verified with staff in-service sign in sheets. On 06/02/20 elopement drills were conducted successfully on each shift. On 07/07/20 interviews from 9:00 A.M. to 11:15 A.M. with State tested Nurse Aide (STNA) #89, STNA #90, LPN #91 and on 07/08/20 from 10:05 A.M. to 10:34 A.M. with Registered Nurse (RN) #96, Licensed Practical Nurse (LPN) #85 and STNA #95 revealed all had been in-serviced and were knowledgeable of supervision of residents, the elopement policy, door alarm response, residents at risk for elopement and proper use of alert bracelets. All of these staff worked routinely on the secured dementia unit. STNA #89 and STNA #90 were present when Resident #1 successfully eloped from the facility. On 06/22/20 the quarterly Quality Assurance meeting minutes indicated the facility self-implemented a quality assurance plan including door audits daily for 30 days then monthly thereafter completed by the maintenance director and chart audits daily for 30 days by the director of nursing. Findings include: Review of the medical record revealed Resident #1 as admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1 was a court ordered admission and placed on the secured dementia unit after police completed a wellness check at his home where he resided with his wife. Resident #1 was found in his bathtub [MEDICAL CONDITION] his back from the hot water. Resident #1 was discharged to the hospital on [DATE] following a fall and did not return to the facility. Review of the admission Minimum Data Set (MDS) 2.0 dated 05/01/20 indicated Resident #1 had short and long-term memory problems and was severely cognitively impaired in daily decision making. Resident #1 rejected care on one to three days of the assessment period but wandering was not exhibited. Review of activities of daily living indicated the resident required the supervision of one person for transfers, walking in the corridor on the unit and off the unit. His balance was steady at all times. He had no functional limitation in range of motion and used a walker for mobility. The assessment indicated Resident #1 had a fall with a fracture in the month prior to admission to the facility. Review of the elopement risk assessment dated [DATE] indicated Resident #1 was physically capable of leaving the facility and was confused to time and place. The list of interventions put into place was left blank leaving the determination of whether the resident was at risk for elopement unclear. However, review of the resident's care plan completed on admission and dated 04/25/20, indicated Resident #1 was at risk for elopement. The form was marked to interview the resident/family about whether there was a history of the resident attempting to leave his home or other facilities. The form also indicated Resident #1 had behaviors and to observe the resident's behaviors for the first 72 hours after admission, report any behaviors that could affect the resident's quality of life and/or affect other residents, and in the event he displayed disruptive behavior, redirect the resident and report the behavior. Review of the care plan related to Resident #1 being at risk for alteration in mood and behavior revealed resistance to care, verbal abuse and placing himself on the floor. Interventions included acknowledging the resident moods, one to one interactions, convey acceptance of the resident and provide repeated honest appraisals of his strengths, discuss feelings about placement and options of appropriate channeling of those feelings, encourage loved one to contact/visit, monitor mental and mood status changes when new medications were added and observe and report changes in mental status. Review of the progress notes since Resident #1's admission revealed he was frequently agitated, refused to sign forms or be assessed. The progress note authored by LPN #85 on 05/28/20 at 11:26 A.M. indicated Resident #1 was up in the hallway with his walker, exit seeking. The note did not identify specifics of Resident #1's actions. Review of the progress note documented as a late entry for 05/31/20 at 7:20 P.M. by the DON on 06/01/20 at 1:41 P.M. indicated Resident #1 was last observed on 05/31/20 at 7:00 P.M. and was noted absent from his room as evening snacks were being passed. A search was initiated. Resident #1 was found approximately 20-25 minutes later walking on a sidewalk on a main street. Review of the witness statements contained in the investigation revealed RN #88 entered the secured dementia unit to bring Resident #1 a snack. RN #88 was not able to find Resident #1 and asked STNA #89 and #90, currently assigned to work the unit, where Resident #1 was because she had a snack for him. STNA #89 and #90 searched the unit and the adjacent secured courtyard. Resident #1's walker was found leaning against a six-foot wood fence in the secured courtyard. No alarm had sounded. The nurse called a code green for missing persons and 911 was called. The STNAs completed a head count of the residents on the unit. The police returned Resident #1 to the facility on [DATE] at 8:15 P.M. Resident #1 sustained a small laceration on his right forearm and re-opened old skin tears on his left wrist. Interview with the Administrator on 07/06/20 between 7:15 A.M. and 7:46 A.M. during tour of the facility reported Resident #1 successfully eloped from the facility on 05/31/20 by scaling a six-foot wood fence using his walker in the enclosed courtyard located off the secured unit. The Administrator reported the resident was found with no major injuries a short time later. He reported putting a self- imposed plan of correction in place including staff education, and resident assessment, and updating of resident care plans. Observation of the secured unit on 07/06/20 between 7:15 A.M. and 7:46 P.M. with the Administrator revealed a keypad with a code was required to enter or exit the unit. Only staff had the code. If the doors were pushed on for 15 seconds an alarm would sound alerting staff someone was attempting to leave. Not all residents on the secured dementia unit had alert bracelets only those identified at risk for elopement. When residents wearing alert bracelets were in close proximity to exit doors including those to the courtyards, the alarms would sound. A code had to be punched into the keypad to silence the alarm. The doors were tested and found to alarm after being pushed for 15 seconds. The alarms were intensely loud. Once outside in the large courtyard there was a six-foot vertically slatted wood fence that was intact and encompassed two exit doors from the secured unit. No cameras were in the secured unit or the courtyard. Interview with the DON on 07/07/20 at 9:10 A.M. revealed Resident #1 was a court ordered admission and placed in the secured unit due to dementia related behaviors including yelling and resisting care, not for the purpose of preventing elopement. The DON denied the resident was at risk for elopement. The DON acknowledged the resident had verbalized he did not want to be in the facility, and he was going to get out, but said that alone did not make Resident #1 an elopement risk. She said he made no physical attempts to leave the facility prior to 05/31/20. The 05/28/20 nurse's note at 11:27 A.M. was reviewed with the DON which indicated Resident #1 was physically exit seeking. The DON then verified Resident #1 should have been reassessed for elopement risk at that time and a care plan with individualized interventions to prevent elopement should have been developed and implemented for the resident. Interview with STNA #89 on 07/07/20 at 10:31 A.M. revealed Resident #1 had significant negative behaviors. Resident #1 resisted care, swore, was loud, threatening, mad, did not want to be in the facility and wanted to go home since his admission. STNA #89 recalled the events of 05/31/20 indicating Resident #1 was having a particularly bad day and was talking about wanting to go home. They tried taking a walk with him in the courtyard and called his daughter to try and calm him. STNA #89 stated the resident cussed the daughter out. STNA #89 reported she was shocked and surprised that Resident #1 used his walker, scaled a six-foot fence and eloped from the facility. STNA #89 reported not one alarm was sounding at the time the resident was missing and prior to that the alarms went off non-stop and were loud. Interview with STNA #90 on 07/07/20 at 11:15 A.M. indicated Resident #1 refused care, was loud and rude. STNA #90 recalled the events of 05/31/20 indicating Resident #1 was set on trying to exit, pushed on the doors until they alarmed and yelled out that he was going to leave. STNA #90 reported they had him talk with his daughter and he cussed her out. STNA #90 said RN #87 was at the nurse's desk when RN #88 came

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) looking for Resident #1 to give him a snack. When RN #88 was not able to locate Resident #1 they began to look and found his walker up against the fence in the courtyard. STNA #90 reported when the police returned Resident #1 to the facility he was very angry and was swearing. STNA #90 provided him a pair of disposable pants because his were ripped and he had a little spot of blood on his arm. Resident #1 was provided one to one supervision at that time. Interview with the responding police officer (Officer #100) on 07/08/20 at 3:04 P.M. indicated on 05/31/20 at 7:40 P.M. a call came in about a missing person. The officer spoke to RN #99 who reported Resident #1 was in a fenced courtyard, and used his walker as a step to get over a fence and fell . RN #99 reported he may have scrapes and bruises. Officer #100 found Resident #1 at an intersection of a very busy roadway. The officer reported it was a pretty good hike for an older man. Officer #100 said Resident #1 was confused and asked for a ride home to see his wife and feed the dog. The officer reported Resident #1's pants were completely ripped and he had some scrapes on his hands and probably his knees. Resident #1 was medically cleared by Emergency Medical Services (EMS) on the scene and they transported him back to the facility. The officer recalled the resident did not want to go back to the facility. Review of the maintenance log since May 2020 revealed the exit doors were tested on a monthly basis. Review of the elopement policy dated December 2007 indicated If an employee discovered a resident was missing from the facility, he/she shall: Determine if the resident is out on an authorized leave or pass; If the resident was not authorized to leave, initiate a search. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: Examine the resident for injuries; Contact the Attending Physician and report findings and conditions of the resident; notify the resident's legal representative; Notify search teams that the resident has been located; Complete and file an incident report; and Document relevant information in the resident's medical record. Review of the safety and supervision of residents policy dated July 2017 indicated the facility would assess, determine and implement targeted interventions and monitor interventions for effectiveness. This deficiency substantiates Complaint Number OH 813.