STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365990	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW DAWN REHABILITATION AND HEALTHCARE CENTER	865 EAST IRON AVENUE DOVER, OH 44622

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 observation, closed medical record review, review of a facility investigation, police report, Elopement policy and interviews with facility and agency staff, Physician Office Staff #201 and Resident #53's family the facility failed to provide appropriate and adequate supervision and implement effective interventions to prevent one cognitively impaired resident (#53), who was identified to be an elopement risk/wanderer and exhibited exit seeking behaviors, from leaving the facility without staff knowledge on 06/20/20. The facility failed to ensure the circumstances of the elopement incident involving Resident #53 were accurately and timely documented in the resident's medical record. This resulted in Immediate Jeopardy on 06/20/20 at approximately 6:00 A.M. when Resident #53 was last seen by staff in the facility. Once determined by staff to be missing, initial searches both inside and outside the facility were unsuccessful in locating the resident. Resident #53's family was notified of the elopement and suggested the facility check to see if the resident had returned to his home in the community. The resident was subsequently found (on 06/20/20 at 8:45 A.M.) at this location. The potential for actual harm, serious injury or death was identified as the resident traveled approximately one mile from the facility to his home with the route identified to be a major highway with four lanes of traffic and no sidewalks. This affected one resident (#53) of three sampled residents reviewed for elopement. The facility census was 54. On 06/30/20 at 10:10 A.M. the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #120 and facility legal counsel were notified Immediate Jeopardy began on 06/20/2020 at approximately 6:00 A.M. when Resident #53, who was ambulatory, cognitively impaired, exhibited exit seeking behaviors and had a wander guard in place was last seen by staff in the facility. A facility investigation determined the resident had left the facility without staff knowledge via the window from his room to the outside. The resident was located by staff after discussion with his family on 06/20/20 at approximately 8:45 A.M. at his previous home in the community. The Immediate Jeopardy was removed on 07/01/2020 when the facility implemented the following measures: On 06/20/20 at approximately 9:30 A.M. Resident #53 returned to the facility with family and was provided one on one supervision until he was transferred to an inpatient psychiatric hospital on [DATE] at 5:20 P.M. The resident had not returned to the facility as of 06/29/20 the date of the onsite survey. On 06/20/20 the DON reviewed the medical records for Resident #20, #22, #27, #28, #32, #41 and #56, who had orders for wander guards to ensure elopement risk assessments were current and accurate. These residents with wander guards were placed on every 15-minute checks until the windows in the resident's rooms were adjusted to not open more than six inches. On 06/20/20 every facility window was checked by Maintenance #114. The windows were modified by placing a screw mechanism to prevent all windows from opening beyond six inches if the window bar was removed. This was completed on 06/20/20 at 2:45 P.M. On 06/20/20 the facility Quality Assessment Performance Improvement (QAPI) team (which included the Administrator, DON, ADON, Clinical Care Manager, Maintenance Director, Director of Admissions and Social Service) discussed and determined the root cause of the resident's elopement was the window lock ability being removed. On 06/20/20 all facility staff were sent a text message of the facility Elopement policy and Call Off Policy. On 06/22/20 a plan for housekeeping staff to monitor for signs of damage to windows as part of their daily cleaning routine and notify the Maintenance Director to address any issues was implemented. On 06/23/20 a plan for the Director of Maintenance or designee to audit weekly for 4 weeks all resident windows for effectiveness of new devices to stop window from opening at six inches was implemented. The audits would be discussed at monthly quality assessment performance improvement (QAPI) meetings and if no further concerns were identified would be deemed effective. On 06/25/20 the DON provided education to six agency staff nurses regarding the facility call off procedures. Agency staff were also educated related to documentation including ensuring the nursing progress notes included change in condition, incidents and skilled notes which encompassed resident cognition and safety interventions such as wander guard bracelets. A plan for any new agency staff to be given this education as part of their orientation to the facility was implemented. On 06/26/20 Consultant Registered Nurse (RN) #118 completed an audit for Resident #20, #22, #27, #28, #32, #41, #56 and #1 who had orders for a wander guard device to ensure care plans and assessments were appropriate and accurate. On 07/01/20 a plan for the DON to monitor staff schedules daily for the next day for adequate staffing levels was provided as part of the facility corrective action plan. The plan revealed that if at any point the staffing would fall below facility minimum requirements, the DON would activate the emergency staffing plan utilizing agency staff, employee mandated staff and/or management nurses assigned to the floor. On 07/01/20 a plan for the DON, ADON and Clinical Manager to provide all staff including any agency staff working in the facility education (prior to their next scheduled shift) related to resident behaviors of exit seeking and prevention of elopement was implemented. On 07/01/20 a plan for the DON, ADON and Clinical Care Manager to review the 24 hour report for documentation related to exit seeking behaviors and appropriate interventions daily during the clinical review meeting was implemented. On 07/02/20 a plan for the DON/designee to complete random audits at a minimum of five staff per week for four weeks for staff retention of education regarding response to behaviors of exit seeking and wandering was implemented. The results of the audits will be discussed during QAPI meetings. Although the Immediate Jeopardy was removed on 07/01/20 the facility remains 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 continued to provide staff education and monitoring of corrective actions. Findings include: Review of Resident #53's closed medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review revealed a physician's orders [REDACTED]. The order indicated to check placement, function and skin integrity every shift. An admission assessment, dated 06/04/20 revealed Resident #53 was only oriented to person and required extensive assistance from staff for bed mobility, transfers, dressing and toilet use. The assessment revealed the resident required limited assistance with personal hygiene and independence with eating. An elopement screen, dated 06/05/20 revealed the resident was not at risk for elopement as he scored an eight on the screening tool. A resident was considered at risk for elopement with a score of nine or higher. Review of undated State tested Nursing Assistant (STNA) Kardex information revealed Resident #53 had a wander guard and staff were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. Review of Resident #53's nursing progress note revealed a note authored by Registered Nurse (RN) #130, dated 06/06/20 at 9:51 P.M. which documented the resident was exit seeking. Record review revealed there was no elopement screen completed following this incident, no plan of care developed at this time and no written evidence of interventions being in place to address the exit seeking behavior. In addition, the progress note failed to elaborate on specific circumstances surrounding the residents exit seeking behaviors (i.e. was the resident talking about going home, trying to exit or successful at exiting a particular door and/or whether this a repeated behavior that was occurring or isolated behavior). Review of the five-day admission Minimum Data Set (MDS) 3.0 assessment, dated 06/10/20 revealed Resident #53 had severely impaired cognition, required

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) supervision for all activities of daily living, exhibited wandering behavior one to three days in the assessment period and used a wander/elopement alarm daily. Record review revealed a plan of care was initiated on 06/17/20. However, documentation included on the care plan noted a created dated of 06/22/20 and a revision date of 06/22/20 indicating Resident #53 was an elopement risk/wanderer as evidenced by impaired safety awareness, impaired cognition, behaviors of wandering and exit seeking related to dementia. Interventions included to assess for fall risk, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books, monitor for fatigue and weight loss and a wander guard. Review of Resident #53's nursing progress notes revealed a note dated 06/17/20 at 7:27 A.M. and authored by Agency LPN #115 indicating Resident #53 was exit seeking last night and was redirected by the nurse which was effective. The nursing note documented the resident was being monitored closely and was in his room resting at that time. Record review revealed there was no elopement screen completed following this incident. In addition, the progress note did not elaborate on the type of re-direction that was provided to the resident, evidence of interventions included on the plan of care being attempted and whether these interventions were successful or not. A nursing progress note, dated 06/19/20 at 10:03 P.M. and authored by Agency LPN #115 revealed Resident #53 was exit seeking around 9:55 P.M., redirection was given and was not effective. The resident continued to stand by the door (which door was not specified). The nurse asked the resident to go get ready for bed and the resident had become combative grabbing the nurse's arm and using swear words. The nursing progress note revealed the resident entered his room and slammed the bedroom door. There was no evidence the physician or resident's family were notified of this incident. The note failed to contain evidence any identified interventions from the plan of care were attempted and did not contain any type of follow up assessment or note on 06/20/20 to ensure the resident was safe in his room after entering the room and slamming the door. Review of a police report, dated 06/20/20 at 8:35 A.M. revealed the facility reported an [AGE] year-old missing resident, Resident #53. The police report documented the subject had exited through his bedroom window. It was unknown when he left or his last clothing description. He has dementia. The report continued and indicated the subject had been located at his previous residence and was being returned to the facility. The police arrived at the facility at 8:47 A.M. and the case was cleared at 9:03 A.M. Review on the STNA flow sheets for 06/20/20 revealed there was no documentation of care provided to Resident #53 from 12:00 A.M. to 7:00 A.M. The care documented on the STNA Flow sheets should have included ambulation in the corridor, ambulation in the room, bathing/showers, mobility, bladder continence, bowel movements, dressing, locomotion on and off the unit, personal hygiene, toileting, transferring and the amount eaten for each shift and should have been initialed by the nursing staff providing the care. The next nursing progress note (after the 06/19/20 note at 10:03 P.M.), dated 06/23/20 at 12:27 A.M. as a late entry note for 06/20/20 at 6:55 A.M. revealed the nurse (Agency LPN #115) had done rounds every two hours and the last round was at 5:15 A.M. The note indicated Resident #53 was resting in bed with the call light within reach. A nursing progress note, dated 06/23/20 at 8:28 P.M. as a late entry for 06/20/20 at 9:56 A.M. and authored by the DON revealed Resident #53 had left the facility and went home. The note documented the family brought the resident back to the facility and a head to toe assessment and skin check were completed with no issues identified. The DON also documented in the progress note that the family, physician, DON and Administrator were updated. A nursing progress note, dated 06/29/20 at 7:04 P.M. as a late entry note for 06/20/20 at 8:52 P.M. and authored by LPN #119 revealed the DON was notified by the nursing management (no specific staff identified) Resident #53 was not inside the facility building and that staff (no specific staff identified) were walking inside and outside looking for resident. LPN #120 had been notified and was on her way to the facility. The resident's family and 911 were called. The resident's daughter stated the resident had done this once before and he had gone to his house in New Philadelphia. Review of the facility staffing schedules and unit assignments for 06/19/20 and 06/20/20 revealed Agency LPN #115 was scheduled to work the rehabilitation unit from 06/19/20 at 8:00 P.M. until 06/20/20 at 7:00 A.M. Agency STNA #116 was scheduled to work on 06/19/20 from 11:00 P.M. to 06/20/20 at 7:00 A.M. to care for 40 residents residing on the rehabilitation unit (which was the 200 unit), the 300 unit and 400 unit. On 06/20/20 at 2:00 A.M. a personal care assistant from the attached assisted living (PCA #110) was pulled from the assisted living to work in the nursing home and was noted to work on the rehabilitation unit. Additional record review revealed PCA #110 was not State tested . Record review revealed the facility initiated an investigation related to the incident of Resident #53 eloping on 06/20/20. Statements obtained from the three staff members assigned to the unit where Resident #53 resided revealed: A witness statement obtained from Agency STNA #116 dated 06/20/20 revealed she only went over to the 200 (rehabilitation) hallway to help a few times and she never saw the resident (Resident #53). A witness statement from PCA #110 dated 06/20/20 revealed she saw Resident #53 between 5:30 A.M. and 6:00 A.M. when he came out of his room and then went back into his room shutting the door. A witness statement from Agency LPN #115 revealed the last time she saw Resident #53 on 06/20/20 was around 5:15 A.M. when she was passing medications and last rounds had started. In addition, a witness statement from agency LPN #121, dated 06/20/20 revealed she had seen Resident #53 between 12:00 A.M. and 1:00 A.M. She indicated he had been up walking the halls and looking out the doors. This agency LPN was working on the facility 400 unit on this night. A witness statement obtained from LPN #113, dated 06/20/20 (no time documented) revealed she had come in to work (on 06/20/20 for day shift), gotten report, counted narcotics, cleaned and set up her medication cart and went to the bathroom. When she came out of the bathroom STNA #112 had informed her Resident #53 was not in his room and the elopement process was started. A witness statement from STNA #112, dated 06/20/20 revealed the STNA had walked onto the unit (rehabilitation unit) at 7:00 A.M. on 06/20/20. She did not get report from the midnight aide because this aide had already left the floor. She went and got a resident up and dressed for the day. Around 7:30 A.M. the breakfast cart arrived and the nursing assistant she was working with went into the room of Resident #53 and he was not in his room. She indicated they noticed the window had been cracked open after they searched his room. She indicated she never saw the resident on her shift until he came back to the facility. The investigation also contained a statement from LPN #120 who was the staff member who first encountered Resident #53 at his home. The LPN's statement revealed she drove to the resident's home (which was close to facility) and found him sitting in his back yard at the picnic table at 8:45 A.M. She then notified the DON the resident had been found. The resident was wearing a T-shirt, flannel button up shirt and jeans. His flannel was warm and damp. The statement did not indicate if the resident was wearing shoes or what type of shoes he was wearing. The resident refused to return to the facility with the nurse. His daughter and her husband arrived and gave the resident a bottle of water. The LPN's statement revealed when questioned what time he left the facility he stated 8:00 A.M. and stated he went out through the window. The resident was pleasant with general conversation, but when questioned if he would like to go for a ride in the LPN's car, he became agitated and refused. The witness statement revealed the resident was returned to the facility by his family and placed with one on one supervision upon returning to the facility. During the complaint investigation the following staff interviews were obtained related to Resident #53, the elopement incident on 06/20/20 and staff knowledge of the resident's exit seeking behaviors: On 06/29/20 at 11:35 A.M. interview with STNA #107 revealed Resident #53 was very agitated and tried to get out of the building numerous times while he resided in the facility. During the interview the STNA revealed the windows in the resident rooms had been easy to open but since the incident with Resident #53 eloping, the facility had placed something on them so they would no longer open. On 06/29/20 at 11:40 A.M. interview with the Administrator revealed Resident #53's window did not have a screen and it was open about three inches at the time it was determined the resident was missing from the facility (on 06/20/20). The Administrator revealed she believed the resident had exited the facility via this window. The Administrator revealed Resident #53 did have a wander guard bracelet on at the time he eloped. However, the Administrator revealed she did not believe Resident #53 left the facility through an exit door. On 06/29/20 at 11:40 A.M. observation of Resident #53's window revealed a sliding glass window without a screen on the window with a screw in the window frame preventing it from opening more than six inches. On 06/29/20 at 1:32 P.M. interview with Resident #53's family, Family Member #122 revealed she had brought the resident to the facility on [DATE] because of his confusion. She indicated he had exit seeking behaviors since he had been admitted to the facility. She indicated the facility had to change the codes on the doors because the resident knew the codes from when he would visit his wife at the facility prior to his admission and because he had watched the staff put the codes in the door key pad. Family Member #122 revealed she was told by staff that on 06/20/20 at 5:15 A.M. the resident was in bed and staff had not noticed he was missing until around 8:00 A.M. LPN #120 had went to his house to look and see if he was there and he was found sitting on the picnic table because he could not get into the house. Her sister had to bring him back to the facility. He had an ankle bracelet on. She indicated her father did not know how he got out of the building. She stated his house was about one to one and a half miles from the facility. Review of the route from the facility to the resident's location revealed the route was a major four lane busy highway with no sidewalks available. The area contained multiple businesses. On 06/29/20 at 3:36 P.M. interview with LPN #113 revealed on 06/20/20 she had gotten report from the

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) off going nurse (Agency LPN #115 and the nurse stated she had last seen Resident #53 at bedtime. She stated the off going Agency LPN indicated the resident had become angry with her, so he went into his room. She indicated they had done report and counted medications. They finished up around 7:30 A.M. LPN #113 revealed shortly after this she received a call on her cell phone from the 400 hall nurse telling her one of her residents (Resident #53) was missing. She indicated there were staff inside and outside looking for him. She indicated the other nurse told her to call the family and 911 and she would call the administrator. When she was talking to the daughter, she told her the resident had done this before when he lived with them and they found him at his house. The police showed up and she was giving them his address and at the same time a staff member called her and stated they had found him at his house but he would not get into the car with him and so the family was bringing him back to the facility. On 06/29/20 at 5:00 P.M. interview with Agency LPN #115 revealed on 06/20/20 she saw Resident #53 during her medication pass around 5:00 A.M. and he was in his room in bed. She stated she did not give him any medications at that time. The Agency LPN revealed at the time she left the facility (at the end of her shift) she was unaware Resident #53 was missing and was not aware until she received a call from the a day shift nurse around 8:30 A.M. that morning. During the interview, the Agency LPN denied hearing any door alarm sound during the morning. During a follow up interview with agency LPN #115 on 06/29/20 at 5:56 P.M., Agency LPN #115 revealed she had worked from 8:00 P.M. on 06/19/20 until 7:00 A.M. on 06/20/20 and had not charted on Resident #53 because she had run out of time. When the DON called her to question her about that night, she had told her she would chart the next day she came in to work (which was on 06/23/20). She stated she had been coming to the facility to work (through the agency) for about two weeks now and voiced concerns there were never enough staff working. She stated on 06/20/20 her one nursing assistant scheduled to work left at the beginning of the shift and she was the only one working the unit until a nursing assistant came in at 2:00 A.M. She indicated Resident #53 had been trying to get out of the building all night. She stated he was trying to exit the facility via the door at the end of the rehabilitation unit. She stated she was in a resident room trying to hang an intravenous medication and the door alarm kept going off and she would have to stop what she was doing, run down to get him away from the door and shut the alarm off. Agency LPN #115 revealed she did not feel Resident #53 was appropriately placed on the rehabilitation unit and indicated he required more supervision. On 06/29/20 at 5:06 P.M. interview with Agency STNA #116 revealed she was the only STNA working the night of 06/19/20 from 11:00 P.M. to 7:00 A.M. shift and was assigned for the 200/rehabilitation unit, 300 and 400 units (40 residents). She indicated one nursing assistant was a no call/no show and the other one supposedly came in and went home but she never saw him. She stated around midnight she asked the nurse if there were any additional staff coming to help. At 2:00 A.M. she stated she asked the aide from the assisted living to help her do rounds on the rehabilitation unit. She indicated she had not been on the rehabilitation unit at all that night up to that point. She indicated PCA #110 came over from the assisted living and ended up staying on the rehabilitation unit the rest of the shift and she stayed on the 300/400 unit. She indicated she had gone over a few times to help but had not seen Resident #53 at all. On 06/29/20 at 5:21 P.M. interview with STNA #108 revealed the STNA was aware that Resident #53 was always trying to get out the doors and he had been caught (she did not say by who) putting the door code in and it had to be changed. Upon further interview, the STNA was unable to provide any dates as to when this had occurred. On 06/30/20 at 7:20 A.M. interview with STNA #112 revealed on 06/20/20 when she came on shift (day shift) she had gone to get supplies to start getting residents up around 7:30 A.M. She stated the other nursing assistant (STNA #131) she was working with said Resident #53 was not in his room when she took his breakfast tray into the room. She stated they searched his room and that was when she noticed the window was open about an inch to an inch and half. She told the nurse (LPN #113) on duty and they started to search the building and outside for him. She stated he was always talking about going home and was always trying to get out. She indicated his wife had been a resident at the facility for awhile and he would walk to the facility (from home) to see her after his family took his car away from him, so she thought he would know his way home. She indicated she did not remember seeing a bar in the window of the resident's room at the time he was identified to be missing. On 06/29/20, 06/30/20, 07/01/20 and 07/02/20 attempts to reach PCA #110 via telephone were unsuccessful. In addition, requests were made to the DON to facilitate communication with PCA #110 which were also unsuccessful. On 06/30/20 at 10:27 A.M. telephone interview with the Administrator revealed there was no bar located in Resident #53's window on 06/20/20. On 07/01/20 at 9:53 A.M. an additional interview with Agency LPN #115 revealed following the incident involving Resident #53 she was not provided any facility education related to elopement, residents with exit seeking behaviors and/or the timely implementation of interventions related to exit seeking behaviors for residents. In addition, she was not aware she could document incident details on a piece of paper at the time of an incident to later be uploaded into the computer during an emergency. On 07/01/20 at 3:00 P.M. interview with Physician's Office Staff #201 revealed the physician was unable to speak to with the surveyor personally, however he indicated he had been notified Resident #53 had left the building without staff knowledge and indicated the resident was not safe to leave the building without supervision. On 07/01/20 at 3:47 P.M. interview with the DON verified the unit assignments for 06/19/20 and 06/20/20 revealed Agency LPN #115 was working the rehabilitation unit from 06/19/20 at 8:00 P.M. until 06/20/20 at 7:00 A.M. Agency STNA #116 was working on 06/19/20 from 11:00 P.M. to 06/20/20 at 7:00 A.M. to care for 40 residents residing on the rehabilitation unit (which was the 200 unit), the 300 unit and 400 unit. During the interview, the DON verified PCA #110, who was a patient care assistant (non State tested) from the assisted living did work in the nursing home on the rehabilitation unit on 06/20/20, but the DON was unable to provide the exact time PCA #110 came over to help. The DON revealed PCA #110 would have only answered call lights and passed ice to help the nurse, she would not have provided hands on care to the residents. On 07/02/20 at 9:49 A.M. interview with the DON revealed the midnight shift staff would be responsible to document on the STNA flowsheets for any care provided to the resident during their shift. On 07/20/20 at 12:16 P.M. interview with the DON verified there was no care documented for the resident on the flowsheets and the only documentation of provided on 06/20/20 was what was in the nursing progress notes as noted above. The DON indicated only the nurse (Agency LPN #115) would have provided any care to the resident. Review of the undated facility policy titled Elopements revealed staff would investigate and report all cases of missing residents. An elopement was defined as a resident who had left the facility and his or her location was unknown by the staff. This deficiency substantiates Master Complaint Number OH 757 and Complaint Number OH 669.