DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **366095**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/19/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENWOOD CARE AND REHABILITATION	**836 WEST 34TH STREET NW CANTON, OH 44709**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0689

Level of harm - Immediate jeopardy

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY >

Based on review of the medical record and facility video monitoring, staff and visitor interview, review of the National Weather Service report, the facility elopement policy and a local electronic news article, the facility failed to provide adequate supervision to prevent the elopement of one cognitively impaired resident, (Resident #33) who resided on the facility secured (memory care) unit and was assessed to be at risk for elopement. This resulted in Immediate Jeopardy when Resident #33 eloped from the facility on [DATE] at 7:59 P.M. without staff knowledge. Actual harm occurred when Resident #33 was found deceased outdoors by the local County Sherriff's Department, 4.3 miles from the facility on [DATE] at 4:10 P.M. This affected one resident of 14 residents identified to be at risk for elopement who resided on the secured unit (Resident #38, #40, #41, #42, #43, #44, #45, #47, #48, #49, #52, #53 and #54). The facility census was 91.

On [DATE] at 11:15 A.M., the Nursing Home Administrator (NHA), Director of Nursing (DON), Regional Director of Nursing (RDON) #11 and Regional Director of Operations (RDO) #12 were notified Immediate Jeopardy began on [DATE] at 7:59 P.M. when

Resident #33, who was assessed to be at risk for elopement and exhibited exit seeking behaviors, exited the secured unit of the facility by entering the elevator with a visitor. The resident then exited the front entrance with the visitor after being provided assistance with the exit code out the facility main entrance by State tested Nursing Assistant (STNA) #10. Resident #33 was found deceased on [DATE] at 4:10 P.M. by the local County Sheriff's Department, outdoors and 4.3 miles from the facility.

The Immediate Jeopardy was removed on [DATE] at 12:00 P.M. when the facility implemented the following corrective actions:

· Beginning on [DATE] and completed on [DATE], the DON in-serviced 14 department heads who then in-serviced all remaining staff, including 36 STNAs, 15 Licensed Practical Nurses (LPNs), four Registered Nurses (RNs), 11 housekeeping staff, four maintenance staff, six therapy staff and three activity staff on the following:
a. Identifying residents who were at risk for elopement
b. Elopement policy
c. Resident Leave of Absence sign out procedure
d. Importance of verifying residents are signed out prior to them exiting facility
e. Reinforce duties and responsibilities of nursing assistants

· Elopement drills were completed by Maintenance #14 and Maintenance #21 on [DATE] at 1:51 P.M. and at 4:30 P.M. Twenty four staff members participated including 11 STNAs, four LPNs, four administrative staff (administrator, DON, Business Office Manager and facility social worker), two maintenance staff, one housekeeping staff and two activity staff.

· Director of Maintenance #14 completed functional testing of all coded doors including elevators on [DATE] by 8:15 A.M. All doors passed inspection.

· On [DATE] and [DATE] elopement assessments for all residents identified to be at risk for elopement, who resided within the secured unit were completed (Residents #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56 and #57). The care plans for these residents were updated to reflect the assessments.

· On [DATE] the facility receptionist ensured all elopement books (one on each unit and at the front desk) were updated and accurate. On [DATE] at 8:45 A.M., observation of elopement books at each unit and front entrance verified the accuracy.

· New signage was posted on [DATE] at 11:00 A.M. on all secured unit exit doors and the secured unit elevator stating PLEASE DO NOT PERMIT ANYONE/RESIDENT TO EXIT THESE DOORS BEFORE CHECKING WITH A STAFF MEMBER FIRST.
Signs were observed in place on [DATE] at 8:40 A.M.

· On [DATE] the elevator key pad code was changed and a plan to change the code on a monthly basis was implemented for an indefinite time period.

· A new facility policy and procedure titled Head Count Protocol was initiated on [DATE]. Staff was to count all residents on their assigned units at the beginning of their shift to ensure all residents were in the facility.

· On [DATE] from 8:45 A.M through 8:55 A.M. interviews with LPN #17, LPN #18 and STNA #19 revealed staff members had knowledge on preventing resident elopement and knowledge of the policy and procedure for an actual elopement.

· The facility denied any additional resident elopements from the facility had occurred since [DATE].

· The facility identified in the Quality Assurance and Performance Improvement (QAPI) Program the need for ongoing auditing and monitoring including:
a. A special QAPI committee meeting was held on [DATE], consisting of the NHA, DON and medical director via phone to discuss the events set forth in the notification of the immediate jeopardy. A special QAPI committee meeting will occur weekly for the next four weeks to discuss audit finding and assess for plan effectiveness.
b. DON or designee will monitor for head counts to be completed daily on each shift. Monitoring will continue until otherwise directed by the QAPI committee.
c. DON or designee will conduct interview audits of five staff to ensure retention of education, weekly for four weeks. Audits will consist of questions pertaining to items discussed during the in-service. After the initial four weeks, three staff members will be audited for four weeks.
d. NHA or designee will conduct elopement drills on random shifts once per week for four weeks with findings reported to the QAPI committee.
e. Audit findings will be discussed in the monthly QAPI and the committee will determine the strategies for ongoing compliance.

· On [DATE] at 12:00 P.M. LPN #13, STNA #22 and STNA #23, the staff working at the time of the elopement were terminated by the facility for failure to identify Resident #33 was missing between [DATE] at 8:00 P.M. and [DATE] at 5:00 A.M.

Although the Immediate Jeopardy was removed, the facility remained out of compliance at Severity Level II (no actual harm with 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 Resident #33's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 was moderately cognitively impaired and able to ambulate independently. An elopement risk assessment completed on [DATE] identified Resident #33 as high risk for elopement.

Review of Resident #33's care plan, dated [DATE] identified Resident #33 was an elopement risk due to history of attempts to leave the facility unattended, frequent statements of going to try to leave and impaired safety awareness. The care plan

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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Residents Affected - Few

(continued... from page 1)
identified Resident #33 had impaired cognitive function and was an elopement risk. Care plans also indicated Resident #33 had a history of [REDACTED].
Review of nursing notes revealed Resident #33 displayed exit seeking behavior on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. These included behaviors of wandering the hallways of the secured unit and seeking exits including the elevator and statements made of the desire to leave the facility. Further review of nursing notes revealed no evidence of documentation of the elopement from the facility on [DATE]. The last nursing progress note was dated [DATE].
On [DATE] at 8:20 A.M. interview with the NHA and the DON revealed Resident #33 eloped from the facility on the evening of [DATE]. The NHA and DON revealed on [DATE] at 7:55 A.M., the local police department was notified Resident #33 was missing from the facility. However, the administrative staff revealed they were informed that the police department was unable to provide assistance to the facility as the resident had not been missing for 48 hours. The NHA and DON revealed facility staff members were continuing to search for the resident as of [DATE]. Further interview revealed the facility had electronic video evidence that on [DATE] at 7:57 P.M. Resident #33 eloped from the facility.
On [DATE] at 8:35 A.M. and again on [DATE] at 10:10 A.M., observation of the electronic video surveillance with the NHA and the DON revealed on [DATE] at 7:57:23 P.M., Resident #33 was observed standing beside the elevator of the secured unit on the second floor wearing a coat. Visitor #15 approached the elevator, entered the elevator code and waited for the elevator. When the elevator doors opened Visitor #15 and Resident #33 walked into the elevator. At 7:58:19 P.M. Visitor #15 was observed exiting the elevator and going to the front lobby. Resident #33 was not seen on the video at that time. At 7:58:30 P.M. Visitor #15 returned to the elevator area to seek assistance with the code for the front door. At 7:58:54 Resident #33 returned to the elevator area and was standing next to Visitor #15 and talking with Visitor #15. At 7:59:10 STNA #10 was observed walking to the front entrance. Resident #33 and Visitor #15 were observed following STNA #10 towards the front entrance. At 7:59:23 P.M., STNA #10 assisted Visitor #15 and Resident #33 by putting the code into the keypad which unlocked the front door. As STNA #10 held the door open, Visitor #15 and Resident #33 exited the facility. At 7:59:39 STNA #10 then turned around and left the front door area.
On [DATE] at 10:07 A.M. telephone interview with Visitor #15 revealed she was in the facility to return Resident #52 from a leave of absence. Visitor #15 added when she was leaving the secured unit she walked to the elevator and saw Resident #33 standing by the elevator. He was wearing a coat and appeared to be leaving. She thought Resident #33 was also a visitor. Visitor #15 stated she entered the code into the elevator and stepped into the elevator when the door opened. Resident #33 stepped into the elevator with her. She stated Resident #33 informed her that he was going to the hospital to visit his sister. When the elevator door opened she turned to the right to exit the building and Resident #33 turned to the left. She went to the front door, but needed a code to get out the door as the door was locked. Visitor #15 returned to the elevator area and saw Resident #33 returning to the elevator area as well. She then found STNA #10 and requested his assistance in helping them out of the front entrance. STNA #10 walked with her and Resident #33 to the front door and entered the code so both her and Resident #33 could exit the facility.
On [DATE] at 10:18 A.M., interview with STNA #10 revealed he was approached by Visitor #15 who requested to help us with the code to get outside. STNA #10 further added that he knew it was Resident #33, but assumed he was with the visitor and was going outside with the visitor. STNA #10 further added that he watched Visitor #15 and Resident #33 exit the building onto the sidewalk and he then returned to work. He did not advise any staff members or question any staff members if Resident #33 was going on a leave of absence with Visitor #15. He assumed Resident #33 left the secured unit with Visitor #15 and he was permitted to leave.
On [DATE] at 2:55 P.M., interview with LPN #13 revealed on [DATE] a little before 5:00 A.M., she found Resident #33 was not in his room when she was making rounds and administering morning medications. She notified staff on her floor to search for Resident #33, and then alerted other staff in the building to search. She then called the DON to advise her of a missing resident. She added staff members searched the entire facility and outside of the facility and did not locate Resident #33. LPN #33 stated she did not check for Resident #33 prior to 5:00 A.M. and indicated her shift had started on [DATE] at 6:00 P.M.
As of [DATE] at 4:00 P.M. according to interview with the NHA and the DON Resident #33 remained missing and staff were continuing to search for the resident.
Review of the National Weather Service Report temperatures for Canton Ohio revealed the following temperatures:
[DATE] at 7:51 P.M., 55 F
[DATE] at 12:51 A.M., 46 F
[DATE] at 6:51 A.M., 41 F
[DATE] at 12:51 P.M., 36 F
[DATE] at 7:51 P.M., 35 F
[DATE] at 12:51 A.M., 32 F
[DATE] at 8:51 A.M., 31 F
[DATE] at 12:51 P.M., 34 F
Review of an electronic news article from News 5 Cleveland revealed on [DATE] at 4:10 P.M. Resident #33 was found deceased by the Stark County Sheriff's department. He had been found outdoors at an unoccupied business building, 4.3 miles from the facility.
On [DATE] at 9:00 A.M., interview with Regional Director of Nursing (RDON) #11 and Regional Director of Operations (RDO) #12 verified on [DATE] at 4:10 P.M., Resident #33 was found by local law enforcement 4.3 miles from the facility and was deceased .
On [DATE] at 9:55 A.M., interview with Physician #20, Resident #33's primary physician revealed Resident #33 had impaired safety awareness as well as delusions and other medical problems. He would have difficulty surviving outside in cold weather for an extended period and also with no medications or nutrition. Review of the resident's current Medication Administration Record [REDACTED]
On [DATE] attempts to reach STNA #22 and STNA #23 via telephone were unsuccessful.
Review of the facility policy titled, Elopements with a revision date of (MONTH) 2007 revealed staff shall investigate and report all cases of missing residents. Staff shall promptly report any resident who tried to leave the premises or was suspected of being missing to the Charge Nurse or Director of Nursing. If an employee discovered that a resident was missing from the facility, he/she shall:
a. Determine if the resident was out on an authorized leave or pass;
b. If the resident was not authorized to leave, initiate a search of the building(s) and premises;
c. If the resident was not located, notify the Administrator and Director of Nursing Services, the resident's legal representative (sponsor), the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., Emergency Management, Rescue Squads, etc.);
d. Provide search teams with resident identification information; and
e. Initiate an extensive search of the surrounding area.
This deficiency substantiates Master Complaint Number OH 510 and Complaint Number OH 386.