| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365828 | A. Building<br>B. Wing | 11/01/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Harvard Gardens Rehabilitation & Care Center | 18810 Harvard Ave<br>Cleveland, OH 44122 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973<br><br>Based on interview, observation, and record review, the facility failed to notify hospice and Resident #35's guardian regarding a change in her tube feeding orders. This affected one resident (Resident #35) out of three residents reviewed for notification of change in condition. The facility census was 79.<br><br>Findings included:<br><br>Review of closed medical record for Resident #35 revealed an admitted [DATE] and that she had passed away at the facility on 10/22/22 under hospice services. Her diagnoses included altered mental status, multiple myeloma not having achieved remission, chronic kidney disease, and diabetes. Review of medical record revealed Resident #35 had a guardian of person.<br><br>Review of care plan dated 01/07/22 revealed Resident #35 was dependent on tube feeding for nutrition and hydration. She was at risk for aspiration and other complications related to the tube feeding. Interventions included administer tube feeding and flushes as ordered, check residuals as ordered, and notify physician of any complications.<br><br>Review of care plan dated 05/18/22 revealed Resident #35 and Resident' #35 family elected hospice services as Resident #35 desired to be kept comfortable and not receive life sustaining measures. Interventions included communicate to hospice regarding changes in condition, and coordinate plan of care with resident, family, and hospice.<br><br>Review of physician order dated 09/22/22 and completed by Hospice Registered Nurse (RN) #727 revealed Resident #35 was readmitted to hospice services with a terminal diagnosis of multiple myeloma. The order revealed to contact hospice prior to initiating any treatments, after a fall, or with any change in status.<br><br>Review of Significant Change Minimum Data Set (MDS) dated [DATE] revealed Resident #35 had impaired cognition. She was totally dependent of one person with eating, and she had a tube feeding.<br><br>Review of physician order dated 10/13/22 and wrote by Dietician #677 revealed an order for Resident #35 to receive Diabetisource continuous at 40 milliliter (ml) per hour. There was no order discontinuing the previous tube feeding order of Diabetisource 240 ml bolus per peg tube every six hours.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of nursing note dated 10/18/22 at 4:00 A.M. and completed by RN #679 revealed Resident #35 had a large emesis (process of vomiting) that appeared to be tube feeding material. The nursing note revealed Resident #35 was grimacing and crying in pain when moved or when her abdomen was palpated. Hospice was notified. Primary Care Physician #725 was notified and stated he would contact hospice.<br><br>Review of nursing note dated 10/18/22 at 4:23 A.M. and completed by RN #679 revealed Resident #35 was grimacing in pain and yelling out when abdominal area was touched.<br><br>Review of Hospice Visit Note Report dated 10/18/22, untimed and completed by Hospice RN #727 revealed Resident #35 was seen earlier than scheduled due to Resident #35 was having emesis and stomach pain. The note revealed when Hospice RN #727 arrived LPN #657 had stated Resident #35 was having stomach pains, nausea, and vomiting over the last few days. Hospice RN #727 requested a printout of the current physician orders and reviewed the orders. Hospice RN #727 noted Resident #35 had a new order for Diabetisource 40 ml per hour continuous as well as she continued to have her previous tube feeding order to still receive Diabetisource 240 ml bolus every six hours. Hospice RN #727 questioned LPN #657 regarding the orders which she was not aware of the reasoning of, and that LPN #657 had stated Resident #35 had a history of not being able to tolerate continuous tube feedings and that was why she was switched to bolus feedings in the past. Hospice RN #727 questioned further LPN #657 regarding who had ordered the continuous tube feeding and was told Dietician #677 had written the order. Hospice RN #727 noted that there was no progress note or anything else in the medical record regarding why the change in order after review. Hospice RN #727 wrote a clarification order to discontinue the continuous tube feeding due to patients' current symptoms that had started on 10/16/22 after the continuous tube feeding order had been started and to continue only the bolus tube feedings as ordered. Hospice RN #727 spoke with LPN #657 regarding the new order.<br><br>Review of Prescriber's telephone order dated 10/18/22 and completed by Hospice Physician #729/ Hospice RN #727 revealed the order stated to please clarify enteral feed order that was changed on 10/13/22 due to patient's history of not tolerating continuous tube feeding and with her being hospice recommended promoting comfort. The telephone order ordered to discontinue continuous tube feeding at 40 ml per hour and to continue Diabetisource bolus 240 ml every six hours. The order was in Resident #35's medical record but was never transcribed by the facility.<br><br>Review of nursing note dated 10/19/22 at 3:39 P.M. and completed by the Director of Nursing revealed Primary Care Physician #725 was notified due to Resident #35 having a large emesis and residual. Primary Care Physician #725 ordered to place tube feeding and water flushes on hold for four hours and use as needed Zofran (medication for vomiting and nausea) to address issues with vomiting. Hospice and Resident #35's guardian was updated.<br><br>Review of nursing note dated 10/19/22 at 11:14 P.M. and completed by LPN #602 revealed Resident #35's tube feeding was held due to 60 ml of residual and severe stomach pain.<br><br>Review of nursing note dated 10/20/22 at 7:09 P.M. and completed by Agency LPN #726 revealed the tube feeding was held due to Resident #35 had increased residual of 60 ml.<br><br>Review of nursing note dated 10/22/22 at 3:01 P.M. and completed by LPN #631 revealed Resident #35 had absent of vitals and Primary Care Physician #725 was at the facility and pronounced her death. Hospice and Resident #35's guardian was notified.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 10/31/22 at 9:20 A.M. with Hospice Director of Clinical Service revealed on 10/18/22 they received a call from the facility that Resident #35 was having severe abdominal pain, vomiting, and was nauseated. She revealed Hospice RN #727 had come to the facility and verified Resident #35 had severe abdominal pain with vomiting. She revealed Hospice RN #727 had found after she completed a record review that Resident #35 was ordered on 10/13/22 Diabetisource continuous tube feeding at 40ml per hour which hospice had not been notified of the new order. She revealed it was in best practice to ensure the facility notified hospice of any order changes. She also revealed Hospice RN #727 had discovered not only was Resident #35 receiving the new continuous tube feeding order but that she was still receiving the old tube feeding order of Diabetisource 240 ml bolus every six hours and most likely the reason of the abdominal pain, emesis, and nausea. She revealed Hospice RN #727 had received an order on 10/18/22 from the Hospice Physician #729 to discontinue the continuous tube feeding order and just to continue the previous bolus tube feeding order. She revealed Hospice RN #727 had checked through the medical record and there was no documentation as to why the continuous tube feeding was ordered and that staff and Resident #35's guardian had stated that Resident #35 had a history of not being able to tolerate continuous tube feedings in the past. She verified she was not aware Resident #35 continued to receive both the continuous tube feeding and the bolus tube feeding after 10/18/22 when Hospice RN #727 had written the order to discontinue the continuous tube feeding order.<br><br>Interview on 10/31/22 at 9:43 A.M. and 11:15 A.M. with the Administrator verified the Dietician #677 had placed the order for Resident #35 into the electronic medical record to receive the continuous Diabetisource 40 ml per hour and had forgot to discontinue the previous tube feeding order of Diabetisource 240ml bolus every six hours. She verified on review of the MAR the nurses documented that Resident #35 continued then to receive both tube feedings orders. She verified on 10/18/22 Resident #35 had severe abdominal pain with nausea and vomiting requiring a call to hospice due to her symptoms. She verified Hospice RN #727 had left an order in Resident #35's medical record to discontinue the continuous Diabetisource 40 ml per hour and to continue only the Diabetisource bolus 240 ml every six hours. She verified this order was never transcribed and Resident #35 continued to receive both tube feeding orders including Diabetisource bolus 240 ml every six hours and Diabetisource 40 ml every hour continuously. She verified from 10/18/22 to 10/22/22 Resident #35 continued to have abdominal pain, nausea, vomiting and increased residuals of tube feeding when checked. She revealed she was unsure why the order was not transcribed. She verified hospice and Resident #35's guardian was not notified regarding the Diabetisource 40ml per hours continuous tube feeding order change dated 10/13/22 and that they both should have been notified.<br><br>Interview on 10/31/22 at 9:54 A.M. and 10:33 A.M. with Dietician #677 revealed she had felt Resident #35 would tolerate better from a continuous tube feeding rather than a bolus so she had changed the tube order to Diabetisource 40 ml per hour continuous on 10/13/22 but that she had forgot to discontinue the Diabetisource bolus 240 ml every six hours as both tube feeding orders should not have been administered at the same time. She verified she had not contacted Resident #35's guardian or hospice regarding the change in tube feeding order on 10/13/22 and could not remember if she had passed it along to nursing.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 10/31/22 at 12:17 P.M. with Resident #35's guardian revealed she was never contacted on 10/13/22 regarding Resident #35's tube feeding order change for continuous tube feeding. She revealed if she would have been contacted, she would have not approved the order change because Resident #35 in the past was not able to tolerate continuous tube feeding and only could tolerate bolus tube feedings. She revealed in the past on continuous Resident #35 would have severe abdominal pain, vomiting and nausea when the tube feeding was continuous and that was why it was changed to bolus. She revealed she was not notified to ensure this did not happen until 10/18/22 and then was told by hospice that the continuous tube feeding would be stopped on 10/18/22 but then she had found out that it continued despite Resident #35 having severe abdominal pain.<br><br>Review of facility policy labeled, Enteral Nutrition, dated 09/29/21, revealed the dietician with input from the physician, nurse, and resident representative would determine the calorie, protein, nutrient, fluid needs and evaluate whether the resident's current intake was adequate. The policy revealed the dietician was responsible for routinely assessing residents who received enteral feedings.<br><br>Review of undated facility policy labeled, Change in Condition Notification Protocol, revealed the facility would inform the residents legal representative when there was a need to alter treatment.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00136986. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>39973<br><br>Based on interview, record review and review of facility abuse policy, the facility failed to implement their abuse policy to ensure all employees were checked against the Nurse Aide Registry (NAR) for findings concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. This affected 27 employees: Director of Nursing #605, Assistant Director of Nursing (ADON)/ Registered Nurse (RN) #683, RN #611, RN #679, Licensed Practical Nurse (LPN) #602, LPN #603, LPN #604, LPN #657, LPN #658, LPN #665, LPN #689, LPN #674, LPN #676, LPN #678, LPN #680, LPN #685, LPN #722, [NAME] #600, [NAME] #692, Dietary Aide #609, Activities Assistant #618, Activities Assistant #640, Activities Assistant #688, Maintenance Director #639, Human Resources (HR) #645, Admission Director #648, and Dietary Manager #664 that were hired between 05/04/21 to 10/24/22 and continued to be currently employed at the facility. This had the potential to affect all 79 residents residing at the facility.<br><br>Findings included:<br><br>Review of personnel file for Registered Nurse (RN) #695 revealed her date of hire was 01/19/22 and there was no evidence in her personnel file that she was checked against the NAR prior to being employed at the facility.<br><br>Review of personnel file for Licensed Practical Nurse (LPN) #674 revealed a hire date of 04/10/22 and there was no evidence in her personnel file that she was checked against the NAR prior to being employed at the facility.<br><br>Interview on 10/24/22 at 12:03 P.M. and 3:11 P.M. with Human Resources (HR) #645 revealed she was hired on 04/01/22 and that she was not aware staff that were not State tested Nursing Assistants (STNA's) were to be checked against the NAR to ensure they did not have a finding entered on the registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of property as required as a screening process to prevent abuse. HR #645 revealed she received a one-day training that she did not feel was sufficient training and was never trained that staff that were not STNA's were to be checked against the NAR. She revealed she had to just kind of winged it as to what she was supposed to be doing regarding background checks. She verified on review of personnel files for RN #695, and LPN #674 they were not checked against the NAR prior to employment. She revealed the following employees that were hired from 05/04/21 to 10/24/22 and continued to be employed by the facility that she had no documentation in their personnel files that they were checked against the NAR prior to starting employment and that they still had not been checked against the NAR which included 27 employees: Director of Nursing #605, ADON/ RN #683, RN #611, RN #679, LPN #602, LPN #603, LPN #604, LPN #657, LPN #658, LPN #665, LPN #689, LPN #674, LPN #676, LPN #678, LPN #680, LPN #685, LPN #722, [NAME] #600, [NAME] #692, Dietary Aide #609, Activities Assistant #618, Activities Assistant #640, Activities Assistant #688, Maintenance Director #639, HR #645, Admission Director #648, and Dietary Manager #664<br><br>Interview on 10/24/22 at 12:17 P.M. with Administrator revealed she was recently hired at the facility on 08/22/22 and revealed recently she was going through personnel files and did notice employees of the facility that were non-STNA's were not checked against the NAR which was part of their screening process on abuse.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, dated October 2020, revealed the facility would undertake background checks of all employees and retain on file applicable records of current employees regarding such checks. The policy revealed the facility would prior to hiring a new employee check the Ohio NAR.<br><br>This deficiency represents non-compliance investigated under Complaint Numbers OH00136176 and OH00136272. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on record review, facility policy review, facility self-reported incident (SRI) review, and interview, the facility failed to thoroughly investigate allegations of neglect. This affected one resident (Resident #21) of six residents reviewed for neglect. The facility census was 79 residents.<br><br>Findings include:<br><br>Review of Resident #21's medical record revealed an original admitted [DATE] and diagnoses including anxiety, schizophrenia, heart failure and chronic obstructive pulmonary disease.<br><br>Review of Resident #21's quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively intact and did not display behaviors including wandering or rejection of care. Resident #21 was independent with bed mobility, required staff supervision for ambulation and transfers and required the limited assistance of one staff for personal hygiene and toileting. No restraints or alarms were coded on the assessment. Review of profile information in Resident #21's electronic medical record revealed he had a guardian.<br><br>Review of Resident #21's assessments indicated a wandering and elopement assessment dated [DATE] that classified the resident as not at risk for elopement and stated Resident #21 was cognitively impaired with poor decision-making skills (i.e., intermittent confusion, cognitive deficits or disoriented), pertinent diagnoses and ambulated independently. No elopement history was noted on the assessment. A box was checked at the bottom of the assessment indicating Resident #21 was at high risk for elopement with a listed goal of remaining safe within facility unless accompanied by staff or other authorized persons through next review.<br><br>Review of Resident #21's care plan dated 09/10/21 revealed Resident #21 was at high risk for elopement and included use of a Wanderguard as an intervention in place.<br><br>Review of a nurses' note dated 10/11/22 at 9:45 A.M. and written by Licensed Practical Nurse (LPN) #623 revealed Resident #21 left for his medical appointment at 9:30 A.M. via the facility's transportation with face sheet and medication list; all parties aware.<br><br>Review of the next available nurses' note in Resident #21's medical record revealed a late entry note dated 10/16/22 at 10:39 P.M. originally for 10/15/22 for 5:30 P.M. and written by the Director of Nursing (DON) indicated Resident #21 returned to the facility on this date at 5:30 P.M. accompanied by this nurse and another staff member (not identified). Resident #21 ambulated with cane, was placed in his wheelchair and taken to his room now on the second floor's secured unit. Resident #21 was assessed and found to have no injuries.<br><br>Review of the SRI dated 10/11/22 for alleged neglect involving Resident #21 revealed the initial allegation was submitted to the State Agency (SA) on 10/11/22 at 7:28 P.M. Resident #21 had an unauthorized departure from a medical appointment in the community. The facility's investigation contained no resident interviews and two staff statements from Transportation Staff (TS) #687 and LPN #623. A police report number but no actual report was included in the file. A separate incident summary dated 10/17/22 was available but not included with the SRI investigation.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 10/24/22 at 8:58 A.M. with Registered Nurse (RN)/Assistant Director of Nursing (ADON) #683 revealed she and the DON helped to search for Resident #21 on 10/11/22 and she also searched for him after work.<br><br>Interview on 10/24/22 at 9:29 A.M. with Social Service Designee (SSD) #650 revealed on 10/11/22 during the early afternoon TS #687 called the facility and the front desk staff (not named) let her know Resident #21 could not be found from the medical center where he had had his medical appointment. SSD #650 and the DON left the facility to search the area around the medical center.<br><br>Interview on 10/24/22 at 10:36 A.M. with the DON revealed on 10/11/22 in early afternoon SSD #650 came to tell her that TS #687 told them Resident #21 was no longer at his appointment in the community and had been observed smoking then getting on a bus. She, RN/ADON #683, State tested Nursing Assistant (STNA)/Scheduler #667 and SSD #650 went to try to locate Resident #21.<br><br>Interview on 10/24/22 at 11:15 A.M. with the Administrator revealed she was the main staff responsible for the investigation and completion of the SRI regarding Resident #21's elopement. The Administrator was asked why additional staff statements were not completed as part of the facility's SRI investigation as Resident #21's elopement occurred in a medical center in the community with multiple witnesses present and the complaint investigation also indicated that RN/ADON #683, SSD #650 and the DON were involved. The Administrator stated she felt it was not necessary to have statements that facility staff looked for Resident #21 for four days in the community.<br><br>Review of the facility policy, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated October 2020 revealed an investigation protocol including interviewing the resident and all witnesses. Witnesses generally included anyone who witnessed or heard the incident, came in close contact the day of the incident (including other residents, family members) and employees who worked closely with the alleged victim the day of the incident. Obtain a statement from the resident and each witness. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on observation, interview and record review, the facility failed to develop an accurate comprehensive care plan. This affected one (Resident #21) of three residents reviewed for elopement risk. The facility census was 79 residents.<br><br>Findings include:<br><br>Review of Resident #21's medical record revealed an original admitted [DATE] and a readmitted to the facility of 10/28/21 and diagnoses including anxiety, schizophrenia, heart failure and chronic obstructive pulmonary disease. Resident #21 discharged from the facility on 10/13/21 to the hospital directly from a medical appointment and readmitted to the facility on [DATE].<br><br>Review of Resident #21's quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively intact and did not display behaviors including wandering or rejection of care. Resident #21 was independent with bed mobility, required staff supervision for ambulation and transfers and required the limited assistance of one staff for personal hygiene and toileting. No restraints or alarms were coded on the assessment.<br><br>Review of Resident #21's physician's orders revealed no orders for a Wanderguard (device that would alarm when approaching a door to alert staff).<br><br>Review of Resident #21's assessments indicated a wandering and elopement assessment dated [DATE] that classified the resident as not at risk for elopement and stated Resident #21 was cognitively impaired with poor decision-making skills (i.e., intermittent confusion, cognitive deficits or disoriented), pertinent diagnoses and ambulated independently. No elopement history was noted on the assessment. A box was checked at the bottom of the assessment indicating Resident #21 was at high risk for elopement with a listed goal of remaining safe within facility unless accompanied by staff or other authorized persons through next review. Listed interventions included BLANK intervention for editing; apply Wanderguard to reduce risk of elopement; check device for proper functioning per facility protocol; develop an activity program to divert attention and meet individual needs; discuss with resident/ Family risks of elopement/ wandering; if resident is missing from facility, follow elopement protocol, notify physician and family immediately and document; if resident is wandering in potentially unsafe area or situation, redirect to safer area; observe/ record/ report to physician or nurse practitioner risk factors for potential elopement; and take photograph of resident to maintain on file for identification purposes. No further elopement assessments were completed for Resident #21 until 10/12/22 when Resident #21 was still missing from the facility.<br><br>Review of Resident #21's care plan dated 09/10/21 revealed Resident #21 was at high risk for elopement and included use of a Wanderguard as an intervention in place also as of 09/10/21.<br><br>Observation on 10/20/22 at 12:47 P.M. of Resident #21 revealed he was seated in his wheelchair with a coat over a t-shirt and had sweatpants on with no Wanderguard noted.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 10/24/22 at 9:29 A.M. with Social Services Designee (SSD) #650 revealed she and Licensed Practical Nurse (LPN)/MDS Coordinator #661 were responsible for resident care plans which were updated quarterly and as needed. SSD #650 verified Resident #21 did not have a Wanderguard. SSD #650 was made aware during the interview that Resident #21's care plan inaccurately stated he utilized a Wanderguard as an elopement intervention.<br><br>Review of an undated document, Wanderguard List, revealed only Resident #15 was identified as having a Wanderguard in the facility. |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973<br><br>Based on interview, observation, record review, and policy review, the facility failed to ensure appropriate interventions were implemented to prevent the development of a pressure ulcer for Resident #58. Actual Harm occurred on 10/11/22 at 2:15 P.M. when Resident #58, who was a paraplegic and required total dependence of two staff with transfers, extensive assist of one person with toileting and dressing and limited assistance of one staff with bed mobility, was found to have a Stage three (full thickness tissue loss that may include undermining, tunneling, and slough {dead skin tissue that may be white and/ or yellow in appearance} which does not obscure the depth of the tissue loss) pressure ulcer to his coccyx area during wound rounds that required debridement. No treatment to the pressure ulcer was initiated from the discovery date of 10/11/22 until 10/17/22 (six days). In addition, review of the medical record revealed the facility did not have any evidence Resident #58's coccyx pressure ulcer was re-assessed and measured after 10/11/22 once discoveed until 10/24/22. This affected one resident (Resident #58) of three residents (Resident #58, #61, and #78) reviewed for pressure ulcers. The facility census was 79.<br><br>Findings included:<br><br>Review of medical record for Resident #58 revealed an admitted [DATE] with diagnoses including altered mental status, peripheral vascular disease, and diabetes.<br><br>Review of care plan dated 10/05/21 revealed Resident #58 had actual skin impairment related to his pressure areas on admission to his left heel that resolved on 12/21/21, right dorsal foot that resolved on 10/19/21, sacrum area that resolved on 12/21/21 and his current right ischium pressure ulcer. The care plan contained no evidence of the regarding new facility acquired pressure ulcer to his coccyx area that was found on 10/11/22. Interventions included initiate wound treatment and continue treatment as ordered, limit time out of bed, and skin observation on bath and shower days.<br><br>Review of Braden Score evaluation dated 08/09/22 and completed by Minimum Data Set 3.0(MDS)/ Registered Nurse (RN) #661 revealed Resident #58 was at moderate risk for skin breakdown due to his sensory perception was slightly limited, he was constantly moist, he was chairbound, his mobility was slightly limited, and he had a problem with friction and shear.<br><br>Review of annual MDS dated [DATE] revealed Resident #58 had intact cognition and required limited assist with bed mobility and was totally dependent of two people with transfers. He required extensive assist of two people with toileting. Resident #58 was at risk for developing a pressure ulcer and had three unstageable (full thickness tissue loss and the actual depth of the ulcer was completely obscured by slough in the wound bed) pressure ulcers that were not present on admission.<br><br>Review of October 2022 physician orders revealed Resident #58 had an order dated 10/16/22 to cleanse his coccyx area with normal saline, pat dry, apply calcium alginate to wound bed and cover with foam dressing daily and as needed.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Treatment Administration Record (TAR) for October 2022 revealed Resident #58's treatment was documented as first initiated on 10/17/22 7:00 P.M. to 7:00 A.M. to cleanse his coccyx area with normal saline, pat dry, apply calcium alginate to wound bed and cover with foam dressing daily and as needed. The TAR revealed there was no treatments for his coccyx area documented as being completed from 10/11/22 when his coccyx pressure ulcer was first found to 10/17/22 (six days).<br><br>Review of physician progress note dated 10/11/22 at 2:15 P.M. and completed by Wound Physician #713 revealed on wound rounds it was identified Resident #58 had a new facility acquired Stage three pressure ulcer to his coccyx area that measured a length of 2.5 centimeters (cm), width of 1.5 cm and depth of .3 cm. The pressure ulcer contained 75 percent granular tissue, and 25 percent slough. The progress note revealed Wound Physician #713 cleaned the wound, flushed, irrigated, and prepared for debridement. The progress revealed the wound was sharply debrided manually with a curette (a surgical instrument used to remove material by a scraping action) to reduce infection and promote wound healing. The progress note revealed a treatment plan was given to the wound care nurse verbally and written.<br><br>Review of facility form labeled, Skin Grid Pressure dated 10/11/22 and completed by the Director of Nursing revealed Resident #58 had an unstageable pressure ulcer that was identified on 10/11/22 to his coccyx area that measured a length of 2.5 cm, width of 1.5 cm and depth of .3 cm. The skin grid revealed the pressure ulcer had 75 percent granular tissue, and 25 percent soft yellow slough. The skin grid revealed Wound Physician #713 debrided the wound with a curette.<br><br>Review of nursing note dated 10/18/22 at 5:44 P.M. and completed by the Director of Nursing revealed Resident #58 was not seen per the Wound Physician #713 because he was out of the facility at an appointment.<br><br>Review of facility form labeled, Skin Grid Pressure dated 10/18/22 and completed by the Director of Nursing revealed the form was opened in the electric medical record but that there was no assessment documented regarding Resident #58's wound to his coccyx including measurements, and description of his wound.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on 10/24/22 at 9:00 A.M. and 10/26/22 at 10:58 A.M. with Assistant Director of Nursing (ADON/ Registered Nurse (RN) #683 revealed she completed wound rounds weekly with Wound Physician #713. She revealed on 10/11/22 during wound rounds they found Resident #58 to have a pressure ulcer to his coccyx area that was not previously reported and/ or documented. She verified Wound Physician #713 staged his coccyx pressure area as a Stage three wound and the wound had contained slough inside the wound bed that needed debrided by Wound Physician #713. She verified there was a discrepancy in documentation as the facility Skid Grid Pressure form dated 10/11/22 and completed by the Director of Nursing revealed the coccyx pressure ulcer was unstageable but Wound Physician #713's progress note revealed the wound to his coccyx area on 10/11/22 was a Stage three. She also verified Wound Physician #713 had given her a treatment order verbally for Resident #58's coccyx that included to cleanse his coccyx area with normal saline, pat dry, apply calcium alginate to wound bed and cover with foam dressing daily and as needed. She revealed there was a lot going on that week and she verified she did not initiate the physician order for Resident #58's coccyx pressure ulcer on 10/11/22 when she received the order and that she did not transcribe the order until 10/16/22. She verified the treatment was not documented on the TAR as being completed until 10/17/22 . ADON/ RN) #683 verified she had no documentation a treatment was completed to Resident #58's coccyx area from 10/11/22 to 10/17/22 (six days). She revealed wounds were to be assessed and measured weekly and that Wound Physician #713 came into the facility on [DATE] but Resident #58 was at an outside appointment. ADON/RN) #683 verified the documentation per the facility form, Skin Grid Pressure dated 10/18/22 was blank and that she did not have any documentation that the coccyx wound was measured and/ or documented on appearance of the wound from 10/11/22 to 10/24/22. ADON/RN) #683 verified Resident #58 was a paraplegic and required total dependence of two staff with transfers, extensive assist of one person with toileting and dressing and limited assist of one staff with bed mobility. She verified staff should have found and reported the pressure ulcer to his coccyx area prior to the wound being found as a stage three on wound rounds and stated, I really can not explain why it was not found earlier as it should have been.<br><br>Observation and interview on 10/24/22 at 1:00 P.M. of wound care for Resident #58's coccyx area completed by Wound Physician #713 and ADON/ RN #683 revealed Wound Physician #713 measured the wound as a length of 3 cm, width 2.5 cm and depth of .2 cm. He revealed the wound continued to be a Stage three and had 85 percent granulation and minimal slough. He recommended the same order to continue. Wound Physician #713 verified the wound to Resident #58's coccyx area was found on 10/11/22 during wound rounds and was discovered as a Stage three wound. Wound Physician #713 verifed the wound was larger in length and width from 10/11/22.<br><br>Review of facility policy labeled, Pressure Injury Prevention and Management dated 08/22/22 revealed the facility was committed to the prevention of avoidable pressure injuries and was to provide treatment and services to heal pressure ulcers. The unit manager and/ or designee would review relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly. The policy revealed nursing assistants would inspect skin during bath and would report any concerns to the resident's skin immediately after the task.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00136176. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on observations, interviews, record review, facility self-reported incident (SRI), police report review, facility policy review, and review of weather information from www.wunderground.com, the facility failed to provide accurate and timely assessment, care planning and supervision to prevent the elopement of one resident (Resident #21) who had diagnoses including anxiety and schizophrenia. This resulted in Actual Harm that was Immediate Jeopardy when Resident #21 was dropped off at a medical appointment in the community and subsequently left the appointment without facility staff knowledge on 10/11/22. Facility transportation staff had not received a phone call from Resident #21 or the medical office for 2.5 hours and became concerned, drove back to the medical office and discovered Resident #21 was not there. Medical office and building security staff indicated Resident #21 had gotten on a bus alone and left the premises. Facility transportation staff called the facility to report Resident #21 missing at 1:30 P.M. The resident's whereabouts and condition were unknown until he was discovered in the community four days later on 10/15/22 at 4:44 P.M. by nursing staff at a laundromat in a city approximately 7.2 miles away. This affected one resident (Resident #21) of three residents reviewed for elopement. The facility identified one resident (Resident #15) having a Wanderguard (a device that causes the door to alarm upon exit) and identified five additional residents at risk for elopement (Resident #7, Resident #10, Resident #15, Resident #17 and Resident #27). The facility census was 79 residents.<br><br>Additionally, it was discovered during the complaint survey that Resident #82 had been allegedly selling illegal drugs to staff and residents in the facility during August 2022. The facility failed to further investigate this allegation of illegal drug sales and use, placing all 79 residents in the facility at risk.<br><br>On 10/24/22 at 2:35 P.M. the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 10/11/22 at 9:30 A.M. when Resident #21, who had a legal guardian due to known flight risk and delusions about his ability to provide self-care, left the facility to go to a doctor's appointment in the community without a staff escort. At the time of departure from the facility, Transportation Staff (TS) #687 had asked Licensed Practical Nurse (LPN) #623 if Resident #21 needed a staff escort for the medical appointment and she replied, I don't think so. TS #687 took Resident #21 to the medical appointment and left Resident #21 at the medical office alone. TS #687 had written his phone number at the top of Resident #21's appointment paperwork for medical office staff to contact him when the appointment was over for pick up. TS #687 had not heard anything regarding Resident #21 after about 2.5 hours so returned to the medical office and Resident #21 was no longer there. Resident #21 had last been seen by medical building security staff getting on a bus to an undetermined location. Resident #21 ambulated alone and unsupervised throughout a busy [NAME] environment until he was found four days later by Assistant Director of Nursing (ADON)/Registered Nurse (RN) #683 in a city 7.2 miles away on 10/15/22 at 4:44 P.M. Resident #21 was returned to the facility by staff.<br><br>The Immediate Jeopardy was removed on 10/24/22 when the facility implemented the following corrective actions:<br><br>On 10/11/22 at 1:45 P.M. TS #687 spoke with Social Service Designee (SSD) #650 who informed DON that Resident #21 had an unauthorized departure from medical appointment.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 10/11/22 at 2:00 P.M. Administrator, RN/ADON #683, Admissions Director (AD) #648 and SSD #650 conducted a full facility headcount with all residents present and accounted for.<br><br>On 10/11/22 from 2:00 P.M. to 9:00 P.M. DON, RN/ADON #683, MDS/LPN #661, SSD #650 and TS #687 searched the area where Resident #21 was last seen.<br><br>On 10/11/22 at 5:00 P.M. Administrator completed a SRI with the State Agency (SA).<br><br>On 10/11/22 at 5:15 P.M. Administrator contacted Resident #21's family listed (Family Members (FM) #706 and FM #707) and left message for Legal Guardian (LG) #698 on voicemail.<br><br>On 10/11/22 at 5:20 P.M. DON notified Nurse Practitioner (NP) #709 of Resident #21's elopement.<br><br>On 10/11/22 at 5:30 P.M. DON filed a missing person's report with the police department.<br><br>On 10/11/22 at 5:45 P.M. Administrator contacted and left message for Guardian Supervisor #712.<br><br>On 10/11/22 at 6:00 P.M. Administrator spoke with LPN #623 to inquire why she felt Resident #21 did not need an escort.<br><br>On 10/11/22 Administrator pulled and reviewed Resident #21's Probate Court order from the probate court website.<br><br>On 10/11/22 Administrator educated SSD #650 and AD #648 regarding ensuring guardianship documents are received, reviewed with any individualized instructions being shared with the interdisciplinary team (IDT) to ensure instructions are implemented, care planned and uploaded within the medical record.<br><br>From 10/11/22 to 10/12/22 DON and RN/ADON #683 updated all active residents' wandering/elopement assessments. Care plans were also reviewed and updated if resident is identified as elopement risk. No new residents have been identified as high risk for elopement at this time.<br><br>From 10/11/22 to 10/12/22 DON and RN/ADON #683 updated all active residents' orders to include escort requirement for medical appointments. At this time all current residents have appropriate orders.<br><br>On 10/11/22 SSD #650 retrieved guardianship paperwork for residents with guardians from website, reviewed and uploaded documentation into electronic medical records.<br><br>From 10/11/22 to 10/15/22 the Administrator, DON and RN/ADON #683 as well as law enforcement continued to search communities in an effort to locate Resident #21.<br><br>On 10/12/22 RN/ADON #683 updated Resident #21's elopement/wandering assessment to include need for secured unit and risk for elopement.<br><br>On 10/12/22 the Administrator educated nursing staff via on-shift on regarding the need for all residents to have escorts for medical appointments.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 10/12/22 at 10:00 A.M. the Administrator notified Medical Director #711 of Resident #21's elopement from medical appointment on 10/11/22.<br><br>On 10/15/22 at 4:30 P.M. RN/ADON #683 notified the Administrator and the DON that she had spotted Resident #21 at a laundromat and was currently awaiting law enforcement presence to help assist Resident #21 back to the facility.<br><br>On 10/15/22 at 6:00 P.M. the DON assessed Resident #21 with no negative findings and rehoused on secured unit as stated per probate court paperwork. The DON notified FM #706 and NP #709 that Resident #21 returned to the facility at this time.<br><br>On 10/17/22 the Administrator notified LG #698 of Resident #21's return.<br><br>On 10/21/22 RN/ADON #683 updated Resident #21's care plan to include secured unit/elopement risk.<br><br>On 10/24/22 SSD #650 completed another audit on resident guardianship documentation with no additional findings. SSD #650/designee to complete weekly audits for four weeks on residents identified with guardianship to ensure guardianship documents are received, reviewed updated and shared with IDT for individualized instructions.<br><br>On 10/24/22 the Regional Director of Clinical Services (RDCS) #702 completed an audit to ensure elopement risk assessments are scheduled on a quarterly basis; schedules activated as needed. Going forward, completion of assessments will be the charge nurses' responsibility and MDS/LPN #661 will be responsible for ensuring completion during MDS timeframes.<br><br>On 10/24/22 the Administrator educated TS #687 on ensuring residents have an escort for appointments. Activity Director (AD) #646 is back up transportation driver and has also been educated on need for escort according to new policy. Facility does not use outside transportation outside of Cleveland Emergency Medical Services (EMS) for transport in emergent situations.<br><br>On 10/24/22 RDCS #702 educated the DON, RN/ADON #683 and MDS/LPN #661 on ensuring elopement risk assessments are scheduled/completed on admission/quarterly and as needed. DON/designee to complete an audit on elopement risk assessment on five residents per week for four weeks to ensure elopement risk assessments are completed and scheduled on admission/quarterly and as needed.<br><br>On 10/24/22 RDCS #702 and [NAME] President of Clinical Services (VPCS) #710 implemented a new formal policy on resident escort requirements. At this time the facility has determined all residents will have an escort for outside medical appointments. Facility will continue current practice for 60 days and will reassess practice after 60-day timeframe. At time of reassessment, the IDT will identify residents who require an escort.<br><br>On 10/24/22 RDCS #702 educated the DON and Administrator on the new resident escort policy. DON/designee to complete an audit of five resident appointments weekly to ensure residents have appropriate supervision to and from appointments for four weeks. DON/designee will validate residents with upcoming appointments have escorts assigned for next day appointments.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 10/24/22 the Administrator, the DON, RN/ADON #683 and RDCS #702 educated nurses, management staff, and TS #687 on the new escort policy. New nurse orientation will include policy on escort for medical appointments. At this time, as needed (PRN) nurses identified as active have also been educated.<br><br>On 10/25/22 at 6:00 A.M. Maintenance Director (MD) #639 conducted an elopement drill conducted on night shift and staff responded appropriately.<br><br>On 10/27/22 a quality assurance performance improvement (QAPI) meeting will review audits for further review as part of the facility's ongoing quality improvement initiative.<br><br>Although the Immediate Jeopardy was removed on 10/24/22, the deficiency remained at a Severity Level 2 (no actual harm with the potential for minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.<br><br>Findings include:<br><br>1. Review of Resident #21's medical record revealed an admitted [DATE] with diagnoses including anxiety, schizophrenia, heart failure and chronic obstructive pulmonary disease.<br><br>Review of Resident #21's census data revealed he resided on the first floor until 10/11/22 where he was marked as hospital less than eight hours. Resident #21 was readmitted to the second floor (secured unit) on 10/15/22.<br><br>Review of Resident #21's quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively intact and did not display behaviors including wandering or rejection of care. Resident #21 was independent with bed mobility, required staff supervision for ambulation and transfers and required the limited assistance of one staff for personal hygiene and toileting. No restraints or alarms were coded on the assessment.<br><br>Review of Resident #21's electronic medical record indicated he had a legal guardian and two sisters were listed as emergency contacts.<br><br>Review of a statement of expert evaluation dated 08/18/21 revealed Resident #21 had schizophrenia and impairment of orientation, thought process, affect, memory, concentration, comprehension and judgement. The evaluation indicated that guardianship should be established due to Resident #21's disorientation and confusion.<br><br>Review of a guardianship document from the probate court dated 02/22/22 revealed Resident #21 had schizophrenia and was delusional about his ability to provide self-care, was a flight risk and was maintained on a locked unit. Legal Guardian (LG) #698 was assigned to be Resident #21's guardian.<br><br>Review of Resident #21's physician's orders revealed an order dated 11/16/21 for Zoloft (antidepressant) 50 milligrams (mg) daily for anxiety, an order dated 12/14/21 for Zyprexa (antipsychotic) 20 milligrams each evening for schizophrenia, an order dated 10/07/22 for dermatology appointment on 10/11/22 at 10:10 A.M. in the community and an order dated 10/13/22 for may go on leave of absence (LOA) with supervision, escort required for all appointments.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #21's assessments indicated a wandering and elopement assessment dated [DATE] that classified the resident as not at risk for elopement and stated Resident #21 was cognitively impaired with poor decision-making skills (i.e., intermittent confusion, cognitive deficits or disoriented), pertinent diagnoses and ambulated independently. No elopement history was noted on the assessment. A box was checked at the bottom of the assessment indicating Resident #21 was at high risk for elopement with a listed goal of remaining safe within facility unless accompanied by staff or other authorized persons through next review. Listed interventions included apply Wanderguard to reduce risk of elopement; check device for proper functioning per facility protocol; develop an activity program to divert attention and meet individual needs; discuss with resident/ family risks of elopement/ wandering; if resident is missing from facility, follow elopement protocol, notify physician and family immediately and document; if resident is wandering in potentially unsafe area or situation, redirect to safer area; observe/ record/ report to physician or nurse practitioner risk factors for potential elopement; and take photograph of resident to maintain on file for identification purposes. No further elopement assessments were completed for Resident #21 until 10/12/22 when Resident #21 was still missing from the facility.<br><br>Review of Resident #21's care plan dated 05/02/22 revealed Resident #21 demonstrated manipulative behavior as evidenced by panhandling; Resident #21 would ask staff, visitors and residents for money, can you stand a little change? being his most common request. Review of Resident #21's care plan dated 09/10/21 revealed Resident #21 was at high risk for elopement and included use of a Wanderguard as an intervention in place. Review of a care plan dated 10/20/22 revealed Resident #21 had a diagnosis of dementia and/or psychiatry diagnosis that required secured observation and exhibited one or more criteria for placement on the secured dementia/behavior unit: elopement risk.<br><br>Review of a nurses' note dated 10/11/22 at 9:45 A.M. and written by LPN #623 revealed Resident #21 left for his medical appointment at 9:30 A.M. via the facility's transportation with face sheet and medication list, all parties aware.<br><br>Review of the next available note in Resident #21's medical record revealed a late entry note dated 10/16/22 at 10:39 P.M. originally for 10/15/22 for 5:30 P.M. and written by the DON revealed Resident #21 returned to the facility on this date at 5:30 P.M. accompanied by this nurse and another staff member (not identified). Resident #21 ambulated with cane, placed in his wheelchair and taken to his room now on the second floor secured unit. Resident #21 was assessed and found to have no injuries.<br><br>Review of an interdisciplinary team note dated 10/17/22 at 10:21 A.M. and written by the Administrator revealed Resident #21 returned to the facility from the community without injuries and verbalized he had been staying with his girlfriend in [city approximately 7.2 miles away from facility] and had contacted his sister, Family Member (FM) #707 and his brother to let them know his whereabouts. Family failed to let facility know Resident #21 had contacted them or of his location. Local law enforcement assisted the DON/ADON with Resident #21's return. Per LG #698, Resident #21 was to reside on the secured unit.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of historical weather data from www.wunderground.com revealed on 10/11/22 the high temperature was 73 degrees Fahrenheit (F) and the low temperature was 53 degrees F; on 10/12/22 high 71 degrees F and the low temperature was 56 degrees F; on 10/13/22 the high temperature was 61 degrees F and the low temperature was 49 degrees F with 1.59 inches of precipitation noted; on 10/14/22 the high temperature was 61 degrees F and the low temperature was 41 degrees F; and on 10/15/22 the high temperature was 57 degrees F and the low temperature was 42 degrees F.<br><br>Review of an incident log from April 2022 through October 2022 revealed no elopements or unauthorized absences from the facility were documented.<br><br>Review of a self-reported incident with the facility's investigation dated 10/11/22 at 5:00 P.M. revealed an allegation of neglect regarding Resident #21's unauthorized departure from medical appointment. At the time of the initial report, Resident #21 was still out of the facility. Resident #21 left the facility in the company of the facility's transportation driver to a medical appointment for dermatology. Resident #21 left the medical appointment after getting a prescription from the dermatologist and left the clinic to go to [chain pharmacy] to fill the prescription. Per security guard at the medical building (not named) Resident #21 was seen getting on a city bus. Dermatology office contacted the facility driver to alert him that Resident #21 had departed the medical office and got onto public transit. Driver contacted facility administration and investigation and search for Resident #21 began. The police were contacted. The facility found the allegation of neglect to be unsubstantiated as at the time of the final submission (10/18/22 9:41 P.M.) Resident #21 was back in the facility and told staff he had told his sister (not identified) he was going to leave his appointment and go to his girlfriend's house. Resident #21 was moved to the secured unit as well. The investigation included an email dated 10/12/22 at 10:23 A.M. to LG #698. A quality assurance form dated 10/11/22 revealed Resident #21 had a dermatology appointment in the community. The transportation driver had asked the nurse if Resident #21 needed an escort and the nurse said an escort was not required for Resident #21. Resident #21 was taken to the appointment, was observed smoking by building staff and then was observed getting on a bus. The facility transportation driver went to get Resident #21 and was notified Resident #21 had left. Police were involved. LG #698 was concerned Resident #21 was sent to his appointment without the appropriate supervision. A text-message was sent to all facility staff on 10/12/22 at 10:48 A.M. indicating all residents leaving the facility for appointments must have an escort. Staff statements were included from TS #687 and LPN #623.<br><br>Review of TS #687's written statement dated 10/12/22 revealed he had driven Resident #21 to his doctor's appointment in the community on 10/11/22 at 8:50 A.M. When he got to the nurses' station to pick up Resident #21 he asked the nurse (not identified) if the resident needed an escort and was told no. At the facility, Resident #21 was given TS #687's phone number and instructed to call him when his appointment ended. After two hours TS #687 had not heard from Resident #21 so he drove back to the dermatology office and was told by medical office staff (not identified) Resident #21 was taken downstairs to smoke. Building security staff (not identified) and the medical office staff indicated that Resident #21 left and went on a bus. TS #687 drove around looking for Resident #21.<br><br>Review of LPN #623's written statement dated 10/11/22 revealed she cared for Resident #21 on 10/11/22. Resident #21 had a dermatology appointment at 10:10 A.M. Resident #21 and the driver (not identified) were already aware of the appointment and Resident #21 left the facility at 9:30 A.M. with the driver.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a separate incident summary dated 10/17/22 revealed on 10/11/22 at 1:30 P.M. TS #687 alerted the facility Resident #21 was no longer at the medical building he had dropped the resident off at earlier that day for a medical appointment. Resident #21 had not been sent to the appointment with a responsible party per LPN #623's direction. Building security took Resident #21 downstairs to smoke a cigarette when Resident #21 walked away and got on a bus. The DON, ADON/RN #683, MDS/LPN #661, TS #687 and Social Service Designee (SSD) #650 went to the medical center to search for Resident #21 until 4:45 P.M. A police report was filed and an SRI was initiated. Facility staff continued to follow up with local police departments and search the vicinity for Resident #21. Contact was made with Resident #21's sisters. On 10/15/22 at 4:44 P.M. ADON/RN #683 spotted Resident #21 at a laundromat in [city approximately 7.2 miles from the facility] and was waiting for police to arrive. Resident #21 stated with police, the DON and the Administrator present, that he had been at his girlfriend's house and since it was Sweetest Day, he would come back to the facility on Monday 10/17/22. Resident #21 contacted FM #707 for the local police and FM #707 stated she had known Resident #21's whereabouts as Resident #21 had called her to inform her of his location. FM #707 did not tell the facility of Resident #21's whereabouts as she did not believe he needed a guardian. It was noted on Resident #21's probate orders Resident #21 was to reside on the secured unit when originally admitted to the facility. The facility unsubstantiated the SRI for neglect as Resident #21 had a clear plan and had no adverse outcomes. The facility planned to re-evaluate Resident #21's need for a guardian and it would be completed within 90 days.<br><br>Review of a police report dated 10/11/22 at 4:39 P.M. revealed the DON stated Resident #21 was missing after a dermatology appointment. Resident #21 was seen panhandling in the medical building and was escorted to the first floor by building security who saw Resident #21 get on the bus. Resident #21 was last seen wearing a gray sweater and blue sweatpants and had a blue grocery bag. Resident #21 was ambulatory using a 3-prong cane. Resident #21's appointment was at 10:10 A.M. and they do not know what time he left the medical building. Before leaving he stated to the security office that he needed to pick up his medication from the pharmacy in [city over 12 miles from the medical building]. Police spoke with the Administrator who stated Resident #21 was probated to the nursing home and not free to leave.<br><br>Interview on 10/20/22 at 12:11 P.M. with TS #687 verified his written statement indicating he asked LPN #623 if Resident #21 needed an escort for his medical appointment and she had replied she didn't think so. TS #687 stated when the current Administrator began working at the facility, all residents that had an appointment required an escort. Prior to this, if staff thought people would be ok they did not need an escort for appointments. TS #687 indicated he wrote his phone number on Resident #21's paperwork and told him or the medical office to call him when the appointment was over. TS #687 took Resident #21 into the building and left the premises. After 2.5 hours TS #687 was concerned he had not heard anything so he drove back to the medical facility. Two receptionists (not identified) indicated Resident #21 went downstairs because he wanted to smoke. A building security guard (not identified) and receptionist (not identified) said Resident #21 acted strange and asked where the bus was. Resident #21 went to the road the medical center was on and got on a bus. Between 1:00 P.M. and 1:30 P.M. TS #687 called ADON/RN #683 or SSD #650 to report that Resident #21 was gone and he did not know where Resident #21 went. TS #687 stated Resident #21 used a wheelchair but could use a cane to walk short distances. TS #687 stated Resident #21 was packing his pockets prior to leaving for the appointment and had a bag but he did not know what was in Resident #21's pockets or bag.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 10/20/22 at 12:47 P.M. with Resident #21 revealed he was seated in his wheelchair with a coat over t-shirt and sweatpants on. Resident #21 asked the surveyor if she was probate court. When asked about leaving the facility recently, Resident #21 stated he had left the facility for three days and was with his girlfriend in [city approximately 7.2 miles from the facility]. Resident #21 verified he had been at a doctor's appointment without a staff escort then abruptly ended the interview.<br><br>Interview on 10/20/22 at 1:32 PM with the Administrator revealed she was made aware Resident #21 was gone on 10/11/22 at 1:30 P.M. as the front desk had spoken to SSD #650 and she told her and the DON. The Administrator stated the DON and RN/ADON #683 went to the medical facility to see if Resident #21 was there and they could not find him. The Administrator verified LPN #623 was asked how staff determined if an escort was required; LPN #623 could not tell her and she verified TS #687 had even asked LPN #623 regarding an escort but she did not indicate he needed one.<br><br>Interview on 10/20/22 at 3:25 P.M. with LPN #623 revealed she cared for Resident #21 on 10/11/22, who left around 9:00 A.M. with the facility driver. LPN #623 indicated Resident #21 did not need an escort, there was no physician's order for him indicating that he needed one. LPN #623 stated usually the ADON/RN #683 and Scheduler/STNA #667 would decide if residents needed an escort based on a paper. LPN #623 indicated management notified Resident #21's physician and guardian of his elopement.<br><br>Phone interview on 10/21/22 at 9:25 A.M. with LPN #697 revealed escorts were to go with residents for all appointments and if the facility could not provide an STNA then TS #687 would stay with the resident.<br><br>Phone interview on 10/21/22 at 11:27 A.M. with LG #698 revealed he had been Resident #21's guardian since 02/22/22. LG #698 stated he was not aware until Resident #21's elopement that he had not been residing on the facility's locked unit and could not imagine why Resident #21 was not on that locked unit from the very beginning. LG #698 stated he felt Resident #21 should have a Wanderguard as he had eloped from other facilities and was very crafty as he was a known flight risk. LG #698 was first made aware of Resident #21's elopement on 10/13/22 when he spoke with the Administrator. LG #698 checked his phone records and indicated 10/13/22 was the first date he had heard from the facility regarding Resident #21's elopement and stated he was made aware Resident #21 did not have a staff escort for this medical appointment. LG #698 verified he did not feel Resident #21 would be safe in the community without an escort.<br><br>Follow-up interview on 10/24/22 at 8:29 A.M. with the Administrator revealed on 10/11/22 when the facility pulled Resident #21's probate guardianship documents they learned he was to have been on the secured unit this whole time. The Administrator did not know when the physician was notified.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 10/24/22 at 8:58 A.M. with RN/ADON #683 revealed Resident #21 was alert and oriented but had a guardian. RN/ADON #683 indicated she and the DON helped to search for Resident #21 on 10/11/22 and she also searched for him after work. On 10/15/22 after 3:30 P.M. she saw Resident #21 in [city approximately 7.2 miles from the facility] walking on the street towards the laundromat using a quad cane with a clear garbage bag with laundry detergent and clothes. RN/ADON #683 approached Resident #21 and told him he had to return to the facility; Resident #21 told her he had told his brother and sister where he was and he wanted to come back to the facility on Monday 10/17/22. The police were called and the Administrator and the DON arrived to the scene. Resident #21 returned to the facility in the DON's vehicle. RN/ADON #683 stated LPN #623 was disciplined for the failure to send an escort with Resident #21 to this appointment. RN/ADON #683 verified residents were to be assessed for elopement risk quarterly and after an incident and was made aware during the interview that Resident #21 lacked evidence of routine, quarterly elopement assessments. RN/ADON #683 verified Resident #21 did not have a Wanderguard even though his care plan stated one was in place.<br><br>Review of LPN #623's personnel file indicated no disciplinary actions. Time punches for LPN #623 revealed no suspensions were noted for the period 10/09/22 to 10/20/22.<br><br>Interview on 10/24/22 at 9:29 A.M. with SSD #650 revealed Resident #21 had a high BIMS score but he had periods of forgetfulness and did have a legal guardian. SSD #650 verified after reviewing some evaluations previously he was supposed to be on the secured unit and he had been in the facility for some time and had not been on the secured unit. SSD #650 verified Resident #21 was never placed on the secured unit at the time the guardianship was established. SSD #650 verified Resident #21 did not have a Wanderguard and verified his care plan for elopement risk was inaccurate. SSD #650 stated on 10/11/22, early afternoon, TS #687 called the facility and the front desk let her know Resident #21 could not be found. SSD #650 and the DON left the facility to search the area around the medical center. SSD #650 stated building security brought Resident #21 downstairs since he was panhandling in the waiting room and his appointment was over. Resident #21 came down to smoke, then came back inside the building to tell security he did not know where to go now and then ambulated with his cane to the bus stop. SSD #650 stated she had been concerned with him being on his feet for long periods of time since she usually saw Resident #21 in a wheelchair. SSD #650 verified Resident #21 should have had an escort for the appointment and verified due to his history of drug and alcohol use, Resident #21 would not be safe in the community by himself.<br><br>Interview on 10/24/22 at 10:36 A.M. with the DON revealed she had been employed by the facility since 09/09/22. The DON stated on 10/11/22 in early afternoon SSD #650 came to tell her that TS #687 told them Resident #21 was no longer at his appointment and had been observed smoking then getting on a bus. She, RN/ADON #683, STNA/Scheduler #667 and SSD #650 went to try to locate Resident #21. The DON verified all residents were to have a Leave of Absence physician's order that would reference the need for an escort. The DON verified residents were to be assessed for elopement status quarterly. The DON also stated a progress note indicating doctor and guardian notification of incidents was also required and verified that was not completed for Resident #21. The DON confirmed the facility did not know about Resident #21's guardianship papers indicating he was a flight risk and required the secured unit until pulled during this incident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 10/24/22 at 10:58 A.M. with medical center Receptionist #699 revealed everyone at the medical facility knew about Resident #21 leaving the medical appointment. Resident #21 was in a wheelchair and must have gotten in one as he had a cane or a walker. Receptionist #699 stated she recalled Resident #21 was asking everyone in the office for money then stated the surveyor needed to talk to a hospital supervisor.<br><br>Interview on 10/24/22 at 12:04 P.M. with Hospital Nurse Manager (HNM) #700 revealed she had been told Resident #21 was alert and oriented. Resident #21 went to his appointment and medical center staff took Resident #21 downstairs to get his ride and he told them (not identified) he was going to get his prescription. HNM #700 verified Resident #21 was ambulatory but she was not sure if he was using a cane at the time of the appointment. HNM #700 stated this was not the first time Resident #21 had done this and shared he was well known to the medical center's police department. HNM #700 stated the facility's bus did not show up until late afternoon to get Resident #21 but Resident #21 was already gone.<br><br>Interview on 10/24/22 at 11:15 A.M. with the Administrator revealed when she had asked LPN #623 how the need for a resident escort was determined, her answer was not sufficient so she was disciplined for her failure to send Resident #21 to his doctor's appoin [TRUNCATED] |

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| F 0693<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973<br><br>Based on interview, observation, and open and closed record review, the facility failed to ensure tube feedings were ordered and implemented appropriately to prevent gastrointestinal symptoms including severe abdominal pain, nausea, and vomiting. Actual Harm occurred on [DATE] when Dietician #677 wrote an order for Resident #35 to receive Diabetisource (tube feeding) 40 milliliters (ml) per hour continuously but did not discontinue the previous tube feeding order of Diabetisource bolus 240 ml every six hours resulting in Resident #35 receiving both tube feeding orders. On [DATE] at 4:00 A.M. Resident #35 had a large emesis, and abdominal pain causing her to cry out in pain. On [DATE] Hospice RN #727/ Hospice Physician #729 ordered to discontinue the continuous tube feeding and only administer the bolus tube feeding order. The facility failed to transcribe the physician order and Resident #35 continued to receive both tube feeding orders (continuous and bolus) that resulted in continued abdominal pain, nausea and vomiting. Resident #35 expired on [DATE]. In addition, the facility failed to ensure Resident #35 and #39 had an annual comprehensive nutritional assessment completed monitoring their tube feeding status. This affected two residents (Resident #35 and #39) of three residents (Resident #23, #35, and #39) reviewed for tube feedings. The facility had a total of three residents with orders for tube feedings (Resident #23, #35, and #39) residing at the facility.<br><br>Findings included:<br><br>1. Review of closed medical record for Resident #35 revealed an admitted [DATE] and the resident expired on [DATE] under hospice services. Diagnoses included altered mental status, multiple myeloma not having achieved remission, chronic kidney disease, and diabetes. Review of medical record revealed Resident #35 had a guardian of person.<br><br>Review of facility form labeled, Comprehensive Medical Nutrition Therapy Assessment- V1 dated [DATE] revealed Former Dietician #724 completed the admission comprehensive nutritional evaluation. There were no other Comprehensive Medical Nutrition Therapy Assessments in the resident's medical record until [DATE].<br><br>Review of the care plan dated [DATE] revealed Resident #35 was dependent on tube feeding for nutrition and hydration. She was at risk for aspiration and other complications related to the tube feeding. Interventions included administer tube feeding and flushes as ordered, check residuals as ordered, and notify physician of any complications.<br><br>Review of care plan dated [DATE] revealed Resident #35 and Resident' #35's family elected hospice services as Resident #35 desired to be kept comfortable and not receive life sustaining measures. Interventions included communicate to hospice regarding changes in condition, and coordinate plan of care with resident, family, and hospice.<br><br>Review of a physician order dated [DATE] and completed by Hospice Registered Nurse (RN) #727 revealed Resident #35 was readmitted to hospice services with a terminal diagnosis of multiple myeloma. The order revealed to contact hospice prior to initiating any treatments, after a fall, or with any change in status.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Significant Change Minimum Data Set 3.0 (MDS) dated [DATE] revealed Resident #35 had impaired cognition. She was totally dependent on one person with eating, and she had a tube feeding.<br><br>Review of Medication Administration Record (MAR) for [DATE] revealed Resident #35 had a physician order with a start date of [DATE] for Diabetisource 240 ml per peg tube every six hours (12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M) The MAR revealed the nurses documented they administered the bolus tube feeding as ordered from [DATE] to [DATE] except on [DATE] at 6:00 A.M. and 12:00 P.M. due to resident being nauseated, [DATE] at 12:00 P.M. and 6:00 P.M. with no indication provided, and on [DATE] the MAR was blank for 12:00 A.M., and 6:00 A.M. and the tube feeding was held at 6:00 P.M. Resident #35 had an order that started on [DATE] at 11:00 P.M. for Diabetisource continuous at 40 ml per hour through peg tube. The nurses documented every shift that Resident #35 received this as ordered beginning [DATE] through [DATE] except on [DATE] 7:00 A.M. to 3:00 P.M., [DATE] 3:00 P.M. to 11:00 P.M., [DATE] from 11:00 P.M. to 7:00 A.M., [DATE] 7:00 A.M. to 3:00 P.M., and [DATE] 3:00 P.M. to 11:00 P.M. as the tube feeding was held.<br><br>Review of physician order dated [DATE] and written by Dietician #677 revealed an order for Resident #35 to receive Diabetisource continuous at 40 ml per hour. There was no order discontinuing the previous tube feeding order of Diabetisource 240 ml bolus per peg tube every six hours.<br><br>Review of nursing note dated [DATE] at 7:25 P.M. and completed by Licensed Practical Nurse (LPN) #657 revealed the tube feeding was held for Resident #35 because it was not continuous but there was no further documentation.<br><br>Review of facility form labeled, Comprehensive Medical Nutrition Therapy Assessment- V1 dated [DATE] and completed by Dietician #677 revealed the assessment was in progress and the only things completed on the assessment were name, room number, admitted , date of birth, age, physician, assessment type (significant change), diagnoses, and medications as all the other areas were left blank. There was no further documentation including meal intake, impairments, tube feeding order including calories, protein, and water flushes, body type, laboratory data, nutritional needs, nutritional risks, plan of care and how Resident #35 was tolerating the tube feeding.<br><br>Review of nursing note dated [DATE] at 4:00 A.M. and completed by RN #679 revealed Resident #35 had a large emesis that appeared to be tube feeding material. The nursing note revealed Resident #35 was grimacing and crying in pain when moved or when her abdomen was palpated. Hospice was notified and was refusing to come see Resident #35. Primary Care Physician #725 was notified and stated he would contact hospice.<br><br>Review of nursing note dated [DATE] at 4:23 A.M. and completed by RN #679 revealed Resident #35 was grimacing in pain and yelling out when abdominal area was touched.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Hospice Visit Note Report dated [DATE], untimed and completed by Hospice RN #727 revealed Resident #35 was seen earlier than scheduled due to Resident #35 was having emesis and stomach pain. The note revealed when Hospice RN #727 arrived LPN #657 had stated Resident #35 was having stomach pains, nausea, and vomiting over the last few days. Hospice RN #727 requested a printout of the current physician orders and reviewed the orders. Hospice RN #727 noted Resident #35 had a new order for Diabetisource 40 ml per hour continuous as well as she continued to have her previous tube feeding order to still receive Diabetisource 240 ml bolus every six hours. Hospice RN #727 questioned LPN #657 regarding the orders which she was not aware of the reasoning of, and LPN #657 had stated Resident #35 had a history of not being able to tolerate continuous tube feedings and that was why she was switched to bolus feedings in the past. Hospice RN #727 questioned LPN #657 further regarding who had ordered the continuous tube feeding and was told Dietician #677 had written the order. The Hospice RN #727 noted that there was no progress note or anything else in the medical record regarding why there was a change in order. Hospice RN #727 wrote a clarification order to discontinue the continuous tube feeding due to patients' current symptoms that had started on [DATE] after the continuous tube feeding order had been started and to continue only the bolus tube feedings as ordered. Hospice RN #727 spoke with LPN #657 regarding the new order.<br><br>Review of Prescriber's telephone order dated [DATE] and completed by Hospice Physician #729/ Hospice RN #727 revealed the order stated to please clarify enteral feed order that was changed on [DATE] due to patient's history of not tolerating continuous tube feeding and with her being hospice recommended promoting comfort. The telephone order ordered to discontinue continuous tube feeding at 40 ml per hour and to continue Diabetisource bolus 240 ml every six hours. The order was in Resident #35's medical record but was never transcribed by the facility.<br><br>Review of nursing note dated [DATE] at 12:35 P.M. and completed by Director of Nursing revealed Resident #35's tube feeding was held because she had a residual of 60 ml.<br><br>Review of nursing note dated [DATE] at 3:39 P.M. and completed by the Director of Nursing revealed Primary Care Physician #725 was notified due to Resident #35 having a large emesis and residual. Primary Care Physician #725 ordered to place tube feeding and water flushes on hold for four hours and use as needed Zofran (medication for vomiting and nausea) to address issues with vomiting. Hospice and Resident #35's guardian were updated.<br><br>Review of a nursing note dated [DATE] at 11:14 P.M. and completed by LPN #602 revealed Resident #35's tube feeding was held due to 60 ml of residual and severe stomach pain.<br><br>Review of nursing note dated [DATE] at 7:09 P.M. and completed by Agency LPN #726 revealed the tube feeding was held due to Resident #35 had increased residual of 60 ml.<br><br>Review of nursing note dated [DATE] at 3:01 P.M. and completed by LPN #631 revealed Resident #35 had absence of vital signs and Primary Care Physician #725 was at the facility and pronounced her death. Hospice and Resident #35's guardian were notified.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on [DATE] at 9:20 A.M. with Hospice Director of Clinical Service revealed on [DATE] they received a call from the facility that Resident #35 was having severe abdominal pain, vomiting, and was nauseated. She revealed Hospice RN #727 had come to the facility and verified Resident #35 had severe abdominal pain with vomiting. She revealed Hospice RN #727 had found after she completed a record review that Resident #35 was ordered on [DATE] Diabetisource continuous tube feeding at 40ml per hour and hospice had not been notified of the new order. She revealed it was in best practice to ensure the facility notified hospice of any order changes. She also revealed Hospice RN #727 had discovered not only was Resident #35 receiving the new continuous tube feeding order but that she was still receiving the old tube feeding order of Diabetisource 240 ml bolus every six hours and most likely the reason of the abdominal pain, emesis, and nausea. She revealed Hospice RN #727 had received an order on [DATE] from the Hospice Physician #729 to discontinue the continuous tube feeding order and just to continue the previous bolus tube feeding order. She revealed Hospice RN #727 had checked through the medical record and there was no documentation as to why the continuous tube feeding was ordered and that staff and Resident #35's guardian had stated that Resident #35 had a history of not being able to tolerate continuous tube feedings in the past. She verified she was not aware Resident #35 continued to receive both the continuous tube feeding and the bolus tube feeding after [DATE] when Hospice RN #727 had written the order to discontinue the continuous tube feeding order.<br><br>Interview on [DATE] at 9:43 A.M. and 11:15 A.M. with the Administrator verified Dietician #677 had placed the order for Resident #35 into the electronic medical record to receive the continuous Diabetisource 40 ml per hour and had forgot to discontinue the previous tube feeding order of Diabetisource 240ml bolus every six hours. She verified on review of the MAR the nurses documented that Resident #35 continued then to receive both tube feedings orders. She verified on [DATE] Resident #35 had severe abdominal pain with nausea and vomiting requiring a call to hospice due to her symptoms. She verified Hospice RN #727 had left an order in Resident #35's medical record to discontinue the continuous Diabetisource 40 ml per hour and to continue only the Diabetisource bolus 240 ml every six hours. She verified this order was never transcribed and Resident #35 continued to receive both tube feeding orders including Diabetisource bolus 240 ml every six hours and Diabetisource 40 ml every hour continuously. She verified from [DATE] to [DATE] Resident #35 continued to have abdominal pain, nausea, vomiting and increased residuals of tube feeding when checked. She revealed she was unsure why the order was not transcribed. She also verified that there was a comprehensive admission nutritional assessment completed on [DATE] but that there were no further comprehensive nutritional assessments completed as the one dated [DATE] was almost completely blank. She verified a comprehensive nutritional assessment should be completed at least annually and on any significant change. She verified hospice and Resident #35's guardian were not notified regarding the Diabetisource 40ml per hours continuous tube feeding order change dated [DATE] and that they both should have been notified.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on [DATE] at 9:54 A.M. and 10:33 A.M. with Dietician #677 revealed she had felt Resident #35 would tolerate better from a continuous tube feeding rather than a bolus so she had changed the tube order to Diabetisource 40 ml per hour continuous on [DATE] but that she had forgot to discontinue the Diabetisource bolus 240 ml every six hours as both tube feeding orders should not have been administered at the same time. She verified Resident #35's last comprehensive nutritional assessment was completed on [DATE] and that an annual had not need completed in [DATE]. She verified she had only started the comprehensive significant change nutritional assessment on [DATE] with basic information but had not gotten a chance to complete the assessment before the resident passed away. She verified she had not contacted Resident #35's guardian or hospice regarding the change in tube feeding order on [DATE] and could not remember if she had passed it along to nursing. She verified she was not aware Resident #35 was having abdominal pain, vomiting, and nausea after she had added the continuous tube feeding order and she was not notified regarding hospice consulting and recommending discontinuing the continuous tube feeding and only maintaining the bolus tube feeding order. She revealed she was not aware the order from hospice on [DATE] was never transcribed.<br><br>Interview on [DATE] at 12:17 P.M. with Resident #35's guardian revealed she was never contacted on [DATE] regarding Resident #35's tube feeding order change for continuous tube feeding. She revealed if she would have been contacted, she would have not approved the order change because Resident #35 in the past was not able to tolerate continuous tube feeding and only could tolerate bolus tube feedings. She revealed in the past on continuous tube feeding Resident #35 would have sever abdominal pain, vomiting and nausea that was why it was changed to bolus. She revealed she was not notified to ensure this did not happen until [DATE] and then was told by hospice that the continuous tube feeding would be stopped on [DATE] but then she had found out that it continued despite Resident #35 having severe abdominal pain.<br><br>2. Review of medical record for Resident #39 revealed an admitted [DATE] and diagnoses included hypertension, dementia, peripheral vascular disease, and asthma.<br><br>Review of facility form labeled. Comprehensive Medical Nutrition Therapy assessment dated [DATE] and completed by Former Dietician #724 revealed Resident #39 was evaluated upon admission and continued on tube feedings per physician orders and was tolerating them without any issues. There was no other comprehensive nutritional assessments completed in her medical record.<br><br>Review of care plan last revised [DATE] revealed Resident #39 had altercation in her nutrition and hydration status. She received enteral feedings and was on hospice. Interventions included collaborate with the hospice team, provide enteral nutrition per physician orders and weigh per policy.<br><br>Review of quarterly MDS dated [DATE] revealed Resident #39 was cognitively impaired as she was rarely and/ or never understood. She was totally dependent of one person for eating as she received tube feedings.<br><br>Observation and attempted interview on [DATE] at 9:06 A.M. revealed Resident #39 was receiving tube feeding per order and was unable to be interviewed due to impaired cognitive ability.<br><br>Interview on [DATE] at 9:54 A.M. and 10:33 A.M. with Dietician #677 verified the last comprehensive nutritional assessment for Resident #39 was completed on [DATE]. She verified comprehensive nutritional assessment were to be completed at least annually and upon any significant change. She revealed Resident #39's comprehensive assessment must have been missed in [DATE].<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of facility policy labeled, Enteral Nutrition dated [DATE] revealed the dietician with input from the physician, nurse, and resident representative would determine the calorie, protein, nutrient, fluid needs and evaluate whether the resident's current intake was adequate. The policy revealed the dietician was responsible for routinely assessing residents who received enteral feedings.<br><br>Review of facility policy labeled, Nutritional Management dated [DATE] revealed a comprehensive nutritional assessment would be completed by the dietician on admission, annually, and upon significant change in condition.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00136986. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observe each nurse aide's job performance and give regular training.<br><br>39973<br><br>Based on interview and record review, the facility failed to ensure state tested nursing assistants (STNA's) had at least 12 hours of in-service education per year. This affected two STNA's (STNA #655 and STNA #673) out of two STNA's (STNA #655 and STNA #673) personnel files that were reviewed as they were employed over a year at the facility. This had the potential to affect all 79 residents residing at the facility.<br><br>Findings included:<br><br>Review of personnel file for STNA #673 with a hire date of 10/16/89 revealed she had no in service training in her personnel file within the last year.<br><br>Review of personnel file for STNA #655 with a date of hire of 11/14/19 revealed she had no in service training in her personnel file within the last year.<br><br>Interview on 10/26/22 at 11:12 A.M. with Human Resource Director #645 verified she had no in service educations for STNA #655 and STNA #673 in their personnel file. She revealed the facility did not have a tracking form that they utilized to track the in-service educations of STNA's to ensure they met the 12-hour requirement.<br><br>Interview on 10/26/22 at 2:29 P.M. with Administrator revealed when she started at the facility on 08/22/22 she knew that training of the STNA's was an issue as there was no specific tracking form to see what training an STNA had received and that they met their 12 hours in service requirement per year. She verified she had no evidence that STNA #655 and STNA #673 met the 12 hours in service education for the year. She also revealed the facility did not have a policy regarding in service education for STNA's. |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>38522<br><br>Based on interview and record review, the facility failed to be administered in a manner which enabled it to use its resources effectively and efficiently to ensure all residents attain or maintain their highest practicable physical, mental and psychosocial well-being. This had the potential to affect all 79 residents residing in the facility.<br><br>Findings include:<br><br>During the complaint and partial extended survey the following concerns were identified:<br><br>1. Review of the medical record for Resident #21 along with review of a facility self-reported incident (SRI), police report and interviews revealed concerns were identified related to the facility's lack of routine and accurate assessment and care planning related to elopement risk, a lack of obtaining and implementing instructions contained on guardianship paperwork and a lack of staff supervision for medical appointments in the community to prevent Resident #21's elopement. This resulted in Immediate Jeopardy on 10/11/22 when Resident #21 was dropped off at a medical appointment in the community without staff supervision and subsequently left the appointment at a medical center and got on a bus. The facility was unaware of Resident #21's condition and whereabouts until staff located him in the community on 10/15/22, four days later.<br><br>Interview on 10/24/22 at 8:58 A.M. with Registered Nurse (RN)/Assistant Director of Nursing (ADON) #683 verified residents were to be assessed for elopement risk quarterly and after an incident and was made aware during the interview that Resident #21 lacked evidence of routine/ quarterly elopement assessments. RN/ADON #683 also verified Resident #21 did not have a Wanderguard even though his care plan stated one was in place.<br><br>Interview on 10/24/22 at 10:36 A.M. with the Director of Nursing (DON) verified all residents were to have a Leave of Absence physician's order that would reference the need for an escort for appointments in the community and Resident #21 did not have such an order at the time of his elopement. The DON verified residents were to be assessed for elopement status quarterly. The DON confirmed the facility did not know about Resident #21's guardianship papers indicating he was a flight risk and required placement on the secured unit until these documents were pulled during this incident.<br><br>Interview on 10/24/22 at 11:15 A.M. with the Administrator revealed she was the main staff responsible for the investigation and completion of the SRI regarding Resident #21's elopement. The Administrator was asked why additional staff statements were not completed as part of the facility's SRI investigation as Resident #21's elopement occurred in a medical center in the community with multiple witnesses present and the complaint investigation also indicated that RN/ADON #683, Social Service Designee (SSD) #650 and the DON were involved. The Administrator stated she felt it was not necessary to have statements that facility staff looked for Resident #21 for four days in the community.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 10/25/22 at 12:14 P.M. with Licensed Practical Nurse (LPN) #606 verified she made the original appointment and order for Resident #21's dermatology appointment on 10/11/22. LPN #606 indicated an order would be placed by the nurse into the electronic medical record and a paper slip that for the appointment that would also indicate if a resident needed an escort or not would be placed into the schedule book on the unit. Paper copies of the form would also go to administrative staff as well as the staff scheduler so that a staff member would be scheduled to escort the resident as indicated. LPN #606 verified she had indicated Resident #21 needed to have an escort for the dermatology appointment on 10/11/22 and text-messaged the surveyor a photo of the form which did indicate Resident #21 needed an escort for this appointment. See findings at F610, F656 and F689.<br><br>2. Review of personnel file for Registered Nurse (RN) #695 revealed her date of hire was 01/19/22 and there was no evidence in her personnel file that she was checked against the NAR prior to being employed at the facility.<br><br>Review of personnel file for Licensed Practical Nurse (LPN) #674 revealed a hire date of 04/10/22 and there was no evidence in her personnel file that she was checked against the NAR prior to being employed at the facility.<br><br>Interview on 10/24/22 at 12:03 P.M. and 3:11 P.M. with Human Resources (HR) #645 revealed she was hired on 04/01/22 and that she was not aware staff that were not STNA's were to be checked against the NAR to ensure they did not have a finding entered on the registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of property as required as a screening process to prevent abuse. HR #645 revealed she received a one-day training that she did not feel was sufficient training and was never trained that staff that were not STNA's were to be checked against the NAR. She revealed she had to just kind of winged it as to what she was supposed to be doing regarding background checks. She verified on review of personnel files for RN #695, and LPN #674 they were not checked against the NAR prior to employment. She revealed the following employees that were hired from 05/04/21 to 10/24/22 and continued to be employed by the facility that she had no documentation in their personnel files that they were checked against the NAR prior to starting employment and that they still had not been checked against the NAR which included 27 employees: Director of Nursing #605, Assistant Director of Nursing (ADON)/ Registered Nurse (RN) #683, RN #611, RN #679, Licensed Practical Nurse (LPN) #602, LPN #603, LPN #604, LPN #657, LPN #658, LPN #665, LPN #689, LPN #674, LPN #676, LPN #678, LPN #680, LPN #685, LPN #722, [NAME] #600, [NAME] #692, Dietary Aide #609, Activities Assistant #618, Activities Assistant #640, Activities Assistant #688, Maintenance Director #639, Human Resources (HR) #645, Admission Director #648, and Dietary Manager #664.<br><br>Interview on 10/24/22 at 12:17 P.M. with Administrator revealed she was recently hired at the facility on 08/22/22 and revealed recently she was going through personnel files and did notice employees of the facility that were non-STNA's were not checked against the NAR which was part of their screening process on abuse.<br><br>Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property dated October 2020 revealed the facility would undertake background checks of all employees and retain on file applicable records of current employees regarding such checks. The policy revealed the facility would prior to hiring a new employee check the Ohio NAR. See findings at F607.<br><br>3. Review of personnel file for STNA #673 with a hire date of 10/16/89 revealed she had no in service training in her personnel file within the last year.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of personnel file for STNA #655 with a date of hire of 11/14/19 revealed she had no in service training in her personnel file within the last year.<br><br>Interview on 10/26/22 at 11:12 A.M. with Human Resource Director #645 verified she had no in service educations for STNA #655 and STNA #673 in their personnel file. She revealed the facility did not have a tracking form that they utilized to track the in-service educations of STNA's to ensure they met the 12-hour requirement.<br><br>Interview on 10/26/22 at 2:29 P.M. with the Administrator revealed when she started at the facility on 08/22/22 she knew that training of the STNA's was an issue as there was no specific tracking form to see what training an STNA had received and that they met their 12 hours in service requirement per year. She verified she had no evidence that STNA #655 and STNA #673 met the 12 hours in service education for the year. She also revealed the facility did not have a policy regarding in service education for STNA's. See findings at F730.<br><br>4. Review of QAA Committee meeting minutes revealed since 05/04/21 the facility only had one QAA meeting dated for 09/28/22.<br><br>Interview on 10/26/22 at 2:29 P.M. with Administrator revealed she had started 08/22/22 and she discovered that the facility QAA Committee had not been meeting on a quarterly basis like they should have. She verified she had no documentation the facility QAA Committee met from 05/04/21 to 09/28/22. She revealed she had a meeting on 09/28/22 but that was the only meeting the facility had documentation for during this time frame.<br><br>Review of facility policy labeled, Quality Assurance and Performance Improvement (QAPI), dated 10/01/22, revealed the facility would develop, implement, and maintain an effective, comprehensive, data driven QAPI program, that focused on indicators of the outcomes of care and quality of life and addressed all the care and unique services that the facility provided. The policy revealed the committee would meet at least quarterly and as needed to coordinate and evaluate activities under a QAPI program. See findings for F868. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on interview, record review and policy review, the facility failed to ensure resident records were complete and accurate. This affected one resident (Resident #21) of three residents reviewed for elopement. The facility census was 79 residents.<br><br>Findings include:<br><br>Review of Resident #21's medical record revealed an admitted [DATE] and diagnoses including anxiety, schizophrenia, heart failure and chronic obstructive pulmonary disease.<br><br>Review of Resident #21's quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively intact and did not display behaviors including wandering or rejection of care. Resident #21 was independent with bed mobility, required staff supervision for ambulation and transfers and required the limited assistance of one staff for personal hygiene and toileting.<br><br>Review of a nurses' note dated 10/11/22 at 9:45 A.M. and written by Licensed Practical Nurse (LPN) #623 revealed Resident #21 left for his medical appointment at 9:30 A.M. via the facility's transportation with face sheet and medication list.<br><br>Review of the next available nurses' note in Resident #21's medical record revealed a late entry note dated 10/16/22 at 10:39 P.M. originally for 10/15/22 for 5:30 P.M. and written by the Director of Nursing (DON) which indicated Resident #21 returned to the facility on this date at 5:30 P.M. accompanied by this nurse and another staff member (not identified). Resident #21 ambulated with cane, was placed in his wheelchair and taken to his room which was now on the second floor's secured unit. Resident #21 was assessed and found to have no injuries.<br><br>No nurses' notes were available indicating Resident #21 had eloped from his medical appointment in the community or that Resident #21's guardian or the physician had been notified of the elopement.<br><br>Interview on 10/21/22 at 11:27 A.M. with Legal Guardian (LG) #698 revealed he was made of Resident #21's elopement on 10/13/22 when he spoke to the Administrator and denied any other earlier voicemail messages from the facility regarding the elopement.<br><br>Interview on 10/24/22 at 10:36 A.M. with the DON verified staff were always supposed to write a progress note when the guardian/family member and physician were notified of an incident regarding a resident and verified Resident #21's nurses' notes lacked this documentation.<br><br>Interview on 10/25/22 at 3:20 P.M. with Physician #708 revealed his nurse practitioner was in the facility and had been notified of Resident #21's elopement on 10/11/22.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365828 | A. Building<br>B. Wing | 11/01/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harvard Gardens Rehabilitation & Care Center | 18810 Harvard Ave<br>Cleveland, OH 44122 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility policy, Documentation in the Medical Record, dated 09/01/22, revealed the medical record should contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation. Documentation should be completed at the time of service but no later than the shift in which the assessment, observation or care service occurred. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>39973<br><br>Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) Committee met on a quarterly basis. This had the potential to affect all 79 residents residing at the facility.<br><br>Findings included:<br><br>Review of QAA Committee meeting minutes revealed since 05/04/21 the facility only had one QAA meeting dated for 09/28/22.<br><br>Interview on 10/26/22 at 2:29 P.M. with Administrator revealed she had started 08/22/22 and she discovered that the facility QAA Committee had not been meeting on a quarterly basis like they should have. She verified she had no documentation the facility QAA Committee met from 05/04/21 to 09/28/22. She revealed she had a meeting on 09/28/22 but that was the only meeting the facility had documentation for during this time frame.<br><br>Review of facility policy labeled, Quality Assurance and Performance Improvement (QAPI), dated 10/01/22, revealed the facility would develop, implement, and maintain an effective, comprehensive, data driven QAPI program, that focused on indicators of the outcomes of care and quality of life and addressed all the care and unique services that the facility provided. The policy revealed the committee would meet at least quarterly and as needed to coordinate and evaluate activities under a QAPI program. |