| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365624 | A. Building<br>B. Wing | 03/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Perrysburg Healthcare and Rehabilitation Center. | 28546 Starbright Blvd<br>Perrysburg, OH 43551 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<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** 35033<br><br>Based on review of the medical record, review of a risk alert document, review of fall investigations, observation, interview, and policy review, the facility failed to ensure a thorough investigation was completed to determine how a resident exited the facility through a locked door in the memory care unit. This affected one (Resident #21) of three residents reviewed for elopement. The facility identified five residents (#21, #34, #40, #50 #51) at risk for elopement. Additionally, the facility failed to complete a thorough falls investigation and implement new fall prevention interventions to potentially prevent additional falls for one resident. This affected one (Resident #27) of three residents reviewed for falls. The facility census was 52.<br><br>Findings include<br><br>1. Review of the medical record revealed Resident #21 had an admitted [DATE]. Diagnoses included Alzheimer's disease, chronic pain, and difficulty walking.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment.<br><br>Review of an elopement evaluation dated 12/09/23 revealed the resident was at risk for elopement.<br><br>Review of a nurses note dated 01/17/24 at 8:02 P.M. revealed the nursing assistant reported Resident #21 had opened the back exit door in the memory care unit and was attempting to walk through the back parking lot. The resident remained in clear view of staff at all times and was redirected back to her room without incident. A head-to-toe assessment was completed and the resident denied pain. The resident was moved closer to the nursing station for closer monitoring. There was no documentation how the resident was able to open the locked exit door.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a facility Risk Alert document dated 01/18/24 revealed an elopement event occurred on 01/17/24 at 5:35 P.M. Nurses and nursing assistants were attending to a resident when the nursing assistants saw Resident #21 open the exit door at the end of the hall and walk outdoors. The nursing assistant took off towards the resident in the back parking lot to bring the resident back in the building. The resident was brought back inside immediately, witness statements obtained, a head to toe assessment was completed, and a pain assessment was completed. The Administrator, Resident #21's Power of Attorney (POA), and the physician were notified. The resident was moved to a room closer to nurses' station further from the exit door for closer supervision. Further review of the facility investigation and witness statements revealed no documentation how the resident was able to exit the facility through a door which should have been locked.<br><br>Observation on 03/04/24 at 8:13 A.M., with the Director of Maintenance (DOM) #80 revealed there were four exit doors in the memory care unit. When the door handle was pushed on, the doors remained locked.<br><br>Interview on 03/04/24 at 8:13 A.M., DOM #80 revealed the four exit doors in the memory care unit do not open when continually pushed on. DOM #80 revealed the doors remained locked unless the fire alarm was activated.<br><br>Interview on 03/04/24 at 11:24 A.M., the Administrator revealed Resident #21 got through the locked exit door because when you continually push on the door, the door will unlock. Observation at the time of interview in the memory care unit of the back exit door revealed the Administrator pushed on the door release lever for over a minute and the door would not unlock. The Administrator was unaware the doors would not open when continually pushed upon. The Administrator was unaware how Resident #21 got through the locked exit door and revealed she was going to re-interview staff.<br><br>Further interview with the Administrator on 03/04/24 at 12:06 P.M. revealed the exit door alarmed when Resident #21 went through the door. The Administrator assumed staff had used the door to go out to the parking lot and the door had not completely latched shut allowing Resident #21 to exit the facility. The Administrator revealed she just sent education out to the staff to not exit the facility through the memory care unit exit doors. The Administrator revealed when Resident #21 got out of the facility it was not considered an elopement because the resident remained in sight of staff.<br><br>Interview on 03/05/24 at 9:25 A.M., State tested Nursing Assistant (STNA) #112 revealed Resident #21 went out the back door of the facility. STNA #112 was unaware of how the resident got out of the locked door. STNA #112 revealed she had difficulty unlocking the exit door to go and get Resident #21. STNA #112 revealed she watched the resident in the parking lot until she was able to get the exit door unlocked. STNA #112 revealed the resident was then brought back in the building through the side exit door because there was no code box outside to get back in the back exit door.<br><br>Review of the policy, Missing Resident/Elopement Policy, last revised 01/2022 revealed no guidelines for determining a root cause of a resident exiting the facility without supervision when the incident was not considered an elopement according to facility policy.<br><br>2. Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included dementia, type two diabetes mellitus, atrial fibrillation, hypertension, chronic obstructive pulmonary disease, mood disorder, and anxiety.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment.<br><br>Review of a fall risk assessment dated [DATE] revealed the resident was at high risk for falls.<br><br>Review of the activities of daily living care plan dated 11/20/23 revealed the resident required substantial/maximal assistance of one staff for toileting.<br><br>Review of the care plan through 12/23/23 revealed the resident was at risk for falls related to poor balance and unsteady gait, confusion, incontinence, and psychoactive drug use. Interventions included non-skid footwear, non-slip strips in bathroom, a bathroom door alarm to alert staff when resident was taking self to the bathroom, anti-rollbacks to the wheelchair, a urinal at the bedside at bedtime, to anticipate and meet the resident's needs, to keep the call light in reach and encourage the resident to use it, to keep needed items in reach, and to offer toileting when rounding.<br><br>Review of a nurses note dated 12/24/23 at 10:51 A.M. revealed at 10:32 A.M. the resident was found on the floor in the restroom. The resident was assessed with injuries noted as a bruise to the left side of the forehead and a scratch on the left arm near the elbow. The resident was assisted back to his wheelchair, elbow cleaned and bandage applied. The family and physician were notified.<br><br>Review of a fall investigation dated 12/24/23 at 10:32 A.M. revealed Resident #27 was found on the bathroom floor in his room. There were no witness statements regarding the fall. There was no documentation if the resident's call light was within reach, if the resident had called for help or if the call light had been activated. There was no documentation when the resident was last toileted. Further review of the investigation revealed no documentation if previous interventions were in place at the time of the fall. No new intervention was implemented after the fall to prevent the resident from falling again.<br><br>Review of a IDT (interdisciplinary team) note dated 12/26/23 at 10:16 A.M. revealed the resident's care plan was reviewed and all fall procedures in place and reviewed and will continue with all fall precautions.<br><br>Review of a nurses note dated 01/08/24 at 11:08 A.M. revealed the resident fell next to his bed attempting to go to the restroom again. The resident was assessed with no injuries and vital signs were within normal limits. The physician and family were notified. A new intervention was implemented to offer to get the resident out of bed on first shift.<br><br>Interview on 03/04/24 at 3:02 P.M., the Administrator verified no new interventions was initiated to prevent further falls after the resident sustained a fall on 12/24/23. The Administrator revealed staff offered the resident toileting all the time but he just wants to be independent with toileting. Further interview on 03/05/24 at 2:59 P.M., the Administrator revealed she could see where more investigation could have been done regarding Resident #27's fall on 12/24/23.<br><br>Review of the policy, Fall Policy, last revised 04/2021 revealed an intervention would be put in place after a fall unless the IDT determine all appropriate interventions were in place. An intervention put in place after a fall would be reviewed by the IDT to determine if the intervention put in place was the most appropriate or it should be changed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This deficiency represents non-compliance investigated under Master Complaint Number OH00151286. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>35033<br><br>Based on review of staffing schedules, review of daily posted staffing information, staff interview, and policy review, the facility failed to ensure a Registered Nurse (RN) was present in the facility eight hours per day, seven days per week. This had the potential to affect all residents. The facility census was 52.<br><br>Findings include:<br><br>Review of the daily staffing schedules and daily posted staffing documentation from 02/01/24 through 03/03/24 revealed there was no RN coverage in the facility on 02/04/24, 02/10/24, 02/17/24, 02/25/24, 03/02/24, and 03/03/24.<br><br>Interview on 03/05/24 at 12:18 P.M., the Administrator revealed the only RN employed by the facility was the Director of Nursing. The Administrator verified there was no RN coverage in the building on 02/04/24, 02/10/24, 02/17/24, 02/25/24, 03/02/24, and 03/03/24.<br><br>Review of the policy titled, Nursing Department Guidelines, last revised 11/2022 revealed the facility would staff a RN eight consecutive hours seven days a week.<br><br>This deficiency represents non-compliance investigated under Master Complaint Number OH00151286. |