STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2271R	A. BUILDING _____ B. WING _____	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SAGAMORE HILLS	**997 WEST AURORA ROAD SAGAMORE HILLS OH, 44067**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000	Initial Comments Total Capacity: 214 Total Census: 103 County: Summit Administrator: Greg Kaminsky Survey Type: Complaint Number OH00077579 Completed By: 16009	R 0000		

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

GREG.KAMINSKI | 02/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2271R	A. BUILDING _____ B. WING _____	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SAGAMORE HILLS	997 WEST AURORA ROAD SAGAMORE HILLS OH, 44067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0103	Continued From page 1	R 0103		
R 0103	O.A.C. 3701-17-54 (C)(2) Personnel Requirements O.A.C. 3701-17-54 (C)(2) Each residential care facility shall have the following staff members who are competent to perform the duties they are assigned: (2) Sufficient additional staff members who meet the applicable qualifications of rule 3701-17-55 of the Administrative Code for the services they perform and appropriate scheduling of sufficient staff time to adequately do all of the following: (a) Meet, in a timely manner, the residents' total care, supervisory and emotional needs as determined by the resident assessment required under rule 3701-17-58 of the Administrative Code and consistent with the resident agreement required under rule 3701-17-57 of the Administrative Code and reasonable and appropriate requests for services, including monitoring in excess of supervision of residents with increased emotional needs or presenting behaviors that cause problems for the resident or other residents, or both; (b) Properly provide dietary, housekeeping, laundry, and facility maintenance services and recreational activities for the residents in accordance with the rules of this chapter; and (c) Assist, when necessary, with prompt evacuation of nonambulatory residents. The additional staff	R 0103	Without admitting or denying the validity of the citations and/or allegations, Elmcroft of Sagamore Hills provides the following Plan of correction. Elmcroft of Sagamore Hills affirmatively states that it does not either directly or indirectly admit any wrongdoing or liability, related to any citation and/or allegation. Elmcroft takes seriously its responsibility to ensure adequate supervision and safety for each of its residents. The community asserts that the policies and procedures have been and continue to be appropriate to identify residents at risk for eloping and to maintain their safety on an ongoing basis. As a result of the incident the following additional interventions to address the identified issues were implemented and were utilized to enhance the policies, procedures, protocols, staff training and equipment at the facility: 1. On January 19, 2015 new door alerts which signal to pagers carried by designated staff were installed on front doors and service entrance for after-hours enhanced security in addition to prior existing door alerts. Following the installation of the new door alerts, all perimeter exit doors have door alerts. Alerts were fully functional by January 22, 2015. The front and service door alerts are currently engaged to alarm between 8:30 p.m. to 8:00 a.m. seven days a week. Routine verification of the door alerts	02/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2271R	A. BUILDING _____ B. WING _____	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SAGAMORE HILLS	997 WEST AURORA ROAD SAGAMORE HILLS OH, 44067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0103	Continued From page 2 members needed to implement the facility's evacuation plan required by paragraph (J) of rule 3701-1763 of the Administrative Code shall be present in the facility at all times. (d) Provide or arrange for resident activities required under rule 3701-1761 of the Administrative Code. This STANDARD is not met as evidenced by: Based on observation, review of medical records, review of facility incident investigation reports, staff interviews, and review of policy and procedures, the facility failed to ensure adequate supervision was provided to prevent one cognitively impaired resident (Resident #104) from eloping from the facility. The resident was found unresponsive and expired from hypothermia. On 01/21/15 at 4:41 P.M., the executive director, the regional director of operations and the resident services director were notified Real and Present Danger began on 01/19/15 at 7:35 A.M. when Resident #104 who was cognitively impaired and had difficulty finding her room, eloped from the facility and was found unresponsive at 7:35 A.M. by the executive director after he had been alerted by the snow plow driver that there	R 0103	throughout the facility are being performed and documented to ensure the doors are operational by Maintenance Director (MD) or designee. This verification is conducted at least weekly and results are reviewed to determine ongoing verification requirements. Immediate notification of any alert malfunctioning will be communicated to MD and Executive Director (ED). Executive Director or designee has and will continue to verify that the door checks have been completed as scheduled. Further, residents on the Heartland Village neighborhood are assessed for elopement risk prior to admission and continue to be assessed pursuant to Elmcroft policy. The Heartland Village neighborhood is a secured unit, meaning all perimeter doors are secured internally and externally with delayed egress and audible alarm. 2. Resident Assistant assignments were updated on January 23, 2015 by Resident Services Director to reflect responsibility for pager and specific community areas to identify accountability for perimeter doors. The assignments sheets are updated periodically by Resident Serivces Director or designee. The assignment sheets are paper documents carried by the Resident Assistants containing information regarding the specific residents on their team assignments, resident care needs required, and any other tasks assigned. Further, Elmcroft staff utilize CareTracker, an electronic documentation system, as well as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2271R	A. BUILDING _____ B. WING _____	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SAGAMORE HILLS	997 WEST AURORA ROAD SAGAMORE HILLS OH, 44067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0103	Continued From page 3 was a body on the service road on the west side of the facility. The Real and Present danger was abated on 01/23/15 when the facility implemented the following corrective actions: · New door alarm placement on front doors and service entrance for after-hours monitoring was completed on 01/22/15 by Community Maintenance Director (CMD) #208 and Regional Maintenance Director (RMD)#284. · On 01/22/15 the executive director, an alarm system technician, and RMD #284 tested and verified function of pager alerts and perimeter doors. · On 01/23/15, Resident Assistant Assignments were updated to reflect responsibilities for pager and specific community areas to identify accountability for perimeter doors. · From 01/19/15 through 01/23/15 all staff were educated on the following either in person or via telephone on the following: o Missing resident procedure o Door alarms procedure/pager o Shift change protocol - Complete communication to oncoming shift and visualization of the residents o Resident change in condition § Wandering behaviors § Confusion § Exit seeking behaviors § Any other behaviors/conditions out of the ordinary o Updated Resident Assistant	R 0103	other sources such as a residents' chart and verbal communication with staff, residents, and/or families to document and/or obtain information regarding the needs and preferences of each individual resident. 3. On January 21, 2015 Elmcroft assisted living residents were re-assessed for elopement risk by Resident Services Director. Any changes since their most recent elopement assessment were noted and addressed in the resident service plan. The facility has and continues to perform elopement risk assessments upon admission, at thirty days, six months, and with a change in condition. Ongoing elopement assessments have and will continue to be conducted per Elmcroft policy and as change of condition warrants. When a licensed nurse notes a change in condition, the nurse is to assess the resident and document as needed. Resident's physician and responsible party are contacted upon any change in condition as appropriate. In addition to elopement assessments, a nurse or Resident Services Director completes mini mental, fall risk, or skin assessments as appropriate. Service plan and assignment sheets are then updated by Resident Services Director or designee to reflect and communicate any changes. Further, Heartland Village residents are assessed on an ongoing basis pursuant to Elmcroft policy for elopement risk and changes to service plans are made as needed. 4. Elmcroft staff was re-educated by the Executive Director, Resident Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2271R	A. BUILDING _____ B. WING _____	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SAGAMORE HILLS	997 WEST AURORA ROAD SAGAMORE HILLS OH, 44067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0103	Continued From page 4 assignment responsibilities · On 01/23/15 at 3:15 P.M., 3:30 P.M. and 3:45 P.M. residents were educated on the following: o Sign in/sign out protocol o Reminders to keep pendants on person at all times o Notify staff if self or neighbor exhibiting a change in condition Although the Real and Present Danger was abated, the violation remained as the facility was in the process of implementing ongoing monitoring of the corrective actions. Findings include: Resident #104 was transferred to the facility from a skilled nursing facility on 09/15/14 with diagnoses including senile dementia, hallucinations, unspecified essential hypertension, macular degeneration of retina unspecified, hearing loss, abnormality of gait, lack of coordination, other symbolic dysfunction and altered mental status. Review of a physical therapy re-evaluation dated 10/09/14 revealed prior to the resident ' s admission, on 08/29/14 Resident #104 went missing from her " condo " and was found two to three hours later hiding in a storage shed because she thought people were in her condo. Review of a facility investigation dated 01/19/15, revealed on 01/19/15 at 7:35 A.M., Resident #104 was noted on the ground in the parking lot on the west side	R 0103	Director, Training/Development Coordinator, Regional Director of Operations, and Divisional Vice President on January 21, 2015 regarding the following: missing resident procedure, shift change protocol-complete communication to oncoming shift and visualization of residents, resident change in condition, wandering behaviors, confusion, exit seeking behaviors, any other behaviors/conditions out of the ordinary. Further, Elmcroft staff were educated on January 21, 2015 on revisions to door alarm procedure/pager procedure. This education is also included in the orientation packet provided to new employees during new hire orientation. Resident Assistant education to be monitored and completed with new employees upon hire by the Business Office Coordinator and Training Development Coordinator. Further, elopement drills were conducted, pursuant to Elmcroft policy, on January 25, 2015 for all shifts. These drills were completed at 1:05 p.m. (first shift), 2:35 p.m. (second shift), and 10:30 p.m. (third shift). 5. Residents received education on Elmcroft safety measures on January 23, 2015 by Community Relations Director and again on February 8, 2015 by Healthy Lifestyles Director. The education reviewed guidelines including sign in and out protocol, emergency call system, including the use of pendants and pull cords, security and door locking procedure, and notifying staff regarding observed changes in condition for fellow residents. Resident Handbook is reviewed with new residents and families by Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2271R	A. BUILDING _____ B. WING _____	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SAGAMORE HILLS	997 WEST AURORA ROAD SAGAMORE HILLS OH, 44067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0103	Continued From page 5 of the building by the executive director. The executive director had just been alerted by a snow plow driver that a resident was outside on the ground. Resident #104 was unresponsive with no pulse or respirations. The resident was dressed in a t-shirt, sweater, slacks, and socks. Shoes were noted next to the resident but not on her feet. Resident #104 ' s walker was standing upright next to her facing south. The executive director called 911. The facility investigation revealed Resident #104 was last seen by Licensed Practical Nurse (LPN) #225 at 9:20 P.M. on 01/18/15 in bed resting in night clothes. Resident Assistant (RA) #253, Resident #104 ' s caregiver the afternoon of 01/18/15, provided a witness statement dated 01/19/15 indicating Resident #104 had been extremely sick from what " seemed to be the flu " and had not paged all night. RA #253 indicated she " peeked in " on Resident #104 at 3:30 P.M. on 01/18/15 to see how she was doing since the resident had been sick all weekend. At 5:30 P.M. RA#253 delivered Resident #104 ' s food tray. When RA #253 returned to retrieve the supper tray between 7:00 P.M. and 7:15 P.M., Resident #104 had not eaten or drank anything. Resident #104 refused her shower at that time stating it was too cold. There was no indication RA #253 had reported the above information to the nurse on duty. Review of LPN #225 ' s witness statement	R 0103	Director or designee upon admission. Monthly resident safety reminders to be covered in resident council meetings by Healthy Lifestyles Director. 6. Nursing management and other management staff perform periodic informal rounds at least 3 times a week and these informal rounds will occur on an ongoing basis, to observe the care and services delivered to residents. If during these informal rounds, the nursing management staff identifies any concern; these findings are addressed at the time with appropriate interventions which may include one on one re-education. First and foremost, the facility is incredibly saddened by the occurrence of this unfortunate incident and is committed to consistently safeguarding residents in the facility's care. The facility, nonetheless, disagrees with certain characterizations made in the statement of deficiencies and is submitting the below information: 1. Throughout Resident #104's residency and per the resident service plan, Resident #104 was assessed as independent with dressing, grooming, toileting, and ambulating with the assistance of a wheeled walker. Additionally, Resident #104 had not exhibited exit-seeking behavior while residing at the facility and had twice been assessed not to be at risk for elopement using the facility's elopement assessment tool. The assistance, monitoring, and assessment that were indicated in Resident #104's service plan, as well as per facility policies and procedures,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2271R	A. BUILDING _____ B. WING _____	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SAGAMORE HILLS	997 WEST AURORA ROAD SAGAMORE HILLS OH, 44067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0103	Continued From page 6 dated 01/19/15 revealed she had administered medications to Resident #104 at 7:30 P.M. and at 9:20 P.M. on 01/18/15. LPN#225 was in the nurse ' s office from 11:00 P.M. until 1:00 A.M. with the door open and did not see Resident #104 walk by. There was no indication that LPN #225 was aware that Resident #104 had been sick or that she had not eaten her dinner. Review of RA #256 ' s witness statement dated 01/20/15 revealed on 01/17/15, Resident #104 had exited her room " around 12:30 A.M. to 1:00 A.M. " and asked where her room was located. RA #253 began to walk the resident to her room, but RA #237 took over and let Resident #104 back to her room. RA#253 did not care for Resident #104 during the night shift (10:00 P.M. to 6:00 A.M.) on 01/18/15. There was no evidence that an RA had checked on Resident #104 the night before or the morning of the date she was found outdoors unresponsive. Review of RA #237 ' s witness statement dated 01/19/15 revealed she did not provide care to Resident #104 from 10:00 P.M. on 01/18/15 through 6:00 A.M. on 01/19/15. However, review of Resident #104 ' s print out of electronic caregiver records revealed she RA#237 had electronically documented she had provided assistance to Resident #104 on 01/19/15 at 5:02 A.M. for grooming and hygiene, dressing, toileting, incontinence management, and skin observation.	R 0103	were provided to Resident #104. 2. The citation alleges that on January 21, 2015, the door alarms were not functioning properly. On January 21, 2015, when it became apparent that the perimeter door alerts were not functioning properly, service was promptly obtained, functionality was restored, and the door alerts tested as operational by January 22, 2015. The facility acted in a timely and prudent manor in identifying malfunctioning alarms and implementing appropriate repairs. Further, the prior door alerts for other perimeter doors had been working as late as January 19, 2015. It is believed that when new door alert equipment was installed on the front door, a malfunction occurred resulting in the perimeter door alert issue on January 21, 2015. 3. The citation alleges that the Sagamore Hills Police Department ("SHPD") requested that front door alarms be installed at the facility. Elmcroft is unaware of any requests or recommendations from the Sagamore Hills Police Department to install front door alarms. Current Executive Director since April 1, 2014 states that he had no communications with SHPD regarding front door alarms. Previous Executive Director from October 30, 2009 until March 31, 2014 also states she had no communications from SHPD regarding front door alarms.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2271R	A. BUILDING _____ B. WING _____	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SAGAMORE HILLS	997 WEST AURORA ROAD SAGAMORE HILLS OH, 44067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0103	Continued From page 7 Interview with the executive director on 01/22/15 at 5:35 P.M. revealed RA#237 was suspended pending an internal investigation as she had admitted that she had documented care for Resident #104 but not provided the care. Interview with the resident services director, Registered Nurse (RN) #201 on 01/21/15 at 12:25 P.M. revealed on 01/16/15, Resident #104 was moved from a room on the second floor to a room on the first floor because she had flooded her room on three separate occasions. Interview with RA #215 on 01/22/15 at 4:15 P.M. revealed Resident #104 was a creature of habit and directionally challenged. RA #215 stated if Resident #104 did not get on the same elevator every day when she lived on the second floor she would get turned around and would be lost. RA #215 stated Resident #104 was affected by the room change to the lower floor and became disoriented with direction. Observations on 01/21/15 during a tour with the regional director of operations between 11:32 A.M. and 12:25 P.M. revealed the door alarms were not functioning properly. Staff did not respond when the door to the exterior was opened and the front panel did not register that exit doors to stairwells were being opened. On 01/22/15 at 10:08 A.M., the exit door at the bottom of the stairwell next to Room #530 was opened. No staff responded to the door being opened. Interview with the executive	R 0103		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2271R	A. BUILDING _____ B. WING _____	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SAGAMORE HILLS	997 WEST AURORA ROAD SAGAMORE HILLS OH, 44067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0103	Continued From page 8 director at 10:20 A.M. revealed he did not know why the door was not responded to at 10:08 A.M., but would investigate. Review of the facility incident log for the previous year revealed three previous elopements from the facility on 04/09/14, 05/30/14 and 06/16/14. No residents incurred any injury and were moved to the secure unit. However, the facility alarm system had not been addressed. Interview on 01/23/15 at 1:30 P.M. with Detective #400 revealed the local police department had requested on several occasions the facility install front door alarms. He indicated the department had retrieved residents that had eloped on several occasions.	R 0103		