STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235345	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FROH COMMUNITY HOME	307 N FRANKS AVENUE STURGIS, MI 49091

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 365. Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan with measurable goals in four of four residents reviewed for risk of elopement (Resident #51, #52, #53, and Resident #54), resulting in increased risk of elopement. Findings include: Resident #51 (R51) On 03/03/2020 at 12:30 PM R51 was observed sitting in a recliner in his room eating lunch. During an interview regarding his elopement on 02/12/2020, R51 stated he was bored when he escaped and had wanted to buy cigarettes at a gas station. R51's Minimum Data Set (MDS) assessment dated [DATE] revealed he was [AGE] years old, admitted to the facility on [DATE], and had a Brief Interview for Mental Status (BIMS), a short cognitive screener for nursing home residents, score of 11 (08-12 Moderate Impairment). The same MDS indicated he had a history of [REDACTED]. R51 used a wheelchair for locomotion when he was out of his room. R51's Behavior Care Plan dated 05/11/2018 revealed he was deemed unable to make medical decisions and had a guardian. The same care plan indicated R51 had the [DIAGNOSES REDACTED]. The same care plan revealed on 08/16/2019 wanderguard put in a secured place after he was being transported to the front office, it didn't go off. Stated he cut it off with his meal tray knife . R51's same care plan indicated on 11/10/2019, he continued to attempt to cut off his wanderguard. R51's care plan did not contain include measurable goals with timeframe's related to R51's high risk of elopement. R51's Activities of Daily Living (ADL) care plan dated 08/14/2019, indicated, under Problem, R51 had a history of [REDACTED]. The same care plan revealed his goal, with target dated 04/06/2020 was resident has no d/c (discharge) plans at this time. There were no measurable goals with timeframe's related to R51's high risk for elopement. On 03/04/2020 at approxmiately 10:00 AM, MDS Coordinator H was interviewed and stated each department completed resident care plans and elopement risk was included in the ADL care plan. Elopement Protection policy, dated 6/16/19, indicated elopement risk assessment would be completed quarterly, R51's last elopement risk assessment was completed on 08/14/2019. R51's care plan did not include an intervention to complete an elopement risk assessment quarterly. Nursing Progress Note dated 2/12/2020 at 7:07 AM, recorded as a late entry, revealed in the afternoon on 02/11/2020, R51 requested to go on the bus to ride around all day. The same note indicated facility staff was concerned he would buy cigarettes and alcohol, and then bring it back into the facility. R51 had said he planned to buy cigarettes/alcohol on several other occasions. The same note indicated facility staff contacted R51's guardian; and R51's guardian stated she was not comfortable letting R51 get on the bus himself and voiced concern that he would stop somewhere and buy cigarettes. There were no additional interventions added to R51's care plan. Incident and Accident Report dated 02/12/2020 at 6:20 AM, revealed R51 eloped from the facility and was out in the road in his wheelchair. On 03/04/2020 at 11:05 AM Director of Nursing (DON) B confirmed R51 was back inside facility with staff at 6:45 AM after his elopement on 02/12/2020 and had added a third wanderguard device to his wheelchair. On 03/04/2020 at 2:15 PM, DON B stated R51 planned to transfer to a facility with a secure unit on 03/04/2020. Resident #52 (R52) R52's MDS assessment dated [DATE] revealed, she admitted to the facility on [DATE], and had a BIMS score of 05 (00-07 Severe Impairment). The same MDS indicated a wander/elopement alarm was used daily. R52's ADL Care plan, with target date of 06/26/2020, revealed Resident wishes to return home as soon as she is able, informed her it may take several weeks. The same care plan for Approach revealed to utilize wanderguard due to elopement risk. There were no problems or goals for risk of elopement on R52's ADL care plan or any of her care plans. Resident #53 (R53) R53's MDS assessment dated [DATE] revealed he was admitted to the facility on [DATE] and had a BIMS score of 13 (13-15 Cognitively Intact). The same MDS assessment indicated R53 used a wander/elopement alarm daily. R53's ADL care plan, with target date of 05/12/2020, revealed a goal to have his needs anticipated and met for 110 days and be free of falls through the next review date. R53's same care plan included an approach with start date of 11/07/2019 for a wanderguard on his wheelchair to alert staff if he attempted elopement. There were no goals for R53's risk for elopement. Resident #54 (R54) R54's MDS assessment dated [DATE] revealed he was admitted to the facility on [DATE] and had a BIMS score of 09 (08-12 Moderately Impaired). The same MDS assessment indicated R54 used a wander/elopement alarm daily. R54's ADL care plan, with target date of 03/24/2020, revealed his goal was .to get better so he can return home living by himself, but his guardian has chose for him to reside in a long term care facility. The same care plan with approach start date of 07/15/2019, indicated R54 was an elopement risk and had a wanderguard placed on each wrist. There were no goals for R54's risk for elopement.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 365. Based on observation, interview and record review, the facility failed to provide adequate supervision and care planning to prevent resident elopement in one of four residents reviewed for elopement (Resident #51), resulting in the potential for serious harm including death. Findings include: Resident #51 (R51) On 03/03/2020 at 12:30 PM R51 was observed sitting in a recliner in his room eating lunch. During an interview regarding his elopement on 02/12/2020, R51 stated he was bored when he escaped and had wanted to buy cigarettes at a gas station. According to Google maps, the gas station was 1.8 miles from the facility on a main road. According to the weather.com, the temperature on 2/12/2020, was a high of 36 degrees and a low of 23 degrees; sunrise was at 8:34 AM. R51's Minimum Data Set (MDS) assessment dated [DATE] revealed he was [AGE] years old, admitted to the facility on [DATE], and had a Brief Interview for Mental Status (BIMS), a short cognitive screener for nursing home residents, score of 11 (08-12 Moderate Impairment). The same MDS indicated he had a history of [REDACTED]. R51 used a wheelchair for locomotion when he was out of his room. R51's Behavior Care Plan dated 05/11/2018 revealed he was deemed unable to make medical decisions and had a guardian. The same care plan indicated R51 had the [DIAGNOSES REDACTED]. The same care plan revealed on 08/16/2019 wanderguard put in a secured place after he was being transported to the front office, it didn't go off. Stated he cut it off with his meal tray knife . R51's same care plan indicated on 11/10/2019, he continued to attempt to cut off his wanderguard. R51's care plan did not contain include measurable goals with timeframe's related to R51's high risk of elopement. Elopement Protection policy, dated 6/16/19, indicated elopement risk assessment would be completed quarterly, R51's last elopement risk assessment was completed on 08/14/2019. Nursing Progress Note dated 2/12/2020 at 7:07 AM, recorded as a late entry, revealed in the afternoon on 02/11/2020, R51 requested to go on the bus to ride around all day. The same note indicated facility staff was concerned he would buy cigarettes and alcohol, and then bring it back into the facility. R51 had said he planned to buy cigarettes/alcohol on several other occasions. The same note indicated facility staff contacted R51's guardian; and R51's guardian stated she was not comfortable letting R51 get on the bus himself and

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

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) voiced concern that he would stop somewhere and buy cigarettes. There were no additional interventions added to R51's care plan. Incident and Accident Report dated 2/12/2020 at 6:20 AM, revealed R51 eloped from the facility and was out in the road in his wheelchair. In an interview on 03/04/2020 at 6:25 AM Nurse Assistant (CENA) D stated she was R51's regular CENA on third shift (10:00 PM to 6:30 AM) and on 02/12/2020, R51 got up at 5:00 AM to exercise his legs. CENA D stated R51's wanderguard alarms were on his chair that morning, because she washed his wheelchair earlier that night and the alarm went off when she wheeled the chair near the entrance door. CENA D stated she reminded R51 he needed to take his morning medications from his nurse and did not see him again prior to his elopement. CENA D stated the only way she could think of a way to have prevented R51's elopement on 02/12/2020, was if someone was watching the entrance door. During an interview on 03/04/2020 at 6:30 AM LPN E stated the last time she saw R51 prior to his elopement on 02/12/2020, was about 5:15 AM. LPN E stated she gave R51 his medications, in his room and at that time she did not see him with his coat and hat on. During an interview on 03/03/2020 at 1:30 PM Licensed Practical Nurse (LPN) C stated she primarily worked on the day shift (starting at 6:00 AM) and on 02/12/2020 at 5:30 AM, she came in early to get paperwork ready. At 5:30 AM, LPN C stated she observed R51 near the entrance door and instructed him not get to close, because we didn't want the alarms to go off. LPN C stated R51 went around the corner, sat near the bulletin board, and was still sitting in the same area at 6:00 AM. In an interview with LPN F on 03/04/2020 at 8:45 AM, she stated on 02/12/2020 at approximately 6:00 AM, R51 was at nurses' station one, and wanted to visit. LPN F stated she explained to R51 she needed to give report. LPN F stated she noticed R51 had a coat on and he explained to her that he was cold. During an interview on 03/04/2020 at 9:00 AM, Dietary Aide (DA) G stated on 02/12/2020 at 6:20 AM, she was driving to work in her car with her mother and observed R51 in the middle of the road in his wheelchair. DA G stated it was dark and she could barely see him. DA G stated she drove by R51 but turned around to see if it was someone from the facility. R51 told DA G he was headed to the gas station to get cigarettes. DA G stated it was cold that morning, she had worn a coat and was still cold. DA G attempted to assist R51 back to the facility and he resisted. DA G stated she stayed with R51 while her mother went on the facility to alert staff. On 03/04/2020 at 11:05 AM Director of Nursing (DON) B confirmed R51 was back inside facility with staff at 6:45 AM after him elopement on 02/12/2020. On 03/04/2020 at 2:15 PM, DON B stated R51 planned to transfer to a facility with a secure unit on 03/04/2020.