STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY VIEW CARE CENTER	1050 FOUR MILE NW GRAND RAPIDS, MI 49544

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 696 Based on interview and record review, the facility failed to report to the State Agency (SA) alleged neglect for 1 resident (Resident #106) of 8 residents reviewed for elopement, resulting in an elopement of Resident #106 who was a known elopement risk, when staff failed to respond to an door alarm and the potential for additional reportable incidents to go unreported. Findings include: Review of facility policy ABUSE, NEGLECT AND/OR MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY Revision Date: 12/10/18, revealed, POLICY STATEMENT 1. (name of company withheld) will not tolerate .neglect of its residents .by anyone . staff shall report any incident or suspicion of .neglect . to the Administrator immediately, or in his/ her absence, the Director of Nursing . PURPOSE: To assure each resident in the center is free from .neglect and . Neglect means .reckless failure to provide a resident with any .care .necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident . REPORTING/RESPONSE i) For the alleged violation involving .neglect .the (company name withheld) will report immediately but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the state survey agency, local authorities as appropriate, and adult protective services where state law provides for jurisdiction in long term care facilities), in accordance to the state law, and within 5 working days of the incident with the conclusion . Review of a Face Sheet revealed Resident #106 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 5/20/2020, revealed a Brief Interview for Mental Status (BIMS) score of 7, out of a total possible score of 15, which indicated Resident #106 was cognitively impaired. During an interview on 6/23/2020 at 2:18 PM CCC G stated, I am the Clinical Care Coordinator for 300-, 500-, 600-halls. I was taking temperatures at the front desk around 7:00 AM on May 22nd (2020). (Cook F) came in and said someone was in the parking lot that looks like he should not be out there. I saw (Resident #106); he had a hat and coat and carrying some papers. He was standing behind a row of cars. I went up to him and explained to him he had to come inside the building. I got him back in after a few minutes of talking to him. I do not know how long he had been outside. He was assigned to the 600-hall at the time and he went out the 600-hall entrance. That is my best guess because that is where he was found. Staff figured out after he talks to his guardian it is a trigger for him that he wants to leave. The motion detector on his door was in place at that time. There should have been an incident report done. I did not do one on him. I would think the nurse would have done the incident report. During an interview on 6/23/2020 at 3:35 PM Nursing Home Administrator (NHA) A stated, All that was reported to me about (Resident #106) was that he left out the 600-hall door. I do not know who reported it to me. I was told he was supervised the whole time and brought back in. Clinical Care Coordinator (CCC) G was in the front lobby taking temperatures and CCC J was getting out of her car and coming into the facility. It was during morning shift change and a lot of people were coming in and out of the building. Dietary staff (Cook F) saw him in the parking lot. I was here that morning and talking to (Director of Nursing (DON) B) in her office when we were both notified at the same time. I did not report it to the State Agency because he did not leave the premises, he was supervised by staff the whole time and had eyes on him the whole time. There was no incident report done because it did not feel like an elopement because staff was with him. Either (CCC J, CCC G, or Cook F) all had eyes on him. They were outside with him. During an interview on 6/23/2020 at 4:02 PM CCC J stated, On May 22nd (2020) I did not see (Resident #106) in the parking lot when I got of my car. (CCC G) and I both went out to get (Resident #106). I believe there were 3 of us in the parking lot. I was standing by the front lobby doors I was holding the door open. When (CCC G) brought him in I went to my office. I did not write a statement or document it. (CCC G) took care of everything. I did not do an incident report. I did not notify anyone. I have had training on reporting. During an interview on 6/24/2020 at 1:52 AM, Housekeeping W stated, I came in around 7 AM on May 22nd (2020) and was in the 100-hall to get some water to drink. (Cook F) knocked on the 100-hall door and said (Resident #106) was out of the facility. You cannot see the front lobby when you go to the 100-hall door let alone outside. I went out the main front doors. No one was at the front desk. I was the only one out there with him at that time. He was heading out the main parking lot down the main drive. He is a fast walker. He had a coat and hat on carrying a couple of packed bags. A few seconds later Clinical Care Coordinator (CCC) G came out to help. I was not asked to write a statement. I did not report to anyone because CCC G took over. No one knew (Resident #106) was out-of-the building until Cook F saw him. During an interview on 6/24/2020 at 2:05 PM, Dining General Manager (DM) X stated, I came in to work on May 22nd (2020) about 8:30-9 AM. (Cook F) told me she had found one of the residents outside of the facility. She said she had pulled into the parking lot and parked her car and sat with him then got a hold of nursing. I asked her if nursing knew and she said yes. In hindsight, I should have followed up to see if it had been reported. I assumed nursing staff had done a report. Staff has had education on elopements. If a resident is gone out the building, then it needs to be reported the State Agency. (Resident #106) leaving the building should have been reported. During an interview on 6/24/2020 at 3:00 PM, DON B stated, I don't know who notified me about (Resident #106) going out of the building. Staff had eyes on him the entire time. Reporting should be done right away, but in this case, from what I understand, staff had eyes on him, and he did not go very far. I do not know if an incident report was done. The Administrator did the investigation. During an interview on 6/25/2020 at 4:23 PM, NHA A stated, I am the abuse coordinator. Abuse includes neglect. It is my responsibility to investigate and report to the State Agency as-soon-as-possible but no later than 2 hours from when the incident was discovered. During an interview on 6/23/2020 at 3:23 PM, CCC G stated, I come in at 6:00 AM if I am taking temperatures for COVID-19 staff screening. I was doing staff screening that day. I was in the front lobby. (Resident #106) has always been an elopement risk. Cook F came in that morning and said someone was in parking lot that did not look like he should be out there. (Resident #106) was behind the cars in the second row of the front parking lot. I called (DON B) and she told me to start the 1:1 on him.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 696 Based on interview and record review, the facility failed to to complete a thorough investigation on an resident elopement in 1 resident (Resident #106) of 8 residents reviewed for abuse, resulting in Resident #106 eloping from the facility after staff neglected to respond to a sounding alarm per facility policy and managment was unaware that Resident #106 was not monitored the entire time of elopement. Findings include: Review of facility policy Review of facility policy ABUSE, NEGLECT AND/OR MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY Revision Date: 12/10/18, revealed, POLICY STATEMENT 1. (name of company withheld) will not tolerate .neglect of its residents .by

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) anyone . staff shall report any incident or suspicion of .neglect . to the Administrator immediately, or in his/ her absence, the Director of Nursing . PURPOSE: To assure each resident in the center is free from .neglect and . Neglect means .reckless failure to provide a resident with any .care .necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident . d) PROTECTION & IDENTIFICATION . The Administrator and/or Director of Nursing (DON) must be notified of all alleged violations involving . neglect . immediately .INVESTIGATION i) Time Frame for Investigation (1) The investigation shall be initiated immediately, after the Administrator has knowledge of the incident, but in no event shall the investigation take longer than five (5) working days .Investigation Protocol (1) As part of the investigation, the Administrator, or his/her designee, shall take the following action: Interview the resident .and all witnesses. Witnesses shall include anyone who (1) witnessed or heard the incident; (2) came in close contact with either the resident the day of the incident (including other residents, family members, etc.) .To the extent possible, all interviews should be summarized into a written statement, which is signed and dated .Review the resident's records .Review the Unusual Occurrence Report (incident report) and complete the sections identified to be completed by the Administrator. Optional - The Administrator also has the option to complete the Investigation Summary Checklist . Review of a Face Sheet revealed Resident #106 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 5/20/2020, revealed a Brief Interview for Mental Status (BIMS) score of 7, out of a total possible score of 15, which indicated Resident #106 was cognitively impaired. Review of an email correspondence received on 6/23/2020 at 12:34 PM from Nursing Home Administrator (NHA) A, revealed, There are no incident reports for (name withheld/Resident #106) in the last 6 months. Review of an elopement timeline for Resident #106 provided by Nursing Home Administrator (NHA) A indicated on 5/22/2020, Resident #106 was observed outside 600 hall exit after doors failed to lock after generator load test. Review of Resident #106's Care Plans revealed Focus . history of exit seeking-- will not consistently allow code alert (wander guard) placed on person .Revision on: 01/08/2020 .Goals did not indicate a goal for exit-seeking .Interventions . Door alarm utilized to notify staff when resident leaves room. Date Initiated: 05/21/2020 . Review of Resident #106's Kardex revealed, Safety .Res (resident) had been noted to have increased restlessness aeb (as evidenced by): ambulation and desire to leave after visits from the guardian. SS (social services) will notify staff when next visit is scheduled, and res will be placed on 1:1 . Review of Resident #106's Progress Note dated 5/19/2020 10:26 revealed, Social Service Note DOCUMENT QUARTERLY/ANNUAL NOTE, RESIDENT ISSUES/CONCERNS and FOLLOWUP, ROOM CHANGES: Assisted resident in video chatting with public guardian via facetime. Interaction at baseline . Further review of resident's progress notes did not indicate Resident #106 had been placed on 1:1 after his conversation with guardian. Review of Resident #106's Progress Note dated 5/22/2020 07:00 revealed, Nurses Note DOCUMENT RELEVANT INFORMATION ABOUT THE RESIDENT: REs was walked out of the unit at 0700 and was never out of sight of staff . Review of Resident #106's Progress Note dated 5/22/2020 07:30 revealed, . was anxious and took a walk out to the parking lot area . During an interview on 6/23/2020 at 1:40 PM, Certified Nursing Assistant (CNA) D stated, I take care of (Resident #106). He wanders around the unit and down halls. He has gone out of the building a few times. He has a motion detector on his door. On May 22nd (2020) I was working and in a resident's room providing care. The nurse was in another resident's room. The power went out. I heard (Resident #106's) alarm go off and could not stop resident care. I stayed with the resident I was assisting. It was only me and the nurse on the unit at that time. CNA staff only have pagers and cannot call out on them. The nurse's have facility portable phones. I didn't know at that time if the nurse had heard (Resident #106's) alarm. Staff are supposed to go check on him when his alarm goes off. During an interview on 6/23/2020 at 2:18 PM Clinical Care Coordinator (CCC) G stated, I am the Clinical Care Coordinator for 300-, 500-, 600-halls. I was taking temperatures at the front desk around 7:00 AM on May 22nd (2020). (Cook F) came in and said someone was in the parking lot that looks like he should not be out there. I saw (Resident #106); he had a hat and coat and carrying some papers. He was standing behind a row of cars. I went up to him and explained to him he had to come inside the building. I got him back in after a few minutes of talking to him. I do not know how long he had been outside. He was assigned to the 600-hall at the time and he went out the 600-hall entrance. That is my best guess because that is where he was found. Staff figured out after he talks to his guardian it is a trigger for him that he wants to leave. The motion detector on his door was in place at that time. There should have been an incident report (unusual occurence report) done. I did not do one on him. I would think the nurse would have done the incident report. During an interview on 6/23/2020 at 2:58 PM Cook F stated, This incident happened on a Monday or Friday this May or June (2020) at 7:00 am. I pulled up outside the facility and saw a man standing outside on the sidewalk in front of the therapy gym by the 600-hall exit door. I knew it was (Resident #106) and ran inside the main lobby. I had to use a radio to call for help because no one was at the front desk. I could see him through the front doors, and he was walking across the parking lot then. No one responded so I went to our dementia hall, the 100-hall, which was right by the front lobby. At that time, I could not see him anymore because the door is down the hall and around a little corner. Housekeeping W came to the 100-hall door when I knocked on it. I told her I needed her help. She went outside with me. I told another housekeeper to get help. I don't know her name. Housekeeping W stayed up front to watch him through the doors. CCC J was coming in the lobby from the outside and saw him once she came in. CCC G came to the front lobby and went outside to get (Resident #106). I stayed inside because no one was up front to check me in for COVID-19 screening. I could not go near him because I did not have a mask on. I did not write a statement. I know I am supposed to get help. During an interview on 6/23/2020 at 3:08 PM, Charge Registered Nurse (CRN) C stated, The incident with (Resident #106) was about 7:00-7:30 in the morning on May 22nd (2020). Since COVID-19, the lab does not come in to draw blood. I was drawing blood that morning on a resident; I do not know who. I did not hear the motion detector alarm for (Resident #106). The alarm does not go to a pager. There was me and one (1) CNA on the unit that morning. The motion detector goes off on its own when someone passes by it. There is a sensor that tones for about 3 times and then it stops. I believe (Resident #106) was back on the unit by the time I got done drawing blood. Both me and (CNA D) were busy at the time the alarm went off. We were both in other resident rooms with the doors closed. That day I had 1 CNA. I did the assessment on (Resident #106) as soon as he was back in his room. I made sure he was okay. I called his daughter per his request and notified her. She talked to him. (Social Worker (SW) E called his guardian. I believe I called the provider and got no new orders. CCC G was aware (Resident #106) left the building and we both talked to the DON (Director of Nursing). I did the nurses note after (CCC G or the Director of Nursing (DON) B) told me to. I do not remember who told me. Because at the time, there was a communication glitch I was told to do the nurses note. I do not know who did the morning care for (Resident #106). He is independent with his care. The CNA would have done the care if needed. I came on at 6:30 AM that morning. I saw him at 6:30 AM, his door was open, and he was in the room. The motion detector was still on desk when it went off and not on the medication cart. The medication cart was with me. (Resident #106) is an elopement risk. During an interview on 6/23/2020 at 3:23 PM CCC G stated, I come in at 6:00 AM if I am taking temperatures for COVID-19 staff screening. I was doing staff screening that day. I was in the front lobby. I do not remember if I screened Cook F that morning. I was sitting at the desk up front. I did not see (Resident #106) until I went outside. (Resident #106) has always been an elopement risk. He will not wear a wander guard. There are a lot of issues with him; he will not let staff put one on him. He was a 1:1 (one person always assigned to observe resident) for a long time before the motion detector was installed. I assumed he was on a 1:1 at that time because he does his own tube feedings, he keeps the extra tube feeds for a snack. Yes, I am the Clinical Care Coordinator for (Resident #106's) unit. He has behaviors of exit seeking. (Cook F) came in that morning to be COVID-19 screened and said someone was in parking lot that did not look like he should be out there. (Resident #106) was behind the cars in the second row of the front parking lot. I called (DON B) and she told me to start the 1:1 on him. I told the nurse (CRN C) because she was in another resident's room and the CNA was in another room too. The motion sensor goes off automatically and dings like a doorbell. Administration would have known of (Resident #106's) leaving the building by 9:00 that morning in morning meeting. During an interview on 6/23/2020 at 3:35 PM Nursing Home Administrator (NHA) A stated, All that was reported to me about (Resident #106) was that he left out the 600-hall door. I do not know who reported it to me. I was told he was supervised the whole time and brought back in. (CCC G) was in the front lobby taking temperatures and (CCC J) was getting out of her car and coming into the facility. It was during morning shift change and a lot of people were coming in and out of the building. Dietary staff (Cook F) saw him in the parking lot. I was here that morning and talking to (Director of Nursing (DON) B) in her office when we were both notified at the same time. I did not report it to the State Agency. Because he did not leave the premises, he was supervised by staff the whole time and had eyes on him the whole time. There was no incident report done because it did not feel like an elopement because staff was with him. Either (CCC J, CCC G, or Cook F) all had eyes on him. They were outside with him. During an interview on 6/23/2020 at 4:02 PM CCC J stated, On May 22nd (2020), I parked my car outside the 600-hall door. I

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) came in the front door. I did not see (Resident #106) in the parking lot when I got of my car. As soon as I got into the front lobby. (CCC G) was in the back office; not sitting at the front desk. The dietary person (Cook F) was coming off 100-hall. I did not see anyone with her. CCC G and I both went out to get (Resident #106). I believe there were 3 of us in the parking lot. I was standing by the front lobby doors I was holding the door open. When (CCC G) brought him in I went to my office. I did not write a statement or document it. (CCC G) took care of everything. I did not do an incident report. I did not notify anyone. I have had training on reporting. His CCC (CCC G) was there and he is not my resident. Observed on 6/24/2020 at 10:20 AM the front lobby reception area looking West towards parking lot. Surveyor was unable to see out windows facing the West parking due to rows of brown paper bags clipped on string across windows. When standing inside the lobby to immediately exit facility, there were two (2) sets of doors. Surveyor unable to see the West side of parking lot from inside of lobby at first set of doors due to the brick wall. Inside foyer, between the two (2) sets of doors, surveyor unable to see West side of parking lot due to large bush blocking view. Once inside front entrance lobby at front desk screening station, Cook F would have had to go down the hall approximately 20 feet and around a corner to enter code and gain access to the 100-hall to summons assistance from housekeeping. Cook F eyes-on Resident #106 would have been blocked by the interior walls, paper bags across windows, two (2) sets of doors and a large bush. During an interview on 6/24/2020 at 10:58 AM CNA D stated, The power went out and the generators kicked on the morning of May 22nd (2020). It got dark on the unit. This was the beginning of my shift and was after shift change. My shift starts at 6:30 AM. The charge nurse was already passing medications at that time. (Resident #106) does not need morning care. I did his temperature between 6:30 and 7:00 am. Temperatures cannot be logged into the computer until 7:00 AM. I was in a resident's room when the power went out. I thought all the doors would stay locked. So, I kept working with the resident. (CCC G) told me (Resident #106) had left the building and brought him back to the unit. When I saw him first thing that morning he was in his room, happy and watching television. It was when I first came on shift. (Resident #106) is a fast walker and mobile. He likes to walk and be outside. He has had a wander guard on him several times and fights to have it put on. The motion detector cannot always be heard at the end of the 600-hall. If the other staff is off the hall, I'll take the motion detector alarm with me or stay on the hall so I can hear it. It is hard to hear the motion detector alarm when in a room with a resident. I'm not given a phone or radio to keep in communication with the other staff if I do hear the alarm or they need to get a hold of me. During an interview and observation on 6/24/2020 at 11:32 AM with Maintenance Director R and Maintenance U, Maintenance U stated, On May 22nd (2020) at 6:30 AM I performed a monthly generator test of the entire facility. I shut off the main feed of electricity so the generator will operate. The power went off and for 3-4 seconds there was a delay before the generator kicks on to switch the power back on. The 600-hall entrance has two sets of doors and the inner doors have a mag lock. They are on a timer. Before COVID-19 they were on a timer. They would unlock at 8:00 AM and lock back up at 6:00 PM. When COVID-19 started we set the timer so everything on that door would be locked all the time, except for 4 seconds on May 22nd (2020). I started the generator test at 6:30 AM that morning. That day, the timer failed sometime during this time and the doors stayed unlock. I made a round of the facility, a nurse told me the 600-hall entrance was not locked. Observed and participated with Maintenance Director R and Maintenance U in measuring from the outside of 600-hall exit/entrance door to end of the second row of parking in West parking lot. Distance measured at 64 feet. The second row to the beginning of the main drive was approximately an additional 10-15 feet. During an interview on 6/24/2020 at 12:27 PM Social Worker (SW) E stated, I am the social worker for (Resident #106). At times he is an elopement risk. He has gotten out of the facility. The last time he got out was May 22nd (2020). Pre-COVID-19 shut-down there was furniture in the 600-hall common area and he would sit by the door with his hat and coat. It was concerning to staff that he would get so close to the door. He has a language barrier (Vietnamese speaking). To my knowledge he has only gone as far as the light pole in the west parking lot. He had a wander guard on, but would take it off, which is the reason a motion detector was put on his room. I did not see (Resident #106) outside on May 22nd (2020). I do not have notes about (Resident #106) leaving the facility on May 22nd (2020). I do not remember who told me he left the building. There was an IDT discussion about him leaving the building soon after. I do not have notes on it. During an interview on 6/24/2020 at 1:52 PM, Housekeeping W stated, I came in around 7 AM on May 22nd (2020) and was in the 100-hall to get some water to drink. (Cook F) knocked on the 100-hall door and said (Resident #106) was out of the facility. You cannot see the front lobby when you go to the 100-hall door let alone outside. I went out the main front doors. No one was at the front desk. I was the only one out there with him at that time. He was heading out the main parking lot down the main drive. He is a fast walker. He had a coat and hat on carrying a couple of packed bags. A few seconds later Clinical Care Coordinator (CCC) G came out to help. I was not asked to write a statement. I did not report to anyone because (CCC G) took over. I did tell my supervisor when she came in later that morning. I have been trained on Code 7 elopement protocol. No one knew (Resident #106) was out-of-the building until (Cook F) saw him. During an interview on 6/24/2020 at 3:00 PM DON B stated, I don't know who notified me about (Resident #106) going out of the building. Staff had eyes on him the entire time. Reporting should be done right away, but in this case, from what I understand, staff had eyes on him, and he did not go very far. I do not know if an incident report was done. The Administrator did the investigation. During an interview on 6/25/2020 at 4:23 PM, NHA A stated, I am the abuse coordinator. Abuse includes neglect. It is my responsibility to investigate and report to the State Agency as-soon-as-possible. For an elopement, interviewing staff and all involved should be done until you have clarity of the situation. There are cameras on the exterior of the facility, but I did not look at the video on May 22nd (2020).
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent an elopement and ensure safety in 1 of 8 residents (Resident #106) reviewed for safety/supervision, from a total sample of 8 residents, resulting in an Immediate Jeopardy when on 5/22/2020 at approximately 6:30 AM, Resident #106 exited the facility, unbeknownst to facility staff, during a generator test and the alarms for Main entrance, 200 hall and 600 hall exit doors ceased to work unknowingly to staff, and was found by a staff while walking in the west side of the parking lot heading towards the main drive, approximately 80 feet from facility front door and within approximately 1/2 mile of Alpine Drive. The resident was returned to the facility by staff at approximately 7:00 AM. This deficient practice placed 9 residents, identified as at risk for elopement, at risk for serious harm, injury, and/or death. Findings include: Review of facility policy ELOPEMENT AND/OR EXIT-SEEKING MANAGEMENT revised date 10/11/2019, revealed, .KEY TERMS: Elopement: When a resident leaves a safe or secure area going into an unsafe area without assistance or supervision. PURPOSE: To promote the safety of residents by assessing and managing elopements, thereby minimizing risk. PROCEDURE: 1. Identify resident risk for elopement and implement interventions as needed .b. IDT (interdisciplinary team) to complete the Elopement Assessment following admission, quarterly, and with significant changes. 2. Initiating safety procedures. A. Place an exit guard bracelet on the resident if facility has a wander guard/code alert system .Monitor alarming devices including bracelet and doors for function and expiration routinely. Review of a complaint, intake #MI 696, indicated alleged neglect when a resident eloped from the facility and staff failed to report it to the State Agency. Review of a Face Sheet revealed Resident #106 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 5/20/2020, revealed a Brief Interview for Mental Status (BIMS) score of 7, out of a total possible score of 15, which indicated Resident #106 was cognitively impaired. Further review of MDS indicated no wandering behaviors had been exhibited. Review of an email correspondence received on 6/23/2020 at 12:34 PM from Nursing Home Administrator (NHA) A, revealed, There are no incident reports for (name withheld/Resident #106) in the last 6 months. Review of Resident #106's ELOPEMENT AND/OR EXIT SEEKING BEHAVIOR RISK ANALYSIS dated 5/22/2020 at 3:21PM indicated there had been no change in the resident's elopement risk from last review and was at risk for elopement and interventions had been reviewed. Review of an elopement timeline for Resident #106 provided by Nursing Home Administrator (NHA) A indicated on 5/22/2020 was observed outside 600 hall exit after doors failed to lock after generator load test. Review of Resident #106's Care Plans revealed Focus . history of exit seeking-- will not consistently allow code alert (wander guard) placed on person .Revision on: 01/08/2020 .Goals did not indicate a goal for exit-seeking .Interventions . Door alarm utilized to notify staff when resident leaves room. Date Initiated: 05/21/2020 . Review of Resident #106's Kardex revealed, Safety .Res (resident) had been noted to have increased restlessness aeb (as evidenced by): ambulation and desire to leave after visits from the guardian. SS (social services)

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	235377	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY VIEW CARE CENTER	1050 FOUR MILE NW GRAND RAPIDS, MI 49544

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

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) will notify staff when next visit is scheduled, and res will be placed on 1:1 . Review of Resident #106's Progress Note dated 5/19/2020 10:26 revealed, Social Service Note DOCUMENT QUARTERLY/ANNUAL NOTE, RESIDENT ISSUES/CONCERNS and FOLLOWUP, ROOM CHANGES: Assisted resident in video chatting with public guardian via facetime. Interaction at baseline . Further review of resident's progress notes did not indicate Resident #106 had been placed on 1:1 after his conversation with guardian. Review of Resident #106's Progress Note dated 5/22/2020 07:00 revealed, Nurses Note DOCUMENT RELEVANT INFORMATION ABOUT THE RESIDENT: REs was walked out of the unit at 0700 . Review of Resident #106's Progress Note dated 5/22/2020 07:30 revealed, . was anxious and took a walk out to the parking lot area . During an interview and observation on 6/23/2020 at 12:15 PM, Licensed Practical Nurse (LPN) AA stated, There is a motion detector on (Resident #106's) door. I have heard he has tried to leave the facility. When he pokes his head out his room or anyone enters/exits the alarm at the nursing station goes off. Observed at the 600-hall nursing station a portable alarm the size of a small vertical tissue box. During an interview on 6/23/2020 at 1:40 PM, Certified Nursing Assistant (CNA) D stated, I take care of (Resident #106). He wanders around the unit and down halls. He has gone out of the building a few times. He has a motion detector on his door. On May 22nd (2020) I was working and in a resident's room providing care. The nurse was in another resident's room. The power went out. I heard (Resident #106's) alarm go off and could not stop resident care. I stayed with the resident I was assisting. It was only me and the nurse on the unit at that time. CNA staff only have pagers and cannot call out on them. The nurse's have facility portable phones. I didn't know at that time if the nurse had heard (Resident #106's) alarm. Staff are to go check on him when his alarm goes off. During an interview on 6/23/2020 at 2:00 PM, CNA I stated, (Resident #106) has left the building twice that I know of. Once he went out with a resident that smokes and that resident called the facility to tell staff (Resident #106) was outside. The other time he left the facility he had taken his wander guard off with nail clippers. I was working both times but did not have to write statements per the nurse. I can't tell you when these dates were. During an interview on 6/23/2020 at 2:00 PM Charge Registered Nurse (CRN) C stated, I was working on the 600-hall on the day (Resident #106) left the building, May 22nd (2020). I was in another's resident's room doing care and I didn't hear the motion detector alarm. (CNA D) was in another resident room. (CCC G) told me she saw him going out the 600-hall door and go outside. She had eyes on him and brought him back. When I go into a room, I do not carry the motion detector alarm with me. The alarm does not go to pagers. It is kept at the 600-hall nursing station. If I'm passing medications I'll take it with me; it is mobile. (Resident #106) likes to get out and get fresh air. He is very active. My understanding was because staff was with him and eyes were on him, I didn't need to do an incident report. It was either the DON or (CCC G) who documented in the nurse's notes. During an interview on 6/23/2020 at 2:18 PM CCC G stated, I am the Clinical Care Coordinator for 300-, 500-, 600-halls. I was taking temperatures at the front desk around 7:00 AM on May 22nd (2020). (Cook F) came in and told me someone was in the parking lot that looks like he should not be out there. I saw him him. He had a hat and coat and carrying some papers. He was standing behind a row of cars. I went outside and up to him and explained to him he had to come inside the building. I got him back in after a few minutes of talking to him. I do not know how long he had been outside. He was assigned to the 600-hall at the time and he went out the 600-hall entrance. That is my best guess because that is where he was found. He will not wear a wander guard. He takes them off. We figured out after he talks to his guardian it is a trigger for him that he wants to leave. The motion detector on his door was in place at that time. There should have been an incident report done. I did not do one on him. I would think the nurse would have done the incident report. I did an elopement screen assessment that day. The nurse talked to his guardian. During an interview on 6/23/2020 at 2:58 PM Cook F stated, I pulled up outside the facility and saw a man standing outside on the sidewalk in front of the therapy gym by the 600-hall exit door. I knew it was (Resident #106) and ran inside the main lobby. I had to use a radio to call for help because no one was at the front desk. I could see him through the front doors, and he was walking across the parking lot then. No one responded so I went to our dementia hall, the 100-hall, which was right by the front lobby. At that time, I could not see him anymore because the door is down the hall and around a little corner. Housekeeping W came to the 100-hall door when I knocked on it. I told her I needed her help. She went outside with me. I told another housekeeper to get help. I don't know her name. Housekeeping W stayed up front to watch him through the doors. CCC J was coming in the lobby from the outside and saw him once she came in. CCC G came to the front lobby and went outside to get (Resident #106). I stayed inside because no one was up front to check me in for COVID-19 screening. I could not go near him because I did not have a mask on. When I got to the kitchen, I told my manager I saw resident. I did not write a statement. During an interview on 6/23/2020 at 3:08 PM, Charge Registered Nurse (CRN) C stated, The incident with (Resident #106) was about 7:00-7:30 in the morning on May 22nd (2020). Since COVID-19, the lab does not come in to draw blood. I was drawing blood that morning on a resident; I do not know who. I did not hear the motion detector alarm for (Resident #106). The alarm does not go to a pager. There was me and one (1) CNA on the unit that morning. The motion detector goes off on its own when someone passes by it. There is a sensor that tones for about 3 times and then it stops. I believe (Resident #106) was back on the unit by the time I got done drawing blood. Both me and CNA D were busy at the time the alarm went off. We were both in other resident rooms with the doors closed. That day I had 1 CNA. I did the assessment on (Resident #106) as soon as he was back in his room. I made sure he was okay. I called his daughter per his request and notified her. She talked to him. (Social Worker (SW) E called his guardian. I believe I called the provider and got no new orders. CCC G was aware (Resident #106) left the building and we both talked to the DON. I did the nurses note after CCC G or the Director of Nursing (DON) B told me to. I do not remember who told me. Because at the time, there was a communication glitch I was told to do the nurses note. I do not know who did the morning care for (Resident #106). He is independent with his care. The CNA would have done the care if needed. I came on at 6:30 AM that morning. I saw him at 6:30 AM, his door was open, and he was in the room. The motion detector was still on desk when it went off and not on the medication cart. The medication cart was with me. (Resident #106) is an elopement risk. During an interview on 6/23/2020 at 3:23 PM, CCC G stated, I come in at 6:00 AM if I am taking temperatures for COVID-19 staff screening. I was doing staff screening that day. I was in the front lobby. I do not remember if I screened Cook F that morning. I was sitting at the desk up front. I did not see (Resident #106) until I went outside. (Resident #106) has always been an elopement risk. He will not wear a wander guard. There are a lot of issues with him; he will not let staff put one on him. He was a 1:1 (one person always assigned to observe resident) for a long time before the motion detector was installed. I assumed he was on a 1:1 at that time because he does his own tube feedings, he keeps the extra tube feeds for a snack. Yes, I am the Clinical Care Coordinator for (Resident #106's) unit. He has behaviors of exit seeking. (Cook F) came in that morning to be COVID-19 screened and said someone was in parking lot that did not look like he should be out there. (Resident #106) was behind the cars in the second row of the front parking lot. I called (DON B) and she told me to start the 1:1 on him. I told the nurse (CRN C) because she was in another resident's room and the CNA was in another room too. The motion sensor goes off automatically and dings like a doorbell. Administration would have known of (Resident #106's) leaving the building by 9:00 that morning in morning meeting. Review of facility Punch Detail indicated on 5/22/2020, that Cook F punched into work at 7:11 AM, CNA D punched in at 5:25 AM, CRN C punched in at 6:11 AM, and Housekeeping W punched in at 5:54 AM. During an interview on 6/23/2020 at 3:35 PM NHA A stated, All that was reported to me about (Resident #106) was that he left out the 600-hall door. I do not know who reported it to me. I was told he was supervised the whole time and brought back in. CCC G was in the front lobby taking temperatures and CCC J was getting out of her car and coming into the facility. It was during morning shift change and a lot of people were coming in and out of the building. Dietary staff saw him in the parking lot. I was here that morning and talking to (DON B) in her office when we were both notified at the same time. I cannot remember if we were notified by phone or someone came in. I did not report it to the State Agency. Because he did not leave the premises, he was supervised by staff the whole time and had eyes on him the whole time. There was no incident report done because it did not feel like an elopement because staff was with him. Either (CCC J, CCC G, or Cook F) all had eyes on him. They were outside with him. The nurse did a note. The social worker should have done a note. At the time, the doors were not locked and did not alarm at that time. Shift started that day for CNAs at 6:30 AM and nurses come in at 6:45 AM. During an interview on 6/23/2020 at 4:02 PM, CCC J stated, On May 22nd (2020), I parked my car outside the 600-hall door. I came in the front door. I did not see (Resident #106) in the parking lot when I got of my car. As soon as I got into the front lobby. (CCC G) was in the back office; not sitting at the front desk. The dietary person (Cook F) was coming off 100-hall. I did not see anyone with her. CCC G and I both went out to get (Resident #106). I believe there were 3 of us in the parking lot. I was standing by the front lobby doors I was holding the door open. When (CCC G) brought him in I went to my office. I did not write a statement or document it. (CCC G) took care of everything. I did not do an incident report. I did not notify anyone. I have had training on reporting. His CCC (CCC G) was there and he is not my resident. During an interview on 6/24/2020 at 9:55 AM, NHA A stated, We had a problem the day (5/22/2020) (Resident #106) left the building.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) The generators were being tested and when the power came back on the doors were no longer locked on the 200 and 600 halls exit doors. Observed on 6/24/2020 at 10:20 AM the front lobby reception area looking West towards parking lot. Surveyor was unable to see out windows facing the West parking due to rows of brown paper bags clipped on string across windows. When standing inside the lobby to immediately exit facility, there were two (2) sets of doors. Surveyor unable to see the West side of parking lot from inside of lobby at first set of doors due to the brick wall. Inside foyer, between the two (2) sets of doors, surveyor unable to see West side of parking lot due to large bush blocking view. Once inside front entrance lobby at front desk screening station, Cook F would have had to go down the hall approximately 20 feet and around a corner to enter code and gain access to the 100-hall to summons assistance from housekeeping. Cook F eyes-on Resident #106 would have been blocked by the interior walls, paper bags across windows, two (2) sets of doors and a large bush. During an interview on 6/24/2020 at 10:58 AM CNA D stated, The power went out and the generators kicked on the morning of May 22nd (2020). It got dark on the unit. This was the beginning of my shift and was after shift change. My shift starts at 6:30 AM. The charge nurse was already passing medications at that time. (Resident #106) does not need morning care. I did his temperature between 6:30 and 7:00 am. Temperatures cannot be logged into the computer until 7:00 AM. I was in a resident's room when the power went out. I thought all the doors would stay locked. So, I kept working with the resident. (CCC G) told me (Resident #106) had left the building and brought him back to the unit. When I saw him first thing that morning he was in his room, happy and watching television. It was when I first came on shift. (Resident #106) is a fast walker and mobile. He likes to walk and be outside. He has had a wander guard on him several times and fights to have it put on. The motion detector cannot always be heard at the end of the 600-hall. If the other staff is off the hall, I'll take the motion detector alarm with me or stay on the hall so I can hear it. It is hard to hear the motion detector alarm when in a room with a resident. I'm not given a phone or radio to keep in communication with the other staff if I do hear the alarm or they need to get a hold of me. During an interview and observation on 6/24/2020 at 11:32 AM with Maintenance Director R and Maintenance U, Maintenance U stated, On May 22nd (2020) at 6:30 AM I performed a monthly generator test of the entire facility. I shut off the main feed of electricity so the generator will operate. The power went off and for 3-4 seconds there was a delay before the generator kicks on to switch the power back on. The 600-hall entrance has two sets of doors and the inner doors have a mag lock. They are on a timer. Before COVID-19 they were on a timer. They would unlock at 8:00 AM and lock back up at 6:00 PM. When COVID-19 started we set the timer so everything on that door would be locked all the time, except for 4 seconds on May 22nd (2020). I started the generator test at 6:30 AM that morning. That day, the timer failed sometime during this time and the doors stayed unlock. I made a round of the facility, a nurse told me the 600-hall entrance was not locked. Observed and participated with Maintenance Director R and Maintenance U in measuring from the outside of 600-hall exit/entrance door to end of the second row of parking in West parking lot. Distance measured at 64 feet. The second row to the beginning of the main drive was approximately an additional 10-15 feet. Review of facility, Daily Census indicated nine (9) residents were assigned to the 600-hall on 5/22/2020, two (2) of which were identified as elopement risks. During an interview on 6/24/2020 at 12:27 PM Social Worker (SW) E stated, I am the social worker for (Resident #106). At times he is an elopement risk. He has gotten out of the facility. The last time he got out was May 22nd (2020). Pre-COVID-19 shut-down there was furniture in the 600-hall common area and he would sit by the door with his hat and coat. It was concerning to staff that he would get so close to the door. He has a language barrier (Vietnamese speaking). To my knowledge he has only gone as far as the light pole in the west parking lot. He had a wander guard on would take it off. Which is the reason a motion detector was put on his room. I did not see (Resident #106) outside on May 22nd (2020). I do not have notes about (Resident #106) leaving the facility on May 22nd (2020). I do not remember who told me he left the building. There was an IDT discussion about him leaving the building soon after. I do not have notes on it. During an interview on 6/24/2020 at 1:52 AM, Housekeeping W stated, I came in around 7 AM on May 22nd (2020) and was in the 100-hall to get some water to drink. (Cook F) knocked on the 100-hall door and said (Resident #106) was out of the facility. You cannot see the front lobby when you go to the 100-hall door let alone outside. I went out the main front doors. No one was at the front desk. I was the only one out there with him at that time. He was heading out the main parking lot down the main drive. He is a fast walker. He had a coat and hat on carrying a couple of packed bags. A few seconds later Clinical Care Coordinator (CCC) G came out to help. I was not asked to write a statement. I did not report to anyone because (CCC G) took over. I did tell my supervisor when she came in later that morning. I have been trained on Code 7 elopement protocol. No one knew (Resident #106) was out-of-the building until (Cook F) saw him. During an interview on 6/24/2020 at 3:00 PM DON B stated, I don't know who notified me about (Resident #106) going out of the building. Reporting should be done right away, but in this case, from what I understand, staff had eyes on him, and he did not go very far. I do not know if an incident report was done. The Administrator did the investigation. During an interview on 6/25/2020 at 5:00 PM, Maintenance Director R stated, (Resident #106) has a motion detector on his door. The alarm goes off at the nurse's station. On 6/24/2020 at 2:25 PM, Nursing Home Administrator was notified of an Immediate Jeopardy that began on 5/22/2020 and was identified on 6/24/2020 when Resident #106, who was identified as an elopement risk, eloped from the facility, unbeknownst to facility staff. On 6/25/2020, this surveyor verified the facility completed the following to remove the Immediate Jeopardy: 1. On 5/22/20, Resident #106 was returned to the facility and was assessed for injuries, none noted. 2. On 5/22/20, the Guardian, Administrator, and Director of Nursing were notified of the incident. 3. On 5/22/20, Maintenance staff was notified of resident exiting the center and immediately began checking all door exits to assure proper function. It was identified that the door had disengaged during a generator test and was manually reset by 7:20AM. 4. On 5/22 at 1:000 PM the system was hardwired to prevent further occurrence. 5. On 5/22/20, resident was placed on 1:1 to determine further needs for safety. 6. On 6/24/2020 current residents were re-assessed for elopement risks and care plans and interventions were updated as appropriate. One (1) resident, (R107), did not have care plan updated and was not received until after surveyor exited facility on 6/25/2020. 7. On 6/24/2020, doors within the facility that are equipped with code access were checked to assure proper function. Resident's individual alarm was evaluated to assure proper alarming mechanism. 8. On 6/24/2020, re-education on elopement was initiated. Eighty-two (82) of 161 staff completed education by 3:00 PM day shift (6/24/2020). One hundred twenty-eight (128) of 161 staff completed education by 6/24 (2020) midnight shift. Staff not receiving education by 7AM on 6/25 (2020) will receive education prior to next shift worked. 9. Elopement books were reviewed to reflect current resident assessments. This was completed in conjunction with elopement assessment beginning on 6/24/2020 and 100% completed. This included function and placement of wander guards or additional alarms systems currently in place. 10. Elopement drills were held on 6/24 (2020) PM shift, 6/24 (2020) midnight shift and 6/25 AM shift. Any concerns were discussed with staff at the time of drill. 11. The above plan was discussed at QAPI meeting on 6/24 (2020) with the Medical Director, ED, and Regional Support staff. Althought the immediate jeopardy was removed on 6/24/20, the facility remained out of compliance at a scope of isolated and severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the fact the facility had not yet completed all education and sustained compliance had not yet been verified by the state agency.