STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235332	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTLAND, A VILLA CENTER	**36137 W WARREN WESTLAND, MI 48185**

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 **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** This citation pertains to intake numbers: 7 and 0. Based on observation, interview and record review, the facility failed to secure the back delivery door, allowing one resident (#702) of six residents reviewed for elopement, to exit the building unbeknownst to staff at approximately 9:47 PM on 7/4/2020, resulting in the likelihood of serious injury or death from being outside, unsupervised for an extended period of time. Resident #702 was returned to the facility, escorted by two police officers on 7/10/2020 at approximately 10:05 PM. Findings include: The Immediate Jeopardy (IJ) started on 7/4/2020 and was identified on 7/15/2020. The Administrator was notified of the Immediate Jeopardy on 7/15/2020 at 3:00 PM and was asked for a plan to remove the immediacy. The IJ was removed on 7/05/2020, based on the facility's implementation of the removal plan as verified onsite on 7/16/2020. Although the immediacy was removed, the facility's deficient practice was not corrected and remained isolated with actual harm that is not immediate jeopardy. On 7/15/2020 at 12:10 PM, an interview was conducted with the Nursing Home Administrator (NHA) in regard to a facility reported incident. The NHA stated, (Resident #702) was discharged to another facility yesterday. They were alert and oriented and had a Brief Interview for Mental Status (BIMS) of 15. (Resident #702) wants to smoke cigarettes. (Resident #702) left and stayed out for a week, then came back on Friday. (Resident #702) didn't tell anyone where they were going, they just left out the back door. The NHA explained that when the resident did come back, Resident #702 was unable to say where they went. On 7/15/2020 at 12:30 PM, an observation was made with the NHA of the door that Resident #702 exited. The NHA went through a double doorway that was wide open. There was a sign just above the doorway that referenced the corridor was for staff only. The NHA was asked if the doors always remained open and stated, No, not really. Upon entering the corridor, there was an open door that entered into the employee break room Around the corner from the break room, there was the kitchen, and then another corridor that lead to an exit door (delivery door). The NHA explained that Resident #702 went in the employee break room, looked out the doorway and then walked passed the kitchen and out the delivery door. Upon inspection of the delivery door, there was a key pad next to the door. The NHA was queried on whether or not the door locks. The NHA explained that the door was working earlier on 7/4/2020 when staff checked it but, at the time of Resident #702's exit, the door had not locked or had the alarm sounded. The NHA explained that normally the door would not open without keying in a code, and would sound an alarm if a resident with a wanderguard (a bracelet normally placed on the ankle to trigger an alarm response when near certain doors) when trying to exit through the door. The NHA explained that the door was fixed on 7/5/2020. A record review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #702 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED].#702 had a BIMS score of 15 out of 15, indicating an intact cognition and needed supervision for ambulation and transfers. On 7/15/2020 at 2:30 PM, an observation was made of the camera footage dated 7/4/2020 with the NHA. At 9:47PM, Resident #702 was observed in the staff break room door way. A staff member had walked out of the break room and then Resident #702 exited the break room, walked down the service hallway near the kitchen, turned and walked out of the back delivery door. There was no staff present at the time. A record review of the Progress Notes for Resident #702 revealed the following: 4/1/2020 14:26 (2:26 PM) .Resident chooses not to comply with quarantine. Resident aimlessly wanders unit. Resident was seen knocking on glass window to library wanting to go outside to court yard. Resident was asked to go back to room. Resident chose not to. Doctor notified. Will continue to redirect. 6/25/2020 20:48 (8:48 PM) . Social Service Note . Social worker tried calling resident guardian and case worker to discuss transferring resident to a smoking facility . 7/5/2020 02:35 (2:35 AM) . At approximately 0040 (12:40 AM) CENA (Certified Educated Nurse Assistant) reported that (Resident #702) was not in their room. Room to room search began, then Code White (missing person) called, DON (Director of Nursing) and Administrator called . Police called . CENA walked the perimeter . Authored by Licensed Practical Nurse (LPN) A. 7/5/2020 1:00 PM (nurses note) . Writer finally got a hold of Guardian at about 9:30 am to inform (them) of incident . (Guardian) stated that (they) are not surprised because resident has done that before (eloped). Writer also spoke to (family member) multiple times to see if (they) had any information or any possible area where resident may be but (family member) stated, (family member) doesn't have any ideas, that (family member) was also searching. Police was also informed and police went to (family members) house. Search around the neighborhoods but resident was not found. Search in progress. Let it be noted that Resident #702 was missing from the facility for 6 days. 7/10/2020 22:05 (10:05 PM) .Res (Resident) returned to facility with 2 police officers. Res A&Ox3 (alert and oriented to person, place and time). [MEDICAL CONDITION] (a communication deficit that limits speech and expression) noted. Res still able to make needs known to staff .Res oriented to Station 1. Staff maintaining frequent visual checks to establish a baseline for resident. Call light within reach. A record review of the initial Wander/Elopement Risk Evaluation dated 6/21/2019 indicated a high score of 17, related to Resident #702 being cognitively impaired, independent with ambulation and having a history of attempted elopements. A record review of the care plan dated 7/12/2020 for Resident #702 revealed the following: Focus: (Resident #702) has a hx (history) of elopement risk as they went AWOL from the group home that they previously resided in. Goal: (Resident #702)'s safety will be maintained . Interventions: Frequent monitoring Photo on wander list Staff aware of residents wander history Distract resident from wandering . Identify pattern of wandering . Monitor location . On 7/16/2020 at 11:49 AM, the DON was interviewed in regard to Resident #702 exiting the building on 7/4/2020. The DON stated, Staff called me, they said (Resident #702) was missing and gone for awhile. They did call the police. (Resident #702) was aphasic . had a stroke . They (the staff) did not know where (Resident #702) went or how they got out. We reviewed the cameras .and then gave that information to the police. We walked around and checked the doors. The door was working on and off. We called the hospitals every single day. We walked to the (family member's) house. (Family member) was looking .too. The police found (Resident #702) at a Coney Island (restaurant) in Wayne. On 7/16/2020 at 12:16 PM, Maintenance Director B was interviewed in regard to checking the doors to be sure they are working properly. Maintenance Director B explained that he has staff in the building daily to do the checks and that the door was checked earlier that day and it did work. The Maintenance Director was asked if he had to fix the door and he stated, I had to call to get the door fixed, they (door company) came in the next day. On 7/16/2020 at 2:00 PM, LPN A was interviewed via phone in regard to Resident #702 exiting the building on 7/4/2020. LPN A explained that she was the nurse on duty from 7:00 PM (7/4/2020) through 7:00 AM (7/5/2020). LPN A did not recall the last time she had seen the resident that evening but did explain that when she discovered (Resident #702) as missing she searched the premises, called a Code White and called the police. An attempt was made to contact three CENA's that were in charge of the care for Resident #702 during the night of 7/4/2020 and morning of 7/5/2020, however there were no return phone calls by the end of the survey. A record review of the communication (via email form) between the facility and door alarm repair company revealed the following: (Dated 7/5/2020) .I went out today after I received a call that the mag lock was not working to the freight door. I discovered that the mag

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) lock was not getting proper power. I restored power to it and tested the door several times. It is now working fine. Loss of power to the mag lock in (sic) unknown at this time. A review of the facility policy titled Wandering and Elopement Guideline, dated 3/16/2017 revealed the following: The Facility will provide .safe environment for wandering residents at risk for elopement. Facility procedures-the facility will have a process to evaluate door alarm functioning every day . Door Alarms-Any suspected or confirmed malfunctioning of any door alarm will have an immediate 1:1 supervision of the exit until repairs can be made or alternate alarm accommodations can be applied. Door alarm function will be checked daily by maintenance personnel and weekends and/or holidays designated personnel. IJ Abatement Plan - F689 Element # 1 Resident # 702 returned to the facility on 7.10.2020, a physical assessment was immediately performed with no injury noted. Vital signs stable. Denied pain or discomfort. Resident # 702 was placed on continuous one on one supervision until appropriate discharge planning could occur. Resident # 702 was discharged from the facility on 7.14.2020 to a more appropriate setting. The delivery entrance door was serviced on the same day that Resident # 702 was noted to be out of the facility, July 5, 2020. The delivery entrance door is in full working order and is tested daily for proper functioning. A secondary alarm that is not connected to the same electrical circuit was also engaged at the delivery entrance door. Element # 2 Residents who currently reside in the facility have the potential to be affected. Updated Elopement Assessments were completed on all residents who reside in the facility on July 5, 2020. Residents deemed at risk for elopement had a care-plan review to ensure appropriate interventions were in place. Each Resident room window was audited to ensure the security screw was in place on July 5, 2020 by the Maintenance Director. Facility exit doors were checked to ensure alarms were in place and functioning properly on July 5, 2020 by the Maintenance Director or designee. An audit of the Elopement Binder was conducted by the Corporate Compliance Officer on July 5, 2020 for accuracy. Element#3 The facility administrator and Corporate Compliance Officer hosted an Ad-Hoc QAPI committee meeting with the Medical Director to review the Past Non-Compliance and associated staff education. Facility staff have been educated on the Wandering and Elopement Guidelines with 100% completion. Element # 4 Daily door alarm checks will be conducted by the Maintenance Director or designee. Any alarm failures will immediately be reported to the Administrator and the door will be properly secured until the malfunction is rectified. Audit findings will be reported at the facility monthly QAPI (Quality Assurance Process Improvement) Committee meeting for a period of 6 weeks then as needed moving forward, Twice weekly a window security audit will be conducted by the Maintenance Director or designee Any security discrepancies will immediately be reported to the Administrator and the window will be properly secured until the discrepancy is rectified. Audit findings will be reported at the facility monthly QAPI Committee meeting for a period of 6 weeks then as needed moving forward. Random weekly staff inquiries are in place to ensure staff have an understanding of the Wandering and Elopement Guidelines for a period of 6 week then as needed moving forward. These audits will be reviewed and discussed at the facility monthly QAPI Committee. The Administrator is responsible for sustained compliance.