STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235487	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD WEST BLOOMFIELD	6950 FARMINGTON RD WEST BLOOMFIELD, MI 48322

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 MI 762: Based on observation, interview, and record review the facility failed to prevent a severely cognitively impaired resident with a known history of elopement and exit-seeking behavior from exiting the facility for one (R#801) of five residents reviewed for elopement, resulting in an Immediate Jeopardy when R#801 exited the facility via an alarmed door without the knowledge of facility staff, left the facility property, traveled via foot without shoes down a busy main road with a speed limit of 45 miles per hour, entered into a neighborhood, and was found in the road by a member of the public. Due to the deficient practice, R#801 and additional residents at risk for elopement had the increased likelihood for serious harm, serious injury, and/or death. Findings include: The Immediate Jeopardy started on 6/2/20. The Immediate Jeopardy was identified on 6/15/20. The Administrator was notified of the Immediate Jeopardy on 6/15/20 at approximately 3:05PM, and a plan to remove the immediacy was requested. The immediacy was removed on 6/16/20 as verified onsite. Although the immediacy was removed, the facility remained out of compliance at the scope of isolated and a severity of potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency. Review of a facility reported incident date of 6/2/20 documented, in part, the following per the incident summary: Resident (R#801) was observed walking outside of the facility. Resident was assisted back to the facility . Per the incident investigation summary it was revealed, in part, On 6/02/2020 around 6:10PM (LPN 'B') heard the door alarm sounding. She immediately responded by searching for the exit door on the upper level of the Facility. (Licensed Practical Nurse (LPN) 'B') noticed that the emergency exit patio door was alarming . An onsite investigation was completed 6/15/20 to 6/16/20. On entrance to the facility on [DATE] at approximately 8:30 AM an observation of the first floor patio and door was conducted. Observation revealed a door that lead to a small open area approximately six feet that lead to an emergency exit door with a keypad located on the left side of the door. A staff person keyed open the patio exit door and the surveyors exited outside. The patio had several cracks and uneven cement. A rusted handrail surrounded a handicap ramp, unkempt weeds and an old white fence with an unlocked door leading out to a cracked sidewalk was observed. On 6/15/20 at approximately 10:20 AM, R#801 was observed in their room in their bed. The resident was asked if they went outside, and said that they did. R#801 was queried as to whether the police had ever had to help them come back to the facility and said no. R#801 was queried as to whether they needed someone to go with them when they went out, and R#801 responded they did not. The resident was queried as to where they liked to go when the went out, and R#801 responded to go home. No staff person/one-to one staff supervision was observed in the room with R#801 at the time of the observation. The clinical record for R#801 was reviewed and revealed the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's quarterly minimum data set (MDS) assessment dated [DATE] documented the resident scored 4 out of 15 on a brief interview for mental status exam, which indicated the resident was severely cognitively impaired. Per this assessment it was documented the resident did not display wandering behavior, and the resident was assessed as not steady and only able to stabilize with staff assistance for balance during transitions and walking. Review of Letters of Guardianship for R#801 revealed the resident, documented as a legally incapacitated individual, had been appointed a full guardian on 8/15/19. Guardianship was documented as being active through 7/3/20. Review of physician orders [REDACTED]. Review of a police report dated 6/2/20 at 6:19PM documented, in part, the following: On 6/2/2020, I was flagged down at the north entrance of (Facility Name Redacted) by staff member, (CNA 'D'). He advised they had a resident walk away roughly five minutes ago. The resident's name was (R#801). (R#801) was an (physical description redacted), who suffers from dementia. (R#801) was possibly wearing a dark jacket and pants. I advised Officer (Name Redacted) located (R#801) at the intersection of (Street Name Redacted-neighborhood) and (Street Name Redacted-main road with 45 mile per hour speed limit), a few moments later. (R#801) was with a concerned citizen, (Citizen Name Redacted). (Citizen Name Redacted) advised she was driving east on (Street Name Redacted-neighborhood), when she noticed (R#801). She stated (R#801) was walking up the middle of (Street Name Redacted-Neighborhood), and stopped to check on her when Officer (Name Redacted) pulled up. (R#801) appeared to be in good health, but did not want to be transported back to (Facility Name) by officers. However, (R#801) consented to (Citizen Name Redacted) transporting her back. (Citizen Name Redacted) transported her back as Officer (Name Redacted) followed. (R#801) was turned back over to staff without incident . On 6/15/20 at approximately 11:45AM, Surveyors completed a walk to the (Name Redacted) road where R#801 was found by local police. The surveyors exited the patio area and walked down the Facility driveway leading to (Name Redacted) main road. The speed limit was observed to be 45 MPH. A left turn was made on the west side sidewalk which ended after a short distance at a dense wooded area. Surveyors crossed the street and continued to walk on the east side sidewalk and then crossed the street to (Name Redacted) street where #R801 was located by local police. The walk was approximately one fifth of a mile. Review of a progress note authored by LPN 'A' for R#801 dated 6/2/20 at 7:11PM documented, in part, the following: .Resident was observed by writer to be sitting in dining room nearest nursing station, once writer completed task with another resident went to locate (R#801) she could not be found as I looked for her in building co- worker went outside and found that she was picked up by a passer by and brought back to facility escorted by police . On 6/15/20 at approximately 10:30 AM an interview was conducted with Unit Manager, LPN A. LPN A was queried about the incident involving R#801 that occurred on 6/2/20. LPN A reported that they were assigned to R#801 during the afternoon shift and at approximately 5:45 PM, R#801 was sitting in the dining room near the LPNs station. LPN A reported that R#801 needed to be monitored due to their history of elopement and wandering. Per LPN A, R#801 tended to exhibit exit seeking behaviors and often would put on a coat, hat and gathers their briefs and inform staff that they were going home in the late afternoon often noted as sundowning. LPN A recalled completing the resident's insulin injection in the dining room and leaving the area to perform wound care for another resident. LPN A reported that as they left R#801 they noticed that LPN B was sitting at the A/B Nursing Station and thought they could keep an eye on R#801. LPN A indicated that R#801 was to have a 1:1 sitter that evening, but the scheduled staff person never arrived during the shift. LPN A indicated that they completed the wound care on the resident and returned to the dining area and noticed that R#801 and LPN B were no longer in the dining room area. LPN A stated, sometimes R#801 walks on her own so I went to look for them. I contacted LPN B and told her that I was looking for R#801, by that time the police had brought R#801 back to the Facility. I later learned that R#801 was brought back to the Facility by a bystander that found her on the street, the police followed R#801 who was in the bystander's car back to the Facility. LPN A was queried as to whether R#801 wore a (name redacted) wander device (an elopement/wander control system used to provide alerts through an alarm system as a notification of exit) and reported that R#801 did wear the device. When asked whether she could hear the wander device alarm, LPN A reported that she could not hear the wander alarm or the exit door alarm and indicated that LPN B who was in the bathroom could not hear the alarm from the bathroom.

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) When further queried as to whether R#801 was assigned a Certified Nursing Assistant (CNA), LPN A reported she believed it was CNA D. An interview was conducted 6/15/20 at 12:30 PM with CNA D. CNA D reported being assigned to R#801 and recalled that during the dinner hour on 6/2/20, they were in a room assisting two residents with feeding. Following the feeding completion, CNA D exited the room to dispose of the dinner trays and was asked by LPN B to assist in looking for R#801. CNA D stated that he did not hear an alarm sounding, but LPN B was able to determine that the door to the patio had alarmed. CNA D stated, I told her (LPN #B) we should check the old entry first floor door and when we did not see R#801 in the parking lot, I headed closer to (Name Redacted) road looking for a resident. I waived down a police car. I gave a description and the officer called another officer and they found R#801 down the street with a bystander. The bystander brought R#801 back to the Facility in a car with the police officer following. When queried as to whether R#801 had ever left the Facility prior to 6/2/20, CNA D stated there was one time when she left, but it was a different door and someone heard the alarm and we were able to quickly get them back in the building. Review of a progress note authored by LPN 'B' for R#801 dated 6/2/20 at 11:01PM documented, in part, the following: .Writer was in restroom when alarm sounded. Alarm indicated that patio side door was open. Writer and attending aide went to searched <sic> for patient, patient was not in sight. Police officer rode pass <sic> and asked if Aide and I were searching for someone and her said <sic> that he seen <sic> someone walking towards (Road Name Redacted). Writer and Aide continued to search for patient. Police officer drove pass <sic> again and stated that the patient was being brought back to facility by someone who had passed accompanied by police. Primary LPN aware of incident, endorsed over to assigned LPN (LPN'A') . A phone call was placed to LPN B on 6/15/20 at 11:01AM, and a voicemail message was left at this time. On 6/15/20 at approximately 2:15 PM, LPN 'B' returned the telephone call and an interview was conducted pertaining to the elopement of R#801. LPN B reported that on the evening of 6/2/20 around 5:45 PM they were passing medication along the B unit. They indicated that they were not assigned to R#801 and knew that CNA D was. At some point, LPN B left the unit to use the restroom located off the A/B unit near the first floor lobby area. LPN B stated that while in the bathroom they did not hear any alarm(s) sounding, but heard an alarm after exiting the bathroom. LPN B reported that at the A/B unit they were able to determine an alarm was sounding at the side patio door per the alarm indication box. At that time LPN B did not know who or if a resident was missing and asked CNA D to assist. CNA D ran out to (name redacted) main road and CNA D flagged down Police Officer and reported that a resident was missing. Police Officer F made contact with Police Officer G who described a person that was found by a bystander. LPN B was queried as to whether R#801 was at risk for exiting and was monitored by 1:1 staff on the date at issue. LPN B was not sure if there was a 1:1 monitoring for R#801 that evening, but indicated that R#801 did have 1:1 assistance in the past. Continued review of R#801's medical records revealed a wandering risk scale assessment for R#801 dated 2/17/20 identified the resident as being at high risk to wander, scoring 13 on the assessment. Per the assessment question responses R#801 could not follow directions, was ambulatory, could communicate, had a history of [REDACTED]. It was noted per the assessment a score of 11 or greater would identify a resident as high risk to wander. Review of documentation provided by the facility revealed that on 5/2/20, the month prior to the resident's elopement on 6/2/20, R#801 had triggered their wandering alarm device and had been found sitting on a bench outside an exit door to the facility. Per a plan of care for R#801 created 12/19/19 and initiated on 2/21/20 it was documented, Resident is an elopement risk and/or exhibits wandering behavior r/t (related to) attempts to exit building. Per an intervention dated 6/2/20 it was documented, 1:1 supervision 24/7 related to elopement with no injuries on 6/2/20. On 6/15/20 at approximately 11:10 AM an observation and interview was conducted with Maintenance Director Staff C. Staff C was queried as to the system used that alerts the Facility that residents and others are leaving through locked exit doors, including the patio door. Staff C was asked to set the alarms off at two locations utilizing both the fire exit alarm as well as the (Name Redacted) wandering alarm system. A wander alarm sensor to alert staff was observed approximately 12 feet away from the front door to notify staff. A second alarm would sound if anyone including a resident would push on the front door. Both alarm sounds were the same tone. An observation of the patio door alarm system was made. Staff C explained that there was not a delay in when the (Name Redacted) wandering alarm wound be set off and when the patio door would alarm. It was observed that the alarm was set off at the same time and Staff C explained that the alarm was localized. When queried as to whether staff are able to hear the alarm sound in the building, Staff C reported that in some rooms the alarm noise could not be heard and that they were working on increasing the noise level. They were also working on making a differentiated noise so that staff would know if a resident wearing a (Name Redacted) wandering alarm had passed the sensor and was heading to a door. On 6/15/20 at approximately 1:20 PM an interview was conducted with Staff Scheduler E. Staff E had been working as the Facility scheduler for one month. When queried as to 1:1 scheduling for R#801, Staff E reported that 1:1 scheduling orders would be reported to her by either the Unit Manager or DON. With respect to R#801, Staff E reported a staff member was scheduled to provide 1:1 monitoring on the 6/2/20 afternoon shift. On 6/15/20 at approximately 2:20 PM an interview was conducted with the Administrator and Director of Nursing (DON) persuant to R#802's elopement on 6/2/20 and 5/2/20. The Administrator reported that on 6/2/20 at approximately 6:35 PM she was informed by LPN A that R#801 had exited the building and was located on a street off the main road by a bystander and brought back to the Facility in the bystander's vehicle. The Administrator indicated that R#801 had a history of [REDACTED]. When queried as to what interventions were put into place following R#801's exit on May 2, 2020, the Administrator indicated that R#801 was placed on 1:1 monitoring for 72 hours, staff received in-service training regarding the Facility's elopement policy and continued attempts to monitor and redirect the resident were made. When queried as to whether 1:1 monitoring was provided on 6/2/20 as indicated by Staff E, the Administrator indicated that she did not believe any 1:1 was ordered for R#602 on 6/2/20. The Administrator reported that the Facility had been working to make adjustments to the alarm system, including an increase in volume and stated, Patients should not even be able to get to the patio door, we should have responded faster. The Administrator further explained that Facility Policy required staff to initiate a Code Yellow which would alert the Facility as to a missing resident and indicated that it was not performed on 6/2/20. On 6/16/20 at approximately 9:15 AM the Surveyor heard an alarm sounding while sitting in a room near the first floor lobby entrance door. Following the alarm sound, the DON who was sitting in their office located near the Patio door was asked if they had heard the alarm sound. The DON stated, No. On 6/16/20 at 10:40 AM the Facility Elopement logbook located at the A/B Nursing Desk was reviewed. The logbook contained documentation for two residents noted for exit seeking and included R#801. The documentation provided a black and white photo of R#801 and listed general information including the residents room number. It was noted that the room number located on the document was incorrect. Review of a facility policy titled, Elopement dated 7/11/18 and revised on 2/5/20 revealed, in part, the following: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement .3. All residents who are at risk for possible elopement/wandering shall be accompanied by staff or responsible party when leaving the residents unit and/or facility grounds. 4. Residents at risk for elopement shall be identified in the Elopement Book. The book will have the list of all residents assessed to be at risk for elopement with their name, room number and photo .5. When a door alarm sounds, staff members shall immediately respond to determine the cause of the alarm. a. The staff person responding to the alarm will check the outside of the building/vicinity of the area to determine if a resident has exited the building. b. If upon investigation no reason can be found for the sounding of the alarm, the Administrator/D.O.N./designee must be notified. c. A head count will be initiated on all the units and completed accounting of the residents will be given to the Administrator/D.O.N . Also per the policy was the following: The following procedure is utilized when a resident is determined to be missing: 1. Code Yellow is announced with the resident's unit. 2. Note the time that the resident was discovered to be missing. 3. The staff members assigned to the resident's unit report to the nursing station and verify that the resident has not been signed out. 4. Administrator and Director of Nursing are notified if not on the premises .5. Facility management should report to the Incident Command Post for a briefing and instruction. 6. Activate the Incident Command System (ICS) to manage the incident. The most qualified staff member (in regard to the Incident Command System) on duty at the time assumes the Incident Commander position. 7. A thorough search is initiated by staff members to locate the resident. If the resident is not located, proceed with the following: A. Staff members search the entire facility and the grounds. B. All areas of the facility, ground, and neighboring streets within a 1 mile radius from the facility are systemically searched The facility submitted the following accepted plan of removal: (Facility Name) Action steps taken to remove immediacy: 1.On June 2.2020, resident returned to facility and was immediately assessed and found no injuries. 2. 1:1 around the clock supervision was immediately assigned to resident on 6/2/2020 and continues. 3. Fire doors were assessed and found functional. 4. (Brand Name) guard was assessed and found functional. 5. Resident exited through the fire door and courtyard gate. The courtyard gate was assessed, and the latch was functional. 6.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Maintenance monitors the gate and exit doors daily to ensure operational. 7. No other residents are at risk for elopement. Residing residents were assessed, resident 801 only resident identified as elopement risk based on exit seeking behaviors. 8. Staff that stated they did not hear the alarm was proven to be false. During elopement drill on 6/3 and 6/4, staff in the same location was able to hear and respond to the alarm appropriately. 9. Staff was educated and informed during drill to pay attention, not to become desensitized to sounds and respond to alarm sounding per policy and training to ensure safety of residents. 10. (Company Name Redacted) company was contacted to assess current system to add a destinctively different sound for the (Brand Name-alarm/alert device for wandering). 11. Maintenance ensure the alarms were at maximum volume.