STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235242	A. BUILDING _____ B. WING _____	**08/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULEVARD MANOR, LLC	**464 E GRAND BLVD DETROIT, MI 48207**

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 intake: MI 722 Based on interview and record review, the facility failed to report the unknowing departure of a vulnerable resident (#801) from the facility to the State Agency; resulting in the potential for additional vulnerable residents to leave the facility without the knowledge of the State. Findings Include: On 8/7/20 at 12:30 P.M., a record review of an Incident/Accident (I/A) Report dated 7/29/20, read (in part): Resident #801 left the facility Against Medical Advice (AMA) (Leave without physician's advice counsel releasing facility and staff of potential negative outcomes associated with the resident's decision) by climbing out of a window onto a platform of the facility. The resident then took a cab to St. John's Hospital. Review of the Admission Record revealed R#801 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] indicated R#801 had a Brief Interview for Mental Status (BIMS) of 15 which indicated intact cognition and required limited assist for Activities of Daily Living (ADLs). The facility conducted an investigation which revealed on 7/29/20 between 6:00 A.M and 6:15 A.M., R#801 stated, to the midnight Security Staff D he wanted to leave the facility. The resident was instructed to wait until Social worker E and doctor was in the facility. The resident left the ground floor and returned to his room located in a private room on the first floor. At approximately 6:30 A.M., the nurse reported to the supervisor at change of shift that R#801 had left the facility. On 7/29/20 at 6:50 A.M., during routine rounds, the Security Staff D reported he noted from outside a sheet hanging from the platform outside of the front door and the window shifted out of the frame. He Notified the nurse to check the area right above the window. Elopement protocol and head count identified R#801 had removed the window frame and used a sheet to climb down to exit the facility. Further inspection by Maintenance Director A revealed the resident's window was broken and the resident had used a butter knife on the windowsill and all the stop gap screws had been removed. The resident accessed the window, climbed out and used a drawer from his nightstand to provide a stepping area when he stepped out of the window onto the platform. A sheet was used to aid him in lowering himself to the ground floor to exit. The drawer was located on the platform and removed. At approximately 8:30 A.M., Social Worker E arrived at the facility and contacted an emergency contact person, who informed her R#801 was on his way to Local Hospital J because he did not want to wait for security to let him out. Later the same day (no time documented), the facility staff confirmed R#801 had no injuries but was held in observation at the hospital until 7/30/20. On 7/29/20 (no time documented), while R#801 was in the hospital, Social Worker E completed a full review of the resident's chart and verified that the resident was alert and oriented times (x) 3. A phone interview was conducted with the resident, then an in-person interview with the resident was conducted at the hospital where the AMA process was explained. The resident signed the AMA paperwork dated 7/30/20. On 8/7/20 at 3:00 P.M., during an interview with the Interim Administrator and Unit Manager, both explained they thought when the resident left the facility and was found unharmed, no additional agencies had to be contacted, since the facility reported the incident to the police and Adult Protective Services. The Interim Administrator reported staff met and they decided to follow their facility's policy. The resident was alert and oriented x 3, no abuse occurred, and he wanted to leave. A request was made to review the policy which was presented. On 8/7/20 at approximately 3:20 P.M., A policy titled Elopement/Missing Resident/ Code Pink dated September 2019 documented the following: A resident missing more than 2 hours (less if there is strong potential to become an immediate threat to life, such as inclement weather) must be reported to the Division of Nursing Home Monitoring Licensing Officer responsible for the facility. Notify the family or responsible party and the Attending Physician. Administrator or Command Center will notify the State of Michigan per emergency reporting procedure.

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