STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235057	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Livonia	28550 Five Mile Rd Livonia, MI 48154

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 to resident health or safety 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** 46956 This citation pertains to Intake M100143712. Based on observation, interview and record review, the facility failed to provide monitoring, supervision and door alarm response to prevent the elopement of one (R901) of six residents reviewed for elopement, who was a known elopement risk and wore a Wanderguard (ankle bracelet used to set off an alarm restricting a resident from walking out the door). R901 eloped from the facility on 03/25/24 at 9:10 PM unbeknownst to staff until 5:15 AM on 03/26/24. R901 was located in the community approximately 12 miles away from the facility at 1:30 AM on 03/29/24. R901 was able to exit the facility, triggering the alarm system wearing a Wanderguard without staff being aware for appoximately eight hours. R901 was outside without food, medication, shelter or heat in a heavy traffic area and reportedly was sleeping in abandoned houses on nights when temperature ranged from 23 to 45 degrees farenheight wearing only a jogging suit and open-faced sandals with socks. R901 was located after four days and was subsequently hospitalized for five days. This deficient practice resulted in the likelihood of serious injury, serious harm, serious impairment, or death. Immediate Jeopardy: The Immediate Jeopardy (IJ) started on 03/25/24 and the immediacy was removed 03/29/24 when the resident was located and per review of the facility's responding interventions as verified onsite on 04/04/24. The IJ was identified on 04/03/24 during an abbreviated survey. The facility was notified of the IJ on 04/04/24 at 3:45 PM and asked for a removal plan. Findings include: Review of the facility record for R901 revealed an admitted [DATE] with diagnoses that included Schizoaffective Disorder-Bipolar Type, Anxiety Disorder, Violent Behavior and Vascular Dementia. (continued on next page)

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.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Initial review of the Facility Reported Incident indicated that R901 was identified as missing from the facility on 03/26/24 at approximately 5:15 AM and their whereabouts remained unknown until being located and secured at approximately 1:30 AM on 03/29/24 approximately 12 miles from the facility. The report indicated that R901 was taken to (name of local) hospital after being located. Further review of R901's facility record revealed a Wandering/Elopement Risk assessment dated [DATE] that was scored 10/11 and indicated the resident was considered at risk for elopement and had a history of elopement. R901's care plan dated 01/12/24 included the Focus statement [R901] is an elopement risk related to history of attempts to leave the facility unattended, impaired safety awareness and wandering throughout the facility. Care plan included the Intervention items Redirect resident when wandering or is exit seeking and Wanderguard (left ankle), check placement every shift and function daily. R901's physician orders included the order Wanderguard: Check placement left ankle every shift for wandering risk dated 01/05/24. On 04/03/24 at 11:32 AM, the facility Director of Nursing (DON) was interviewed and reported that at approximately 5:45 AM on 03/26/24 Licensed Practical Nurse (LPN) A ,who was the supervising nurse at the time, called them and reported that LPN B informed them that when they went to administer R901's morning medication they were not in bed and could not be initially located and that the elopement/missing resident protocol had been initiated. The DON indicated that they notified the facility Administrator (NHA). The DON indicated that the family and the (local) police department were contacted. The DON reported that at approximately 1:30 AM on 03/29/24 a former staff member who was aware of and familiar with the missing resident called them and reported observing R901 nearby. The DON reported that they went to the area and R901's daughter K had arrived and had the resident in their car. The DON reported they went to the vehicle and observed R901 and described them as appearing hypothermic .shivering. [They] didn't have a coat on. I asked [them] if [they] had eaten and [they] said No but later at the hospital [they] said people had given [them] food at times. [They were] wearing a jogging suit, socks and flip flops. I asked [them] where [they] had stayed and [they] told me In abandoned houses. The DON confirmed that R901 was found with the Wanderguard in place. On 04/03/24 at 1:22 PM, the Nursing Home Administrator (NHA) reported that R901's family member reported the resident told them they had watched a staff member enter the door code then later went out the front entrance by entering the code. The NHA reported that they were initially led to believe, based upon staff interviews, that the resident left the facility sometime between approximately 3 AM and 5 AM on 03/26/24 but they were subsequently made aware, via the police investigation of surveillance from a business across the road from the facility, that R901 had been outside that business at approximately 9:15 PM on 3/25/24 indicating that the resident had actually been out of the facility for approximately eight hours prior to staff realizing they were gone. On 04/03/24 at 2:00 PM, Sergeant J of the (name of local) police department was interviewed via phone and reported that R901 was viewed on surveillance footage walking into a liquor store on the opposite side of (name of high traffic road) from the facility at 9:16 PM on 03/25/24. Sergeant J reported that subsequent viewing's of R901 via community surveillance footage included one at 9:59 PM 03/25/24 near (names of two high traffice roads) and then at a (name of local) gas station at 10:36 PM 03/25/24. Sergeant J reported that during the initial investigation at the facility the officers noted that the exit door near the laundry, three doors away from the residents room, was ajar and did not appear to be alarming properly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/03/24 at 3:20 PM, R901's daughter K was interviewed via phone and reported that R901 did tell them that they had left the facility by exiting the main entrance by using the code which they learned from watching a staff member enter the code. Daughter K reported that R901 appeared quite cold and reported being hungry when they were located. On 04/03/24 at 3:56 PM, LPN G was interviewed via phone and confirmed they worked the evening of 03/25/24 and did recall R901's elopement incident. LPN G reported they encountered R901 at approximately 8:56 PM on 03/25/24 near the vending machines because R901 had asked if LPN G could buy them a pop. LPN G reported they were able to verify the time of the encounter because their vending transaction was time-stamped on their phone which was used to make the purchase. On 04/04/24 at 9:23 AM, the facility Maintenance Director (MD) H was interviewed and reported they came in to work the morning following R901's elopement and were made aware of what occurred. MD H reported the door/alarm checks on the morning following the incident revealed no problems or malfunctioning equipment. They reported the doors and alarms are checked daily and there had been no recent functional failures identified and a door/alarm company had completed an assessment during the previous week and found everything to be functioning properly. MD H completed a check of all the facility exit doors including use of a wanderguard with the surveyor with the following findings noted: - The D-Wing door did not have a Wanderguard sensor. - The first set of Lobby/A-Wing doors and the first set of B-Wing East doors were the only doors that triggered the alarm when the Wanderguard was in proximity to the door. The remaining nine exit doors did not alarm until they were pushed. On 04/04/24 at 10:57 AM, LPN G was interviewed via phone and reported that they could not recall hearing a door alarm anytime following their interaction with R901 at the vending machine at 8:56 PM on the evening of 03/25/24. On 04/04/24 at 11:07 AM, LPN B reported that they were working on R901's unit the evening of 03/25/24 and said they did not recall hearing a door alarm. On 04/04/24 at 11:30 AM, LPN A was interviewed via phone and confirmed they did work the evening of 03/25/24 and they did not recall hearing any door alarms. On 04/04/24 at 11:43 AM, Certified Nursing Assistant (CNA) I was interviewed via phone and reported they did work the evening of 3/25/24 and they did not recall hearing or responding to any door alarms. On 04/04/24 at 11:49 AM, R901 was observed and interviewed in their room. R901 acknowledged they had left the faciity on the evening of 03/25/24. When asked how they left the building they stated they didn't remember. When asked if they were cold while they were out of the building they stated Yes. When asked if they were hungry while they were out they stated Yes. When asked where they stayed at night they stated Wherever I could. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/04/24 at 4:25 PM, the NHA and DON reported their understanding was when R901 exited the facility the door alarms did sound and that staff did not respond, leading to the eight hour timeframe that staff were unaware that R901 was out of the facility. The NHA reported that the expectation is that resident's identified as an elopement risk would not be able to leave the facility unsupervised. Review of the facility policy Elopement dated 10/19 revealed the Purpose statement Care Team Members who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action is taken. The policy also includes the Procedure entry: 5. Care Team Members will be educated to check the surrounding outside area when the door alarms to ensure no residents have exited the facility unattended. Facility Removal Plan: 1. Corrective Action for Affected Individual(s). -Upon return from the hospital resident was placed on 1 on 1 with Wanderguard in place to reduce the risk of resident leaving the facility without supervision as [NAME] is alert and oriented times three spheres, but her cognition and behavior may fluctuate. -Resident's medication has been reviewed. -The facility will continue to assess the resident and work with family and physician to devise a sustainable action plan. 2. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 3/26/24) An ad hoc QAPI meeting was held on 3/26/24 with ED, DNS, IDT, and Medical Director updated to review the incident, and developed the following action plan. -All current resident's elopement risk evaluations were reviewed and updated with care plans reviewed and updated as needed. -Elopement policies were reviewed on 3/26/24. No revisions made to the current policies -Elopement investigation procedure and documentation process were reviewed on 3/26/24. No revisions made to the current procedures and processes. -Elopement binders reviewed for accuracy on 3/26/24. -UM/Designee reviewed progress notes M-F to identify any resident documented or expressing exit seeking behaviors with appropriate interventions put in place. -Elopement assessment completed for all at risk residents and audit completed for 2 months, and new admits who are assessed to be at risk will be reviewed for Wanderguard placement. (continued on next page)

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