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	08/01/2024

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 - Minimal harm or potential for actual harm 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** 38207 This citation pertains to intake MI00145985. Based on interview and record review, the facility failed to prevent the elopement of one resident (R700) of three reviewed for accidents and supervision. Findings include:: An incident and accident (I/A) report involving R700 was reviewed and revealed the following: Date: 7/25/24 23:22 (11:22 PM0 Incident Location: Outside. Incident Description: Nurse was informed by midnight staff that [R700] was not in [their] room or bed when [they] went to do rounds. Injuries Observed at Time of Incident: Injury Type: No injuries observed at time of incident. A progress note reviewed in R700's electronic medical record (EMR) revealed the following, 7/26/2024 00:49 (12:49 AM) Writer received call from charge nurse .stating that [R700] got out of the facility and an active code green (code used in potentially life threatening situations) was in place .Police [were] called. [R700] Returned to [the] facility with nurse, with no signs [or] symptoms of distress or injury. Further review of R700's EMR revealed R700 was most recently admitted to the facility on [DATE] with diagnoses that included Schizoaffective disorder and Stroke. R700's most recent minimum data set assessment (MDS) dated [DATE] revealed R700 had a severely impaired cognition and required setup-touch assistance for all activities of daily living (ADLs). R700 was petitioned and sent to the hospital on 7/26/24. On 8/1/24 at 2:00 PM, a phone interview was attempted with Licensed Practical Nurse (LPN) A regarding the incident involving R700. No answer. Left voice mail. A written statement documented the following, LPN A reported that .[they] were in their vehicle .located [R700] walking on [the road] .[R700] got in [the car] .[R700] was free from any distress or injury. On 8/1/24 at 2:07 PM, a phone interview was attempted with Certified Nurse Assistant (CNA) B regarding the incident involving R700. No answer. Left voice mail. A written statement documented the following, CNA B reported [they were] assigned to [R700] .and last saw [R700] at approximately 9:30 [PM] .CNA Reported that sometime after 10:00 PM, [they] stepped away from resident care because [they] heard an alarm sounding and upon getting to the .nurses' station [they] observed another employee turning the alarm off and [they observed] a new [food delivery] that had been placed at the desk near the alarming door . (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 2:24 PM, a phone interview was attempted with CNA F regarding the incident involving R700. No answer. Left voice mail. A written statement documented the following, CNA F reported when [they] did [a] bed check on [R700] at approximately 11:45 PM [they were] unable to locate [R700] and immediately began a search. CNA F did not recall hearing any alarms prior to being unable to locate [R700]. On 8/1/24 at 2:35 PM, an interview was conducted with the Nursing Home Administrator (NHA) regarding the incident involving R700. The NHA reviewed the investigation completed by the facility regarding the incident. A facility policy titled Elopement (Risk and Missing Resident) Original Date: October 2019 was reviewed and stated the following, Policy: Purpose: 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. On 8/1/24, the facility provided documentation to address the incident which occurred on 7/25/24. A summary of this plan included the following: (Name of facility) 7/26/24 Past Noncompliance: 1. Corrective Action for Affected Individual(s). Upon return to the facility the resident remained on 1:1 until transfer to the hospital for mental health treatment. Upon returning to the facility and being assessed to have no injury and no psychological distress, resident was interviewed by Education Director (ED) and Director of Nursing Services (DNS or DON) and demonstrated how she exited the facility. 2. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the 1. Corrective Action for Affected Individual(s). citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 7/26/2024) An ad hoc Quality Assurance Program (QAPI) meeting was held on 7/26/2024 with ED, DNS and Interdisciplinary Team (IDT). 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 7/26/2024. No revisions made to the current policies Elopement investigation procedure and documentation process were reviewed on 7/26/2024. No revisions made to the current procedures and processes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Elopement binders reviewed for accuracy on 7/26/2024. Unit Manger (UM)/Designee reviewed progress notes M-F to identify any resident documented or expressing exit seeking behaviors with appropriate interventions put in place. o 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. o All residents in the facility were assessed to determine their wandering/elopement risk with care plans, reviewed, and elopement binder updated to reflect high risk wandering residents on 7/26/2024. The Maintenance Director completed assessment of all exits to verify doors are functioning properly, and door alarms were all working properly on 3/26/24. The Administrator or designee immediately ensured the safety and well-being of the residents who were at risk for elopement by auditing all door alarms to ensure they were working properly on 7/26/2024. All code alert bracelets currently in use were checked for placement, function, and expiration date by Licensed Nurse 7/26/2024 and were functioning properly. Therapeutic Leave (LOA) process was reviewed on 7/26/2024, and no revisions were made. 3. Systemic Changes to Prevent Recurrence: An exterior location for after-hours food/grocery deliveries was implemented with signage that directs delivery drivers to leave deliveries in a sheltered location outside of the alarmed doors to prevent residents from following drivers out of the building. DON/designees started education on 7/26/2024, with all staff on Elopement risk/ Missing resident process with emphasis on when alarms are sounding to respond immediately, start head count, check the perimeter, frequent checks, and reporting any residents stating they want to leave immediately to nurse supervisor, The DON/Designee educated staff on LOA Process. 100 % of staff have been educated. Staff members are not permitted to work a shift until education has been completed. Nursing will complete every two-hour checks on residents that are a high risk for elopement resident to validate that they in the facility. The Administrator or designee educated staff on checking the placement and function of code alert bracelets, along with verifying expiration date. 4. How the Facility Will Monitor its Corrective Action. On 7/26/2024 QAPI meeting was completed to review action plan with ED, DNS, IDT, and directed the following audits to be conducted with results reported back to the QAPI committee for further follow up and review until otherwise directed by the QAPI committee: (continued on next page)

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