STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte St L' Anse, MI 49946

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** 35103 Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent an elopement for one Resident (R1) out of three residents reviewed for elopement. This deficient practice resulted in an unsupervised exit from the facility and unsafe ambulation and wandering off facility property for a cognitively impaired Resident. Findings include: Resident #1 (R1) Review of the facility Incident Investigation of R1's elopement from the nursing home on 4/7/24 at 6:06 p.m., revealed the following information: Visitor entered building and allowed [R1] to exit. R1 was back in the building by 6:15 p.m.; with staff at 6:13 p.m. Staff were alerted to a possible resident outside of the facility . R1 was off facility property . (Elopement verified) . Administrator (NHA), had a discussion with the wife of the visitor who opened the door . She verified it was her husband who opened the door and stated that he doesn't visit regularly and isn't as familiar with the residents as she is (and allowed R1 to exit the building as he entered). Review of R1's Minimum Data Set (MDS) assessment, dated 4/4/24, revealed R1 was admitted to the facility on [DATE] with active diagnoses that included Alzheimer's disease, anxiety, depression, psychotic disorder, and hallucinations. R1 scored 4 of 15 on the Brief Interview for Mental Status (BIMS)reflective of severely impaired cognition. R1 was noted to have clear speech and was sometimes able to be understood and to understand others. R1 was independent in ambulation, had no functional limitations to her range of motion and did not wear a wander/elopement alarm. R1 was documented to have Wandering behavior 1-3 days out of 7 days. R1's Section E - Behavior was documented that R1's wandering did not place them at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility) . Review of the Elopement Risk binder, located at the nurse's station, revealed R1's Admission Record, including photograph, was placed in the binder with 13 other facility Residents identifying all residents in the binder as being an elopement risk. Review of the Weekly Code Alert Checks form, revealed seven residents who had a Code Alert transmitter placed on their person or wheelchair which would alarm when they were within approximately three feet of an exit door or the elevator door. R1's name was not on the Weekly Code Alert Checks form. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/24 at 9:41 a.m., the Code Alert policy was requested from Registered Nurse/MDS Nurse (RN) A who said the facility did not have a policy related to the placement of wander guard alarms on residents in the facility. Witness statements by facility staff were reviewed on 4/22/24 at 9;15 a.m. that included the following statements provided by Licensed Practical Nurse (LPN) E, Certified Nurse Aide D, and Activity Aide F on 4/7/24 following R1's elopement. LPN E documented: Writer feeding resident at 1810 (6:10 p.m.) when a conversation was overheard about a resident and getting out of the building. Writer approached RN on the floor and we both decided writer would go get resident from the gas station - halfway there writer was stopped by a vehicle - person had resident in car - resident brought back to facility. CNA D wrote: .At the end of dinner when picking up trays, [Unidentified Resident's] daughter came up to me and asked if I was missing a patient and showed me a photo on her phone of [R1] at [nearby gas station]. [LPN E] came out of [a resident] room and ran after R1 (toward the gas station). Activity Aide F wrote: I brought her dinner into her room at 5:35 p.m., [R1] left the building at 6:05 p.m., I took my break at 6:08, and did not see patient in driveway/parking lot. During an interview on 4/22/24 at 9:55 a.m., R1's Family Member (FM) B was interviewed regarding R1's elopement from the facility. FM B stated, I don't feel like that alarm (Code Alert) is my responsibility. They (facility administrative staff) knew she had cut about five of them off . [R1] is sharp and they (Code Alerts) are plastic. I told them that the facility was liable if something happened to (R1) . They (facility staff) did not tell me who brought her back to the facility .They are lucky because R1 is something else . They should have somebody at the door when somebody (a resident) is watching the door, but on weekends you have nobody here . It is because they don't have enough help. Staffing is much less during the weekend than during the week . There are times I come up here, and there is nobody around the nurse's station . When I tried to call them back (after notification of R1's elopement) nobody answered the phone . During an interview on 4/22/24 at 10:25 a.m., RN A confirmed it was another Resident's Family Member (FM)G that took a picture of R1 at the gas station and upon arriving at the facility on 4/7/24 to visit her family member, asked staff if they were missing a resident. FM G provided a photograph of R1 she had just taken at the gas station. Staff were unaware that R1 had exited the building. Review of R1's Elopement Evaluations dated 6/28/23, 1/2/24, and 4/8/24 had the following scores, respectively: 5, 2, and 5. The 1/2/24 Elopement Evaluation had the second question: Does the Resident have a history of elopement or an attempted elopement while at home? question answered as NO, while the other evaluations prior and post elopement were documented with YES. The Elopement Evaluation form reads, in part: . Score value of 1 or higher indicates Risk of elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/24 at 11:07 a.m., RN K confirmed the name of the individual who placed R1 in a vehicle and returned her to the facility on [DATE]. The individual Witness J was a former employee of the facility and recognized R1 as a Resident from the nursing home. During a telephone interview on 4/22/24 at 2:05 p.m., the Director of Nursing (DON) was asked how they determine if a Resident will have a Code Alert placement. The DON initially stated, Their risk assessment (elopement evaluation) determines if they get a code alert. The DON confirmed R1 did not have a Code Alert transmitter as she had cut it off multiple times, and it was care planned not to be placed on her. When asked about identification of elopement risk for residents whose documentation was in the Elopement Risk binder, the DON stated, We triggered the elopement risk off of assessments (elopement evaluations). Anybody who triggered (as an elopement high risk) went into that elopement book, until we can narrow down a process of who needs a wander guard. The DON confirmed that there was no consistent process, procedure, or policy for determination of the Code Alert placement on a resident who is an elopement risk. Observation of the surveillance video from R1's elopement from the facility on 4/7/24, showed the following: 6:03 p.m. R1 sitting by the front entrance, walked by entrance doors, pushed on entrance doors, and stands in front of the door. 6:03:59 p.m. - R1 walked away from the door and goes to sit by the front window where a table is located. Looking out front window. R1 appears to see a visitor approaching from outside and walks to the front entrance doors. 6:03:35 - Visitor enters code on exterior side of entrance doors, doors open, visitor enters, R1 immediately walks through the open set of entrance doors to the outside. No staff were present near the entrance doors at the time of R1's exit. 6:08:35 - Two staff members (including Activity Aide F) exit the building. Appears to be unrelated to elopement - as they slowly exited and did not appear in a hurry. 6:12:03 - FM G arrives at facility in vehicle and enters building (with photograph of R1 for staff to identify). 6:13:14 - LPN E runs out the entrance doors in the direction of the gas station. 6:14:11 - Car drives up. R1 gets out of passenger side of vehicle. Car driven by Witness J. 6:16:20 - R1 comes back inside of building. During a telephone interview on 4/22/24 at 2:51 p.m., Witness J confirmed she had returned R1 to the facility in her vehicle on 4/7/24. Witness J stated, .I was getting gas, and then she (R1) started walking right towards me . I told her to stay with me and I got done putting gas in my car and I asked [R1] to come with me for a ride. She just hopped in the car with me .When I started driving down (to the facility) [LPN E] was running up the hill with a terrified look on her face. I said, 'I got her' (R1). [LPN E] looked relieved. Two CNAs were getting into a car across the parking lot. I was ready to get her out of the car, but they (CNAs) got her out. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Elopements and Wandering Residents policy, implemented 6/15/23, read in part: Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering. a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff .