STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235374	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Oaks Senior Care & Rehab Center	22355 W Eight Mile Rd Detroit, MI 48219

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** 39465 This citation pertains to intake MI00147802. Based on interview and record review, the facility failed to prevent an elopement for one resident (R301) out of four residents reviewed for elopement, resulting in R301 exiting from the facility without staff knowledge and the potential for injury for the resident. Findings include: On 12/05/2024 at 10:00 a.m., an investigation was conducted regarding a facility reported incident dated 10/20/2024. The facility's investigation report revealed in part: .on 10/20/2024 At about 8:00 p.m., R301's assigned nurse (Licensed Practical Nurse (LPN) A went to provide the resident with his evening medication and medication could not be administered because she could not locate the resident. R301's room was checked and all surrounding common areas. Nursing staff immediately called security and code [NAME] alert for missing person protocol was initiated. A total head count of all residents was conducted and only R301 was not accounted for . The resident traveled approximately twelve mile as reported by multiple sighting by family and friends. Resident traveled to the areas that he was familiar with to get a loosie (which is another name for a cigarette out of the pack). Resident also visited his maternal Grandmother's house in the morning and took a nap. Since family member had no knowledge of resident exiting facility without completing his Leave of Absence (LOA) paperwork due to his calm demeanor she left for an appointment and when she returned, he was gone. Resident also was spotted on his uncle's ring camera knocking on his door. The individual who saw resident did not notify facility nor police because they had no knowledge of the resident residing at the facility. The resident was found at 1:30 p.m. by R301's son's girlfriend on 10/21/2024. Resident was transported to (Hospital). Resident had no obvious or visible injuries .Conclusion: Resident chose not to return to the facility and is being discharged to stay with family from the hospital. Plan of Action: 6. Security Guard was suspended pending investigation. One-on-One education was provided to security staff and facility staff on Missing Person and Elopement Policy was reviewed. Employee (Security Guard (SG B) Corrective Action documented, Describe Situation and/or concerns as following: (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 - Minimal harm or potential for actual harm Residents Affected - Few	-SG B was unaware of resident whereabouts, she failed to follow front desk safety protocol during shift. Front desk staff must be alert and at tentative to all entering and exiting the building. SG B will be suspended and placed on a final corrective action. Continued violation of company policies will result in further corrective action, up to and including termination. On 12/05/2024 at 1:34 p.m. SG B was called and was not available for an interview. According to the electronic health record (EHR), R301's was admitted to the facility on [DATE] with diagnoses of congestive heart failure, diabetes mellitus type two, chronic kidney disease stage 3A, alcohol dependence with withdrawal and tobacco use. R301's Minimum Data Set (MDS) with a reference date of 10/16/2024 indicated R301 had moderately impaired cognition with a BIMS (brief interview for mental status) score of 09/15. A care plan with a review date of 7/10/2024 documented, Transfer status: one person assists with ambulation: wheelchair when out of bed. On 12/05/2024 at 1:01 p.m. during an interview, the administrator said after reviewing the facility's camera, R301 left out of the front door after SG B buzzed R301 out. The camera also showed that SG B allowed R301 to exit the facility without being accompanied by someone and without making sure the resident had LOA paperwork. The Administrator said the LOA paperwork is to be fully completed by the resident's assigned nurse on the unit before the resident gets to the security guard desk. The LOA paperwork is given to the security guard and kept until the resident return. Then the resident is buzzed out of the door to leave the facility. The Administrator also said R301 does not go out of the facility on a LOA without accompanied by family who is in the facility to sign the LOA papers. Multiple LOA paperwork with family signatures and return dates and times was presented and reviewed. The Administrator said SG B was in-serviced on checking completed LOA paperwork before letting a resident out of the building. SG B was suspended during the investigation but later resigned. The administration said after requesting a LOA policy that the facility did not have a LOA policy but presented a Elopement policy. R301's assigned Nurse A was called on 10/20/2024 at approximately 1:50 p.m. but the number was a non-working number. According to the facility's revision date 10/23/2024 elopement and/or exit -seeking management policy: Elopement: When a resident leaves a safe or secure area, for an unsafe area without assistance or supervision.