STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235444	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Nursing Center	16588 Schaefer Detroit, MI 48235

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is based on Intake#2993239. Based on interview and record review, the facility failed to thoroughly investigate and elopement for one Resident (R304) of three reviewed for accidents. Findings include: A review of the medical record revealed that R304 was admitted to the facility on [DATE] with diagnoses including Schizoaffective Disorder, Bipolar Type; Delusional Disorder; and Post-Traumatic Stress Disorder (PTSD). The resident's Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact.Further review revealed that an Elopement Risk Assessment completed upon admission on [DATE] identified R304 as being at risk for elopement, with a score of five. Despite the identified risk, the facility failed to develop a care plan or implement interventions to address the resident's elopement risk.A review of the facility's incident report revealed on 4/6/26 at approximately 12:00 a.m., R304 exited the facility through a second-story window and landed on the ground. The resident sustained injuries requiring emergency medical treatment and hospitalization. The report also revealed that staff reported to emergency services.The investigation did not document findings in regard to the resident's ability to exit through the second-story window without supervision and the window safety mechanisms and functionality.The investigation did not include documentation of interviews with all staff involved, an evaluation of environmental factors, or a determination of whether facility policies and procedures regarding elopement prevention were followed.During an interview on 5/26/26, the Assistant Director of Nursing (ADON) stated that an incident investigation was completed following the event. However, the ADON was unable to provide evidence that the investigation included an assessment of why interventions were not implemented despite the resident being identified as at risk for elopement upon admission.During an interview on 5/26/26, the Administrator stated that upon notification of the incident, he came to the facility and initiated the reporting process. The Administrator acknowledged that the focus of the investigation was primarily on documenting the occurrence and reporting requirements. Record review failed to identify evidence that the facility conducted a comprehensive root cause analysis to determine system failures that contributed to the incident or to identify measures necessary to prevent a similar occurrence in the future.Further review of the facility's investigation failed to identify corrective actions addressing the lack of a care plan, absence of elopement interventions, staff monitoring practices, environmental safety concerns, or accountability measures related to the resident's ability to exit through a second-story window.There was no additional information provided by the exit of survey

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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(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 Note: The nursing home is disputing this citation.	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** This citation pertains to intake #2993239. Based on interview and record review, the facility failed to provide adequate supervision and implement appropriate safety interventions for one Resident (R304) of three residents reviewed for accidents, resulting in the resident to have jumped out of a two-story window, fracturing (breaking) their leg and required hospitalization. Findings include:Record review revealed the facility submitted an incident report to the State Agency (SA) which stated, in part, that at approximately midnight, Nurse C heard a noise and entered R304's room. Upon entering, Nurse C observed the resident climbing out of the window. Nurse C attempted to intervene; however, the resident jumped from the window and landed on his feet in the yard below. Nurse C instructed a Certified Nursing Assistant (CNA) to call for assistance while additional nursing staff responded to the scene. Emergency Medical Services (EMS) were contacted, and the resident was assessed. Pain and skin assessments were completed, neurological checks were initiated, and the physician and legal guardian were notified.A review of the medical record revealed that R304 was admitted to the facility on [DATE] with diagnoses including Schizoaffective Disorder, Bipolar Type; Delusional Disorder; and Post-Traumatic Stress Disorder (PTSD). The resident's Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact.Further record review revealed that an Elopement Risk Assessment completed upon admission on [DATE] identified R304 as being at risk for elopement, with a score of five. Despite the identified risk, the facility did not develop a care plan or implement interventions to address the resident's elopement risk.During an interview conducted on 5/26/26 at 1:21 p.m., the Assistant Director of Nursing (ADON) explained that upon admission, nursing staff complete an elopement assessment. The ADON stated that residents identified as high risk for elopement are typically placed on the memory care unit, which is a secured unit. The ADON further stated that social services and security personnel are notified of residents at risk for elopement and that a care plan with interventions should be developed and implemented. When asked about their involvement in the incident involving R304, the ADON stated that they were informed of the event by nursing staff and documented a progress note but did not have direct involvement in the incident itself.On 5/26/26 at 2:48 p.m., an interview was conducted with Nurse C. Nurse C reported that the shift had been uneventful and that R304 had been calm and cooperative throughout the evening. Nurse C stated that the resident was alert, oriented, cognitively intact, ambulatory, and able to move throughout the facility independently. According to Nurse C, the last direct observation of the resident occurred at approximately 10:00 p.m. during medication administration. At that time, the resident displayed no signs of distress and did not indicate any desire to leave the facility.Nurse C reported hearing glass break and immediately proceeded to the resident's room, where she observed the resident's foot at the window. She stated that the resident climbed out of the window and jumped, landing on his feet and sustaining injuries that required hospitalization. Nurse C reported that she immediately called for assistance from other staff members.When asked why she was unable to redirect or physically intervene before the resident jumped, despite observing the resident at the window, Nurse C stated that the incident occurred too quickly for her to prevent it.On 5/26/26 at 3:23 p.m., an interview was conducted with the Administrator and the ADON. The Administrator stated that he arrived at the facility after being notified that a resident had jumped from a window. Upon arrival, the resident had already been transported to the hospital. The Administrator stated that he initiated the facility's investigation and completed the required reporting to the State Agency. The Administrator further reported that, during a follow-up discussion with the physician several days later, he was informed that R304 had sustained fractures in three separate locations of the leg but was otherwise stable.When asked what interventions had been implemented for R304 following the admission assessment that identified the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	resident as being at risk for elopement, both the Administrator and ADON acknowledged that no care plan or interventions had been developed or implemented to address the resident's documented elopement risk.There was no additional information provided by the exit of survey