STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235475	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaconshire Nursing Centre	21630 Hessel 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on interview and record review, the facility failed to (1) timely notify the guardian of an acute change in condition and (2) obtain consent and notify the guardian for a room change to a lockdown unit for one resident (R402). Findings include: Review of the facility investigation and other pertinent documentation regarding a facility reported incident (FRI) that occurred on 4/26/24, revealed that it was reported R402 exited the facility to the outside through his second-floor bedroom window between 10:30 PM and 10:45 PM. R402 was brought back into the facility by Licensed Practical Nurse (LPN) C and transported to the hospital at 11:02 PM. Review of the clinical record documented R402 was admitted into the facility on [DATE] to a standard room (not located on a lockdown unit) with diagnoses that included left calcaneus fracture (non-weight bearing), schizophrenia, and convulsions. According to the Minimum Data Set assessment dated [DATE], R402 had moderate cognitive impairment, and required substantial/maximal assistance for sit to stand. The clinical record also revealed R402 had a guardian with the correct phone number listed on the face sheet. Review of LPN C written statement dated 4/26/24 revealed in part .patient arrived on unit (lockdown unit requiring passcode to enter/leave) placed in room (from a standard room). Resident placed in bed at 10:30. Bedroom checked at 10:45. Window noted in up position. Resident not in bed. Writer proceeded to outside of building. Resident noted resting on knees, both hands touching the ground. Abrasions noted treatment implement. Resident placed into wheelchair and taken inside of building. Resident transported to hospital at 11:02 PM. Doctor, Guardian, Director of Nursing (DON) Administrator called at 11:00 PM and notified. On 7/23/24 at 2:06 PM the Director of Nursing (DON) was interviewed and said that the LPN C was no longer employed by the facility and did not provide contact information. On 7/25/24 at 3:14 PM an attempt to interview LPN D via telephone was made. A message was left on the voicemail for a return call. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 3:15 PM Guardian E was interviewed and stated, I don't have a record of anyone from the nursing home requesting permission to move my resident to the lockdown unit or to change rooms. I did not receive a phone call from the nursing home telling me my resident went to the hospital. I got a call from the hospital on 4/27/24 to inform me that the (R402) was in the hospital with injuries due to fall out the window. We get calls after business hours, and they are recorded and transcribed. Review of the facility policy titled Notification of Changes reviewed 7/20/2024 revealed in part .The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistant with his or her authority, the resident's representative when there is a change requiring notification. The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 1. Accidents a. resulting in injury b. Potential to require physician intervention. 4. A transfer or discharge of the resident from the facility. 5. A change of room or roomate assignement.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 This citation pertains to Intakes MI001444419, MI00145071, and MI00145216. Based on interview and record review the facility failed to provide adequate supervision for one resident (R402) of three residents reviewed for elopements, resulting in a moderately cognitively impaired resident with behavior issues exiting a second-floor window and falling to the ground causing a left tension pneumothorax (collapsed lung), multiple acute rib fractures, left clavicle and scapulae fractures, and thoracic vertebrae fractures. Findings include: Review of the facility investigation and other pertinent documentation regarding a facility reported incident (FRI) that occurred on 4/26/24, revealed that it was reported R402 exited the facility to the outside through his second-floor bedroom window between 10:30 PM and 10:45 PM. R402 was brought back into the facility by Licensed Practical Nurse (LPN) C and transported to the hospital at 11:02 PM. Review of the clinical record documented R402 was admitted into the facility on [DATE] to a first floor standard room (not located on a lockdown unit) with diagnoses that included left calcaneus fracture (non-weight bearing), schizophrenia, and convulsions. According to the Minimum Data Set assessment dated [DATE], R402 had moderate cognitive impairment, and required substantial/maximal assistance for sit to stand. The clinical record also revealed R402 had a guardian with the correct working phone number listed on the face sheet. Review of the care plan date initiated 4/17/24, documented: Focus: I am at risk for injury due to behaviors and impaired cognition. Interventions: I will have a sitter with me when my nurse identify I am at risk for injury or appear to be anxious/restless. Resident has impaired ability to complete activities of daily living care and needs assistance related to behavioral concerns, impaired cognition, impaired coordination, impaired mobility. Resident is at risk for falls and injury related to behavioral concerns, impaired cognition, impaired mobility, noncompliance with safety measure I had a fall on 4/18/24, 4/21/24 and 4/26/24. Interventions Nursing staff will provide me supervision and cueing as needed to maintain safety. Review of the following progress notes documented: 4/17/24 at 18:55 Resident observed in the bed at the beginning of shift. 1/2 hour later resident on both knees at the bedside. 4/18/24 at 19:34 Observed patient sliding on butt next to bedside bed sitting upright. Patient has feces on finger and nails. Gown on with soiled brief. Patient asked where was the gold. 4/21/24 at 14:43 It was reported to the writer that resident was observed on the ground outside. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	4/21/24 at 14:46 resident is A&Ox2 continues to stand and walk with unsteady gait. Resident has sudden episodes of unwanted anger. Writer unable to redirect resident physician notified order for Xanax every 8 hrs as needed. 4/21/24 at 14:50 Late Entry Resident had fall when outside on smoke break with staff and other residents. Review of LPN C written statement dated 4/26/24 revealed in part . patient arrived on unit (lockdown unit requiring passcode to enter/leave) placed in room (on the second floor212 from a first floor standard room). Resident placed in bed at 10:30. Bedroom checked at 10:45. Window noted in up position. Resident not in bed. Writer proceeded to outside of building. Resident noted resting on knees, both hands touching the ground. Abrasions noted treatment implement. Resident placed into wheelchair and taken inside of building. Resident transported to hospital at 11:02 PM. Doctor, Guardian, Director of Nursing (DON) Administrator called at 11:00 PM and notified. On 7/23/24 at 2:05 PM the Nursing Home Administrator (NHA) stated LPN D had the (R402) moved to the second-floor lockdown unit because the resident needed more supervision. On 7/23/24 at 2:06 PM the DON said that the only remaining employee from the incident was LPN D. When asked the reason for moving R402 form the first floor to the second-floor lockdown unit the DON replied, I don't recall. On 7/25/24 at 3:14 PM an attempt to interview LPN D via telephone was made. A message was left on the voicemail for a return call. On 7/25/24 at 3:15 PM Guardian E was interviewed and stated I don't have a record of anyone from the nursing home requesting permission to move my resident to the lockdown unit or to change rooms. I did not receive a phone call from the nursing home telling me my resident went to the hospital. I got a call from the hospital on 4/27/24 to inform me that the R402 was in the hospital with injuries due to fall out the window. We get calls after business hours, and they are recorded and transcribed. Review of the Emergency Department Hospital Admission/Discharge record revealed in part .R402 was admitted to hospital on 4/26/24 and discharged to a skilled nursing facility on 5/14/24. Diagnosis listed as schizoaffective disorder, bipolar type. Overview note This patient with a history of schizoaffective disorder was brought into the hospital after jumping out of second story window. It seems that patient may have underlying psychosis and acted on delusions. It did not seem to be a suicidal attempt. Patient was evaluated in the emergency department and found have a left tension pneumothorax (collapsed lung), multiple acute and chronic left rib fractures, left clavicle and scapula fractures, and L T7 and T9 (thoracic spine) fractures. Review of the facility policy Abuse, neglect and Exploitation reviewed/revised 7/11/24 revealed in part .III Prevention of Abuse, Neglect and Exploitation B. identifying, correcting and intervening in situations in which neglect is more likely to occur with deployment of trained and qualified, registered, licensed and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual resident's care needs and behavioral symptoms.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47964 This citation pertains to intake MI00144419. Based on interview and record review, the facility failed to immediately report an elopement resulting in injury to the State Agency (SA) for one (R402) of three residents reviewed for elopement. Findings include: The State Agency received a Facility Reported Incident (FRI) on 4/30/24 for an incident that occurred on 4/26/24. The FRI reported that R402 exited a second-floor window and fell to the ground. R402 was observed on the ground outside by Licensed Practical Nurse (LPN) C. LPN C noted multiple abrasions on mid back and both legs, right hand and right thigh. R402 was transferred to the hospital. On 7/24/24 at 2:00 PM the Nursing Home Administrator (NHA) was interviewed and said the FRI was submitted on 4/30/24 but it should have been submitted on 4/27/24. According to the facility's policy Abuse, Neglect, and Exploitation revised 7/11/24 revealed in part . VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Definitions: Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review, the facility failed to safely secure the second-floor dining room windows and resident room [ROOM NUMBER] bathroom window from fully opening affecting all second floor residents who utilize the dining room and R405, resulting in the potential for additional unauthorized resident egress via the windows. On 7/23/24 at 9:05 AM in an observation with Licensed Practical Nurse/Unit Manager (LPN) B the bathroom window in room [ROOM NUMBER] top pane did not lock and was able to fully open. LPN B said the window should lock and should not open all the way. It is not safe for residents because they can get out the window. On 7/24/24 at 10:45 AM in an observation of the second-floor dining windows with Maintenance Director (MD) A the left window top panel opened fully, middle left window top panel opened fully, the right window top panel opened fully. MD A agreed residents use the room and it would be possible for a resident to open the top panel of the window and exit the building. On 7/24/24 at 11:00 AM the Nursing Home Administrator (NHA) was interviewed and stated, Our policy for windows are that they are not allowed to be opened more than six inches we have the rule so that residents can't get out and get injured. The NHA agreed the bathroom window in room [ROOM NUMBER] and the second-floor dining hall windows were not properly secured from fully opening. Review of the facility policy titled Preventive Maintenance Program, revised January 2024, revealed in part . A preventative maintenance program shall be developed and implemented to ensure the provision of a safe, functional, sanitary and comfortable environment for residents, staff, and the public.