

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/29/2024
NAME OF PROVIDER OR SUPPLIER  Regency at Livonia		STREET ADDRESS, CITY, STATE, ZIP CODE  14900 Middlebelt 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34851</p> <p>This citation pertains to intake MI00147311.</p> <p>Based on observation, interview, and record review, the facility failed to initiate a facility wide elopement code (notification for a missing resident) in a timely manner for one sampled resident (R902) of three reviewed for accidents. Findings include:</p> <p>Incident summary on 9/21/2024 at approximately 5:38 am, resident [R902] exited the door and was returned to the facility with no injury.</p> <p>A review of R902's medical record noted, R902 was admitted to the facility on [DATE] with diagnoses of Vascular Dementia unspecified severity without behavioral disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. A review of R902's Minimum Data Set revealed, R902 with a moderately impaired cognition and required some assistance with activities of daily living.</p> <p>On 10/29/24 at 2:18 PM, R902 was asked about the incident. R902 explained, they left out the front door of the facility, because they needed to go handle some business. R902 also explained they did not give notice to the staff they were leaving.</p> <p>On 10/29/24 at 2:29 PM, Licensed Practical Nurse (LPN) A was interviewed via phone and was asked about the incident with R902. LPN A explained they heard the front door alarm and went to look around to see who went out and didn't see anyone. LPN A continued and explained that she came back to her medication cart to pass medication and is when she was unable to locate R902. LPN A stated, We started to look around in rooms and didn't see [R902]. LPN A explained that she had Certified Nurse Assistant (CNA) B to look around on the unit prior to calling the official facility wide code. LPN A was asked where was R902 found. LPN A explained, R902 was found by the police on Middlebelt and [NAME] at the grocery store. The store is located approximately 0.8 miles away from the facility and is about a 17 minute walk according to Google. The store is at a busy intersection that leads to the freeway. R902 told them they were waiting for the bus to go to the Detroit. LPN A was asked about R902's alertness and stated, [R902] has a little bit of confusion.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's written revealed, LPN A, At approx (approximately) 5:38am. I returned from 2nd floor. Getting supplies, the door alarm was sounding. I opened the floor and looked out from and didn't see anyone. I returned and stated med pass and I didn't see him. I searched the hallways, bathrooms and Kitchen. I instructed the CNA B to search the other hallways and rooms. We were unable to locate him. At approximately 5:55 AM I called a code search overhead, still didn't locate him. I called 911/police at 5:58 AM, Director of Nursing (DON), family and physician.</p> <p>A review of facility's documentation noted, At approximately 6:30am, the resident was returned to the facility by (local police department). There were no injuries noted. The resident was not in any distress.</p> <p>Facility's statement, Laundry Aide, 5:35 AM I was picking up laundry from 1st floor. I observed the resident walking towards the Nurses station, I got on the elevator and approx. 10-15 min (minute) later [LPN A] Overhead paged code search I started looking for the resident in my work area (basement). I then went outside and drove around the building and surrounding streets. I did not locate the resident. I returned to the facility and gave my statement to the police.</p> <p>Facility statement with R902, Resident stated that [R902] left the facility to return to Detroit so that [R902] could be in control of [R902's] finances and affairs. When asked why [R902] didn't notify staff so that we could arrange transportation, [R902] stated it was bets if we didn't know because we would try to talk him into staying. [R902] said the freeway was right up the street and [R902] was going to have the grocery store call [R902] a cab.</p> <p>On 10/29/24 at 12:52 PM, the DON was asked about the incident with R902. The DON explained LPN A was supposed to call the elopement code right away to start the facility wide search for the resident.</p> <p>A review of the facility's policy titled, Elopement Policy dated 4/26/2022, revealed, Policy: It is the policy of this facility to prevent to the extent reasonably possible, the elopement of guests/residents from the facility . Missing Guest/Resident: 1. Check the sign-out form to see if the guest/resident signed out without notifying the staff or left with family if not, call a code Search or designated code for your facility .</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which include interventions/actions to correct the past noncompliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p> <p>FACILITY QAPI / PAST NON-COMPLIANCE FORM Elopement</p> <p>Date: 9/21/24</p> <p>Description of deficient practice: Facility failed to prevent a resident, who requires supervision, from going outside the facility doors independently. The resident was able to exit the Front entrance of the facility lobby. Staff did respond to the alarm initially, look outside the door/perimeter, and searched the facility, however did not immediately call the code search.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>How facility identified resident affected and residents having potential to be affected by the same Deficient practice. Administrative Nurses and or the Social Worker reviewed the residents that reside at the facility to identify residents that are expressing a desire to leave the facility. The IDT (interdisciplinary team) reviewed and validated the last risk for elopement evaluation, any concerns were address, the care plans for elopement are up to date and the wander guard is in place and functioning.</p> <p>Corrective action taken for the resident affected:</p> <p>Resident was assessed and the elopement evaluation was completed</p> <p>The Resident Chart was reviewed</p> <p>The Elopement care plan developed</p> <p>Physician orders for wander guard device were put in place</p> <p>Measures of systemic changes made to ensure the deficient practice will not occur and affect others.</p> <p>A QAPI Meeting was held to review the elopement and the event.</p> <p>Rounds were made on all doors in the facility that exit to the outside to validate alarms are functioning. All doors were alarmed properly.</p> <p>The Elopement policy was reviewed and deemed appropriate. All staff was educated on elopement policy with emphasis on what steps to take when a door alarm sounds.</p> <p>How facility monitors its corrective actions to ensure same deficient practice is corrected and will not recur.</p> <p>The Maintenance Staff or designee will complete Elopement Drills on each shift weekly for 4 weeks, than monthly to ensure staff are responding properly, any concerns will be addressed. Findings will be reported to the QAPI committee monthly for 3 months for recommendations.</p> <p>The IDT will interview staff on rounds on the Elopement Policy and what steps to take when they hear and alarm sounding, weekly for 4 weeks, than monthly for 2 months to ensure staff are responding properly, any concerns will be addressed. Findings will be reported to the QAPI committee monthly for 3 months for recommendations.</p> <p>POC Date: 9/30/24</p>		