STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235589	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Center (the)	26900 Franklin Road Southfield, MI 48034

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 48680 This citation has two Deficient Practice Statements (DPS). DPS #1 This citation pertains to intakes MI00144702, MI00144797, and MI00144715. Based on observation, interview and record review, the facility failed to provide adequate supervision and implement elopement policies for one (R500) of four residents reviewed for elopement, resulting in a severely cognitively impaired resident being let out of a secured door to the patio by an unknown staff member, unsupervised and was found approximately 36 hours later, about five miles away from the facility. This deficient practice resulted in the likelihood for serious harm, injury, impairment, or death. Findings include: The Immediate Jeopardy (IJ) began on 5/26/24. The Administrator was notified of the IJ on 5/28/24 at 5:18 PM and a removal plan was requested. The State Agency completed onsite verification that the Immediate Jeopardy was removed on 5/29/24, however the facility remained out of compliance at a scope of isolated and severity of potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance that has not been verified by the State Agency. On 5/28/24 at 11:17AM an interview was conducted with the Administrator. When asked what happened with R500 and where was R500 found, the Administrator replied R500 was found in Detroit near eight mile and Telegraph road, in a wheelchair. The Administrator further reported R500 didn't state where they were going and the resident was very selective too whom they speak too. The Administrator was then asked about the facility's patio area (where R500 exited) and then explained the patio area had locks but were using it as the front entrance because the main entrance was still under repair. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/28/24 at 11:20AM, an interview was conducted with the Director of Nursing (DON). When asked to provide details of where and when R500 was found and when they were first notified that R500 was missing, the DON replied the resident was found at 8:33 PM on Evergreen and Eight Mile Road, about 10 minutes away. The DON further reported the Nurse on Duty on 5/27/24 (Nurse 'B') notified them around 1:30 PM and they arrived at the facility to help with the search. The DON reported when R500 was located, they did not mention an agenda on why they left the facility and R500 was not much of a talker but they did tell their brother that they wanted to go for a walk and get some air. The DON explained the residents are allowed to sit outside on the patio and that staff does not have to physically be out there, but the receptionist is to monitor residents and let them in and out. The DON also reported they keep the gate open because there is no doorbell or buzzer. The DON was asked if there was a log of who goes in and out the building (according to the facility's investigation documentation the receptionist was suspended) and they replied there was no log that keeps track of who goes out to sit in the patio area but they did have a leave of absence (LOA) book. The DON reported at that time, a housekeeper (HK 'C') was covering for the receptionist. When asked about what covering for receptionist entailed, the DON reported a housekeeper can monitor but would have to follow-up to see if they were educated on the responsibilities. On 5/28/24 at 11:47 AM, an interview was conducted with Receptionist (Staff A). When asked about their ability to effectively monitor or supervise the gate, or people out on the patio from their location in the facility, Staff A reported the view was limited and was not able to see the gate or anything behind that area. On 5/28/24 at 12:31 PM, a phone interview was conducted with Nurse B. When asked to recall the events of R500 on 5/27/24, Nurse B reported when they come in every morning, they do walking rounds with the off-going nurse and they did not see R500 in their room, so they assumed that they were outside, or in the dining room where they'd usually be. Nurse B further reported they continued their rounds and started on the medication pass. Nurse B then went back to check on R500 around 1:00 PM, and noticed they still were nowhere to be found and they called a code w (missing resident alert), notified the Administrator and DON, called the family and continued to follow the protocol for a missing resident. Nurse B reported they never laid eyes on (R500) during their shift, the resident doesn't take any medications, and they felt bad because they assumed R500 was there and the off-going (midnight nurse) didn't mention anything about the resident being gone. On 5/28/24 at 12:56 PM, a phone interview was conducted with HK C. When asked to explain what their responsibilities were when they covered the front desk for a receptionist, HKC replied they did not know, and that Maintenance Worker (Staff Q) asked if they could sit in the room for a minute while they went to the basement. HK C reported they were watching the area for all of five minutes, if that. They further reported they were never told that they needed to watch the outside patio and the facility noticed (after the incident) the resident leaving the facility on Sunday 5/26/24 around 9:45 AM and they got it on the security cameras. HK C was then asked about the details and education provided on their suspension and HK C reported they were not aware of any suspensions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/28/24 at 2:28 PM, a phone interview was conducted with Certified Nursing Assistant (CNA E). When asked if they were assigned to R500 on 5/26/24, they reported yes. When asked about R500's routine and when they last saw the resident on 5/26/24, CNA E replied they saw R500 Sunday (5/26/24) at the beginning of their shift when they did morning rounds, and again around 8:00 AM during breakfast. CNA E recalled the resident refused their tray and wanted to eat it with lunch, but that was the last time they saw the resident. CNA E was asked if they should've checked on R500 throughout their shift and replied Yes. On 5/28/24 at 3:00 PM, an observation of the facility's video surveillance from 5/26/24 - 5/27/24 confirmed R500 exited via wheelchair on 5/26/24 at around 9:45 AM, off the property, through the gate of the patio, and returned to the facility via family on 5/27/24 around 9:00 PM (approximately 36 hours later). On 5/29/24 at 9:25AM, an interview was conducted via phone with Family Member G. When asked what happened with the elopement of R500, Family Member G reported the facility never contacted them, but instead called their husband stating they were doing a wellness check. Family Member G then reported they told the facility that R500 does not live with them and they stay at the facility they were calling me from. They further reported Nurse B was the only person who contacted them to tell me what was going on around 2:20 PM on 5/27/24. They told us the Maintenance Director (Staff N) was looking over the cameras and noticed R500 had left the faciity on Sunday (5/26/24) around 9:15 AM. Family Member G then reported they pulled up to the facility the same time the .Police department arrived and told them that R500 used to live in the independent living next door, so the Police were able to go there and view the cameras and confirmed R500 was seen there around 10:00 AM going to their old apartment unit. Family Member G stated they and their family began to search for R500 and even posted they were missing on social media, and that the whole ordeal was very stressful and should never have happened. On 5/29/24 at 2:10 PM, a phone interview was conducted with Nurse I who confirmed they were assigned to R500 on 5/26/24. When asked about their routine during their shift, Nurse I reported upon their shift on 5/26/24 starting at 7:00 AM, they laid eyes on R500, then started their medication pass. They recalled R500 asked them for pull ups around 8:00 AM and after they finished the medication pass they went to try to get R500 pull ups and the staff person that stocks briefs, so they informed the CNA that R500 needed pull ups and to make sure they got some. Nurse I reported they continued rendering care to their other patients at about 9:00 AM, they laid eyes on R500 going to the elevator on Unit 2, by the dining room where the resident would usually be. When they were doing treatments way after lunch, but before dinner they asked the CNA if they had seen R500 and they didn't but we assumed that R500 was outside on the patio. Nurse I was asked if they checked on R500 after they last saw them at 9:00 AM on 5/26/24 and they stated they did not check on them like they should have. Nurse I further reported that was not like R500 to leave the campus, and they were dealing with a difficult resident who wanders all the time so it was just a crazy day. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/29/24 at 2:14 PM, an interview was conducted with Nurse J. When asked if they were assigned to R500 during the midnight shift (on 5/26/24, into 5/27/24), Nurse J reported no, they did not take care of R500. They reported when they came onto shift, they got a report from the dayshift nurse that R500 was out somewhere so I didn't follow-up immediately. Nurse J reported they have a resident that wanders, and it was busy and the that resident made their night very busy and chaotic. Nurse J reported the off-going Nurse told them that R500 was outside somewhere. This was their second week so they didn't know how the patients were and how they acted, so they thought R500 was out with a family member and they gave the oncoming nurse the following day the same report. Nurse J reported that nurse took the keys from them, so they did not think anything of it. Nurse J confirmed R500 was not present at the start of their shift on 5/26/24 at 7:00 PM. According to the facility's policy titled, Elopement - For Facilities With a Wander Alert Bracelet System dated 8/2022, revised 5/27/2024: .GUIDELINES FOR STAFF WITNESSING A RESIDENT ATTEMPTING TO LEAVE THE FACILITY: Staff members will report to the charge nurse any resident who tries to leave the facility. If a staff member observes a resident attempting to leave the facility or premises, they should .Get help from other staff members in the immediate vicinity or call for assistance .If the resident leaves the facility: Instruct another staff member to inform the charge nurse or director of nursing that a resident has left the facility or premises while staying with the resident . The Immediate Jeopardy that began on 5/26/24 was removed on 5/29/24 when the facility took the following actions to remove the immediacy: Immediate action(s) taken for the resident(s) found to have been affected include: 1) Resident [Name of R500] on 5/27/2024, it was noted at approximately 1330 that resident was missing in the facility, and after initiating the procedure for a missing resident and searching the facility, the resident could not be located. DON, Administrator, Physician, Medical Director, resident's sister, State of Michigan, and the Southfield police department were notified. It was identified the gate was unlocked and resident wheeled himself through the gate to the sidewalk and left facility premises. The receptionist who was responsible for supervising the resident while on the patio alone was immediately suspended, pending investigation. The resident has been returned to the facility, evaluated, and deemed stable with no negative outcomes. Identification of other residents having the potential to be affected was accomplished by: 1) Residents who reside in the facility who are at risk for elopement have the potential to be affected. A facility-wide audit was conducted and residents in the facility had a elopement assessment completed on 5/27/24 to establish elopement risk, and wander guards were applied to residents as appropriate, with physician orders and care plans updated. 2) Facility doors were checked by the Maintenance Department. 3) The facility process changed on 5/27/24 and residents must be attended to on the patio by staff or family. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4) On 5/28/24 the facility gate has been locked and will be observed by 1:1 staff member until a door camera is installed. The gate will remain locked at all times. (It should be noted that this was not verified as implemented adequately until 5/29/24.) Measures put in place and systemic changes you will make to ensure that the deficient practice dose not reoccur: 1) Education was initiated on 5/27/24 for the facility staff by the Director of Nursing, Assistant Director of Nursing, and designee. Staff are educated on elopement policy, procedures for a missing resident, that residents are not allowed on the patio without being attended by staff or family, and that nurses are to complete a head count of their assignment at the start of their shift. Additionally, Nurse Aides and Nurses received and in-service to visualize residents their residents throughout the shift to ensue residents are safe and accounted for. In the event that a resident cannot be located, A staff member will notify the nurse supervisor, administrator, or director of nursing of the possibility that a resident is missing. The supervisor will coordinate and document the search efforts. Any staff member and/or contracted staff who has not been educated will be educated before working their next shift. 2) Patio gate will remain locked and secured. 3) Director of Nursing, or designee, will audit 5x weekly x4 weeks to ensure that residents are not on the patio without being attended by staff or family, and that nurses are completing a head count of their assignment at the start of their shift, to ensure that all residents are in the facility and accounted for. Describe the Quality Assurance & Process Improvement Program that will be put into place (track and trend data over time to ensure action plan met the initially identified goal(s). 1) An Ad Hoc QAPI meeting was held on 5/27/2024 with the Medical Director and QAPI Team 2) QAPI committee will be held weekly for 4 weeks, then monthly for recommendations and further follow-up regarding the above-stated plan. Audits will continue to be submitted to the QAPI committee for review and to ensure compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance. 32568 DPS #2 Based on observation, interview, and record review, the facility failed to adequately supervise and implement effective interventions to prevent wandering into unsafe spaces for one (R502) of four residents reviewed for accidents, resulting in the resident, who had a history of wandering behaviors, using the elevator multiple times to leave the unit and enter the first floor which was a construction zone and off limits to residents. Findings include: On 5/28/24 at approximately 5:15 PM, R502 was observed in the hallway. R502 walked over to the elevator and attempted to enter it. R502 was redirected away from the elevator by a staff member. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/29/24 at 9:36 AM, 10:40 AM, and 12:10 PM, R502 was observed sleeping in bed in the same position. A review of R502's clinical record revealed R502 was admitted into the facility on [DATE] with diagnoses that included: Huntington's Disease and schizoaffective disorder. A review of R502's Minimum Data Set (MDS) assessment revealed R502 had severely impaired cognition and wandering behaviors. A review of R502's progress notes revealed the following documentation: On 5/9/24, it was documented in a Behavior Note that R502 was exit seeking. On 5/10/24 at 10:10 AM, it was documented in a Social Work note that R502 was exit seeking in addition to other behaviors. It was noted that R502's care plan needed to be updated. On 5/10/24 at 12:49 PM, it was documented R502 was observed walking toward the entrance behind staff . (R502) expressed, 'I'm about to go. I'm going home.' Writer made attempt to redirect her back to her room to retrieve footwear. Upon walking to her room, she tried to get on the elevator. Writer redirected her with staff assist . On 5/10/24 at 4:22 PM, Registered Nurse (RN) 'K documented, Resident was observed on the first floor by maintenance worker ('Q') in the old PT (physical therapy) room. (Maintenance Worker 'Q') brought resident back up to unit and stated that was where he observed her .She has been wandering around the facility, on all of the units .throughout this shift .Writer is placing resident on 15 min (minutes - check on resident every 15 minutes) at this time to ensure the safety of resident. On 5/14/24 at 7:43 PM, RN 'K' documented, Resident made several attempts to enter the elevator this shift . On 5/18/24 at 5:10 PM, RN 'K' documented, .Writer observed resident attempting to get on the elevator, but I was able to re-direct her back to the unit . On 5/19/24 at 4:26 PM, RN 'K' documented, Resident was observed by a couple dietary staff members, walking around on the lower level of the facility. They brought resident back to unit and writer explained to resident that it is not safe for her to go down to the lower level and walk around. Resident did not verbalize understanding and cont (continued) to wander around the facility. After several minutes, I was able to re-direct resident back to the unit, but she cont. to wander off the unit when I was doing my med (medication) pass. On 5/19/24 at 6:33 PM (two hours after the previous progress note), RN 'K' documented, Resident was, once again, observed by staff walking on the lower level of the facility into the kitchen. Writer was called and assigned CNA (Certified Nursing Assistant) went down and brought resident back to the unit. Once again, writer reiterated with resident that it is not safe her her to go down to the lower level of the facility, at this time. Resident did not verbalize understanding. Just prior to resident doing downstairs, she was observed by staff attempting to exit the facility through the current (temporary) facility's maintenance door, per CNA . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/28/24 at 7:08 PM, RN 'K' documented, Writer was paged and told that resident was on the lower level, in the kitchen. Writer went down and brought resident back to unit. Wander-guard was on left ankle and did not alarm, due to the fact that she did not walk through the 'double' doors, because she walked through the first kitchen door .Staff had to constantly re-direct resident after this incident so that she would not get on the elevator. Administrator made aware. On 5/29/24 at approximately 9:40 AM, an observation was made of the first floor of the facility. The elevator was accessible from the second floor. Upon exiting the elevator onto the first floor, signage was posted to the left that read Danger. Do Not Enter - Emergency Exit Only. The hallway was partitioned off with plastic. The flooring was removed from that hallway and a fan was installed. Various tools and equipment were observed on the first floor and there were many rooms with open doors. The kitchen was located on the first floor which was accessible from two different doors, one that was accessible after entering through double doors down the hallway. An interview was conducted with Maintenance Director 'N' who explained the first floor was closed off due to a flood that occurred. They were in the process of repairing the damage. On 5/29/24 at 10:37 AM, an interview was conducted with RN 'K'. When queried about R502's wandering behaviors, RN 'K' reported R502 wandered everywhere. When queried about what interventions were in place to prevent R502 from wandering into unsafe spaces, RN 'K' reported R502 had a wander alert bracelet and staff had to supervise and redirect her. RN 'K' explained that she felt R502 required one on one supervision, but due to the way the unit was staffed it was hard to constantly supervise R502 while performing other required duties and caring for other residents. When queried about how R502 got to the first floor on 5/10/24, twice on 5/19/24, and again on 5/28/24 during her shift, RN 'K' reported she did not know R502 went to the first floor until maintenance and dietary staff notified the unit. RN 'K' explained that the wander alert bracelet did not alarm at the elevator and once on the first floor, unless R502 crossed over the sensor at the double doors, it would not alarm. On 5/29/24 at approximately 10:45 AM, an interview was conducted with Unit Manager, Licensed Practical Nurse (LPN) 'P'. When queried about R502's wandering behaviors, LPN 'P' reported R502 wandered all the time in addition to other behaviors. LPN 'P' further reported the elevator was shut down starting at 5:00 PM until 7:00 AM, but it was accessible during the day. LPN 'P' reported R502 required a lot of supervision and she did not feel there was enough staff to watch her. On 5/29/24 at 11:05 AM, an interview was conducted with Maintenance Director 'N'. Maintenance Director 'N' explained that the elevator did not have a sensor for the wander alert bracelets. Maintenance Director 'N' reported that his staff found R502 on the first floor multiple times and the elevator was turned off from 5:00 PM to 7:00 AM each day. When queried about other times of day, Maintenance Director 'N' reported he was just told (on 5/29/24) to shut the elevator down until we can get rid of the wanderer (R502). On 5/29/24 at 2:10 PM, an interview was conducted via the telephone with CNA 'M'. When queried about how R502 got downstairs to the first floor on 5/28/24, CNA 'M' reported she was unaware that the resident went to the first floor. CNA 'M' reported nobody notified her that R502 went down there. Further review of R502's clinical record revealed a physician's order for a wander alert bracelet started on 4/2/24 and discontinued on 4/22/24. A new order for a wander alert bracelet was ordered on 5/27/24 with a start date of 5/28/24. (continued on next page)

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