STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235594	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Niles	1211 State Line Rd Niles, MI 49120

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** 47659 This citation pertains to intake MI00147700. Based on interview and record review, the facility failed to prevent the elopement and ensure the safety in 1 (Resident #238) of a total sample of 18 reviewed for accidents resulting in Resident #238 exiting the facility from a staff exit door and getting 30 feet away from the building before staff found her with the potential for serious harm, injury, and/or death. Findings include: Resident #238 Review of an Admission Record revealed Resident #238 was originally admitted to the facility on [DATE] with pertinent diagnoses which included difficulty in walking. Review of Resident #238's Wandering Risk Assessment Scale dated 9/19/24 indicated that Resident #238 was identified as a high risk to wander, and the facility staff placed a wander guard device on her prophylacticly. Review of incident report dated 10/7/24 revealed, (Resident #238) exited the building and was accompanied by staff back into the facility. (Resident #238) was observed outside in the courtyard, in her wheelchair about 30 feet from the facility from the Apple exit door by CNA (Certified Nursing Assistant) W who was coming back from her break . (CNA W) had to let her (Resident #238) in due to her wander guard locking the door. (CNA W) escorted her (Resident #238) to the Sunshine room where she notified the nurse, Registered Nurse (RN) DD that (Resident #238) was in the courtyard. RN DD then notified Director of Nursing (DON) B, called a resident alert and took a head count for all other residents, completed a skin check, and took a set of vitals. (Resident #238) stated the door was open and she was going outside to call her sister because she gets better phone reception. CNA X exited the Apple door at 6:55 PM for her break and (Resident #238) was seen exiting behind her at 6:55 PM. CNA LL is at Apple nurses station and hears alarm, gets up and walks to the exit door where alarm is sounding and turns is off at 6:56 PM as she thought it was staff member CNA X who triggered the alarm as she had just told her she was going to break . (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	During an interview on 1/8/25 at 1:17 PM, CNA W confirmed that she was the staff member that had found Resident #238 in the courtyard. CNA W' reported that she was on break and heard Resident #238 from where she was sitting and went to the gate and observed Resident #238 in her wheelchair about 30 feet from the facility door attempting to exit the facility's courtyard. CNA W reported that she assisted Resident #238 back into the facility, and that there were no alarms going off in the building. CNA W reported that she immediately told Resident #238's nurse that Resident #238 had exited the building, and they began a count of all other residents. During an interview on 1/8/25 at 1:09 PM, RN DD reported that he found out that Resident #238 had left the building when CNA W reported to him that she had just found Resident #238 in the courtyard. RN DD reported that after he assessed Resident #238 for injury and ensured all other residents in the facility were safe and accounted for, he checked the door to see how Resident #238 had gotten out. RN DD reported that he confirmed that Resident #238's wander guard was working and the door that Resident #238 had exited was also working. During an interview on 1/8/25 at 1:31 PM, CNA LL reported that she had been sitting at the nurses station closest to the door that Resident #238 had exited on 10/7/24. CNA LL confirmed that when the door alarm went off, she had assumed it was a staff member that had just left on break, and she went over to the door and turned off the alarm without checking to ensure that there were any residents outside of the facility. CNA LL confirmed that she was aware of the facility's elopement policy, and that she did not follow the policy when she reset the door alarm without ensuring that a resident had not exited the facility. During an interview on 1/8/25 at 2:00 PM, Nursing Home Administrator (NHA) A reported that she had discovered that the root cause for Resident #238's elopement was a staff member (CNA LL) had not followed the elopement policy. NHA A confirmed that CNA LL had turned off the door alarm when Resident #238 exited the facility, and she (CNA LL) had not checked to ensure that a resident had triggered the alarm. Review of the facility's Elopement Policy last revised February 2021 revealed, Policy: It is the policy of this facility to assess residents and plan their care to prevent foreseeable accidents related to wandering and exit seeking behaviors which has the potential to lead to elopement . 3. Response to a sounding door alarm. a. Check the alarm panel to determine which door has been triggered. DO NOT ASSUME someone else has already done this. b. Check the exit door for any exiting resident by means of a visual check. A visual check means observing the area around the exit and may require leaving the building and checking the grounds. c. If an exit door is triggered, the cause is evaluated and re-set after the resident is re-directed and their safety is assured. Consider the applicability of conducting a census count with an activated alarm. d. If unable to locate a resident, or in the event of an elopement drill, a building search is conducted. The Charge Nurse or designee shall announce Resident Alert, Room . Available employees are to report to their stations for assignments in this regard . The facility was granted a Past Non-Compliance at the time of exit due to no further like incidents had occurred, the facility re-trained pertinent staff, the Elopement policy was reviewed and deemed appropriate, and the facility had achieved sustained compliance. Therefore, no plan of correction will be required. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included re-training pertinent staff, completing elopement drills, and reviewing the elopement policy. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.