STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235664	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Village of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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 - 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** This citation pertains to intakes 2738135 and 2738724.Based on interview and record review, the facility failed to provide supervision for one (R603) of five residents reviewed for accidents, resulting in R603, with a history of severe mental illness, homelessness and frost bite, exiting the facility. This resulted in an Immediate Jeopardy when R603 exited the facility unbeknown to the facility staff, was picked up by Police on 2/8/26 at 1:33 AM and not identified as missing by facility staff until 2/8/26 at approximately 2:50 PM (approximately 13 hours later). Due to the deficient practice, R603 and additional residents at risk for elopement had the increased likelihood for serious harm, serious injury, and/or death including hypothermia, frost bite, hand other health hazards related to being outside in extreme cold weather unsuprevised. Findings include:The Immediate Jeopardy (IJ) started on 2/8/26 when it R603 exited the building without the facility's knowledge. The IJ was identified on 2/17/26.The Administrator was notified of the Immediate Jeopardy on 2/17/26 at 2:46 PM, and a plan to remove the immediacy was requested.The Surveyor confirmed the immediacy was removed on 2/18/26 following acceptance of the facility's removal plan via record review and interviews.Review of the facility's documentation of the Facility Reported Incident (FRI) included: On 2/7/2026 at 7:28 PM, [R603] consumed 100% of his HS (evening) snack. At approximately 10:15 PM, scheduled bedtime medications were administered.At approximately 12:30 AM on 2/8/2026, [R603] was observed by multiple staff members within the facility. He had been in the dining room, sitting alone as he routinely chooses to do during these hours, and was later seen ambulating toward his room. At that time, based on interviews, staff reported no observable distress, agitation, behavioral escalation, verbalization of dissatisfaction, or desire to leave.Based on police documentation, the resident had exited the building on 2/8/26 prior to 1:33 AM. [Local] Police Department documentation confirms that [R603] was encountered walking down the road. He communicated an intention to go to a local casino and was transported by a police officer to an enclosed heated bus shelter to await transportation. Law enforcement documentation indicates the resident was left at the bus shelter shortly after 1:33 AM.At approximately 2:00 PM on 2/8/2026, staff were unable to locate [R603] during a routine attempt to escort him for his customary smoke break. A house-wide sweep and full census head count were completed, confirming all other residents were accounted for.The facility Missing Resident Procedure was activated. The Administrator, law enforcement, the guardian, Medical Director, corporate support and attending provider were notified. Facility staff searched facility grounds and traveled to local vendors, gas stations, and stores questioning the resident's presence and providing contact information to be reached at if they happen to see him. Local hospitals were contacted, [County] Search & Rescue was engaged, and [NAME] (Licensing and Regulatory Affairs) was notified of the event. Local news assisted in broadcasting the resident's description to support search efforts.On 2/9/26 09:57 AM, the Administrator was notified by the police that [R603] was located again outside a [Local Fast Food] a couple miles (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	up the resident at 1:33 AM and when RN ‘A‘ was further questioned by the Police, they acknowledged they didn't actually see the resident as initially reported to Administrator and Police.When asked about what care the direct care staff should've provided and how they didn't identify the resident was missing until approximately 13 hours later, the Administrator reported there were concerns about the Certified Nursing Assistants (CNAs) as well and they were able to verify that the day shift CNA (CNA ‘D') had delivered R603's meal trays for breakfast and lunch and did not identify the resident was missing.On 2/17/26 at 2:00 PM, an observation was made with the Administrator of the alleged window R603 had exited from. There were three large windows in the dining room, with each window having two smaller windows on the right and left sides that could be slide open horizontally. Two of these large windows were observed to directly exit into an external cement stairwell that led to the basement. It should be noted that the smaller side windows that could be slid open contained a screw that prevented the windows from opening beyond approximately four to five inches.When asked how it was possible an adult body (R603 was documented in the FRI as 73 inches tall and approximately 150 pounds) could fit through the window opening that was only four to five inches, the Administrator reported they weren't sure, but the resident reported that and there were footprints. It should be noted that the area outside this window was also a courtyard that was utilized during the facility's smoking activity which included multiple residents. The Administrator acknowledged although they weren't sure how the resident exited the facility, the concern was ultimately with the lack of supervision by facility staff in which R603 left unsupervised without staff's knowledge and not identified until many hours later.On 2/17/26 at approximately 3:25 PM, RN ‘B' was queried regarding R603's elopement. RN ‘B' reported the last time they had seen R603 was early in the morning at around 12:30 AM, and they were in their room. RN ‘B' indicated they did not check on them again for the rest of their shift which ended at approximately 7:00AM that morning (2/8/26). RN ‘B' was asked what the standard of care was for monitoring residents and they stated they check on residents every two hours. RN ‘B' reported they did not check on R603 due to the resident having a history of becoming physically aggressive of anyone going go into their room. On 2/17/26 at 3:35 PM, a phone interview was conducted with RN ‘A'. They confirmed they were the Nurse assigned to R603 on the day shift on 2/8/26 which started at 7:00 AM. When asked if they had conducted any rounds with the nurse going off-shift from midnights, RN ‘A' reported they had with RN ‘B'. RN ‘A' further reported when they got to R603's room that resident is aggressive and a psych patient and doesn't let you open his door, so his door was closed and they thought he was in his room. RN ‘A' further reported they finished passing the morning medications around 12:00 PM to 1:00 PM and R603 was a smoker so when it was time to go smoke they started looking for the resident and couldn't find him. RN ‘A' further reported they had asked another resident if they had seen R603 and that resident said they had and RN ‘A' thought they recalled seeing the resident in the hallway earlier.RN ‘A' further reported they searched everywhere and couldn't find him so around 2:30 PM they called the Administrator and DON. We drove to gas stations, stores to search around and then called 911. RN ‘A' reported the only thing R603 talks about is going out to smoke and he was independent with everything else. Additionally, RN ‘A' reported the Police called them the next day around 10:00 AM and said they found the resident and was taken to the hospital.On 2/17/26 at 3:48 PM, a phone interview was conducted with CNA ‘D' who confirmed they were assigned to R603 on the night shift (2/7/26 into 2/8/26). When asked if they had provided any care to R603 or observed them while working, CNA ‘D' reported they had seen R603 in their room about 12:00 or 12:30 AM to pull the garbage and saw him seated up on the bed. They further reported that was the only thing the resident would let them do and doesn't allow them to go into the room other than to pull out (continued on next page)

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