

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235705	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Helen Newberry Joy Hltcu Golden Leaves Living Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 502 W Harrie St Newberry, MI 49868	

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 - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123</p> <p>This citation has five deficient practice statements:</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Provide adequate supervision to prevent one vulnerable Resident (#2) from eloping from the facility twice within a week of four residents reviewed for wandering and elopement risk. 2. Maintain properly functioning of fire safety doors. 3. Ensure a safe hazard free environment to reduce fall risk potential for Residents (#1 and #8) or two residents reviewed for falls. 4. Ensure beds were properly positioned in a safe distance to prevent burn skin injury for one Resident (#1) of 23 facility residents. 5. Ensure concrete entrance steps for visitors, staff, and residents was not broken and damaged to prevent potential injury. <p>Findings include:</p> <p>This citation pertains to Intake #MI00143451, MI00144327, & MI00144455.</p> <p>Part 1:</p> <p>Review of Intake #MI00144327's Incident Summary, dated 4/28/24 at 5:00 PM, read in part, Call from [Licensed Practical Nurse B] at 1728 [5:28 PM] reporting a resident had eloped out the dining room doors and got outside through [NAME] Conference doors. [Certified Nurse Aide F] was bussing tables in resident dining room .[CNA Q] present in hallway [A] attending to alarm .CNA [B] turned and noticed door [#11] was propped open, she immediately went to door and entered hallway [[NAME] Conference hallway], she noticed door to the outside was closing and she went to door and found resident [R2] .standing outside door [exterior door] .</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 - Some</p>	<p>Review of Intake #MI00144327's Investigation Summary, dated 5/2/24 at 11:07 AM, read in part, .Upon further assessment of door #11 by Maintenance and Security on site were called to assess the door immediately, they re-engaged the alarm .This alarm alerts staff in the nurses station and surrounding areas that the door is attempting to be opened .Parts for the keypad have been ordered and it will be repaired as soon as they arrive .Signage will be placed on the door to indicate this .Door #11 is now .and has been included on daily door checks that are being done by Activities and Restorative Aides .</p> <p>Review of R2's census, revealed an original admission on 4/22/24 into the facility.</p> <p>Review of R2's progress note, dated 4/22/24 at 12:19 PM, read in part, Evaluation: Elopement Score: 3.0 At Risk - History of elopement while at home: Yes. History of attempting to leave the facility without informing staff: Yes. Verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: Yes. Wanders: Yes .</p> <p>Review of progress note, dated 4/22/24 at 5:34 PM, read in part, .Resident admitted this afternoon .Resident is A&O x 1 [alert and oriented], mostly confused .Ambulatory and a high elopement risk. Wander guard placed on resident .</p> <p>Review of progress note, dated 4/22/24 at 5:42 PM, read in part, Late Entry .Resident observed by this writer re-entering facility from inside lobby door .</p> <p>Review of progress note, dated 4/28/24 at 9:22 PM, read in part, .resident had eloped out dining room doors and got outside .Wander guard is working properly at all doors except door #11, which is door resident eloped out .</p> <p>Review of R2's care plan, dated 5/7/24, read in part, Focus: I am a wandered, high elopement risk, and have eloped both from my home and SNF [skilled nursing facility] in the past .I am very quick and focused. Please communicate amongst staff so I am able to be located at all times .Focus: I have impaired cognitive function/dementia or impaired thought processes r/t [related to] Dementia. My most recent BIMs [brief interview for mental status] score is 0.0 .cue, reorient and supervise .</p> <p>Review of the Incident and Accident report, dated 4/28/24 at 5:00 PM, read in part, .Please specify 'Other' cause of event: Alarm was disabled, date unknown .</p> <p>On 5/13/24 at 11:30 AM, an observation was made with Unit Manger/Registered Nurse A of the facilities exit doors. RN A was asked to ensure all doors were working properly. RN A was unable to engage door #5 and door #4's magnet was not releasing or working properly. RN A was asked why the doors were not functioning properly and replied, I am not sure. The activities aide checks them every day. I will ask her if the doors were working properly when she checked them this morning. In the meantime, I will call maintenance and have them look at the doors.</p> <p>Review of video footage with the DON and RN A, dated 4/28/24, revealed R2 had exited the dining room door #11 without staff being aware and then proceeded to the exterior exit door off to the right. CNA B then went through door #11 and then noticed R2 outside of the exterior exit door and guides R2 back into the facility.</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 - Some</p>	<p>On 5/13/24 at 1:30 PM, an interview was conducted with RN A and was asked if door #11 was engaged would R2 have eloped from the facility and replied, No. Door #11 should have been engaged. When we did the investigation, we discovered that door #11 had been disabled. We are not sure how long door #11 had been that way.</p> <p>On 5/14/24 at 1:40 PM, an interview was conducted with LPN B, and was asked to confirm her witness statement from 4/28/24. LPN B's witness statement, dated 4/28/24, read in part, CNA F found that door 11 was not working properly/alarming and had been left ajar. When she investigated she found [R2's initials] just outside the [NAME] exit door LPN B further explained that she was completing med pass at that time in the hall, CNA [Q] was in the hall escorting residents out of the dining room, and CNA [F] was bussing tables in the dining room area.</p> <p>Review of Intake #MI00144455's Incident Summary, dated 5/5/24 at 7:53 PM, read in part, At 1953 [7:53 PM] - DON was notified by Charge nurse that [R2's initials] had eloped from the facility .DON arrived at facility at 2050 [8:50 PM] and interviewed staff .[R2' initials] exited the first door w/o [without] any issues, this door alarms when resident is near door with a Wanderguard in place, door is able to be pushed open freely. The next door he pushed and .exited, this is the main entrance to facility .</p> <p>Review of Intake #MI00144455's Investigation Summary, dated 5/8/24 at 9:00 AM, read in part, .5/7/24 - DON contacted IT [information technology] to review video footage from front door. At 1938 [7:38 PM] resident is shown pushing and leaving front door, he ambulated down steps and to left of camera view. At 1941 [7:41 PM] staff is seen leaving front door after resident. 1943 [9:43 PM] Resident is escorted back into facility. After speaking with IT, the video footage showed he was able to push door open freely and not have to hold for 15 seconds .IT did come and check the door and it pushed open freely. Door was not re-engaged as it should .DON contacted Maintenance and they are repairing door .</p> <p>Review of R2's care plan, dated 5/7/24, read in part, .Focus: I am a wandering, high elopement risk, and have eloped both from my home and SNF [skilled nursing facility] in the past .Interventions .I am very quick and focused. Please communicate amongst staff so I am able to be located at all times .</p> <p>Review of R2's electronic medical record (EMR), revealed, the lack of a physician order for a Wanderguard and lacked a triggered task or order to assess/check R2's Wanderguard.</p> <p>Review of witness statement by CNA M, dated 5/5/24, read in part, I walked down from the bathroom and heard an alarm. It was the frount (sic) door alarm. [R10's name] came down and yelled that [R2's name] was outside .</p> <p>Review of witness statement by CNA G, dated 5/5/24, read in part, I went to do waters .Came out and heard an alarm going off, so we seen [R10's name] calling us saying [R2's name] was outside .</p> <p>On 5/13/24 at approximately 1:45 PM an attempt was made to call and confirm the witness statements from CNA G and CNA M, but Surveyor was unsuccessful, and messages were left for a return call. No returned calls were made by the time of survey exit.</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 - Some</p>	<p>Review of the Incident and Accident report, dated 5/5/24 at 10:12 PM, read in part, .Please specify 'Other' cause of event: known wanderer .</p> <p>On 5/14/24 at 11:00 AM, an interview was conducted with R10 in her room and was asked about R2's second elopement and replied, I was just sitting in my recliner and I saw [R2's name] outside of the facility walking on the sidewalk and so I got up with my walker and walked down to the nurses station where I see the two CNA's and told them [R2's name] was outside of the facility walking on the sidewalk outside my window.</p> <p>On 5/14/24 at 11:15 AM, an interview was conducted with the DON, and was asked if R2 would have eloped if adequate supervision was made and replied, One of the staff members should have been present in the hall to supervise, but the nurse was in the medication room, one CNA was getting waters, and the other was in the bathroom. They should have had better communication, so they knew where one another was. The DON was asked if the facility had an elopement book or some identification for staff to care for identified elopement risk residents and replied, No, we don't have an elopement book.</p> <p>On 5/14/24 at 11:30 AM, during a continued interview with the DON, she was asked how the facility staff check the Wanderguards to ensure they are working properly and replied, Well we used to take the residents who wear them up to the tether doors to check them and check the expiration dates visually, but since the second elopement I ordered a tether transmitter tester on 5/6/24 and it came in on 5/8/24. Now the staff can use the transmitter and hold it up to the Wanderguard to ensure it is working. The DON was asked who was now responsible for checking the Wanderguards and how often and replied, The activities and/or the restorative aides and they are checked daily.</p> <p>Review of policy titled, Code Purple / Elopement, dated 5/16/23, read in part, .Definition of Elopement: Elopement occurs when a resident or patient leaves the premises or safe area without authorization .and/or any necessary supervision to do so.LTC [long term care] Procedure for Care of Resident at Risk for Elopement: .2. If resident is at risk for elopement, a tether will be placed. This will be care planned and placed in the task list .4. Rehab will check the operation of tethers monthly and as needed .</p> <p>Review of policy titled, Standards of Care, dated 4/30/24, read in part, General Standards of Care .Standards of Care - Safety Devices .5. New safety devices implementation requires a progress note to be written by the Charge Nurse and Rehab Coordinator notified .</p> <p>Review of policy titled, Door Alarms, dated 5/24, read in part, Purpose: Define procedure for use of door alarms to prevent elopement .4. Daily the Activity Aide will make checks on each door alarm system .5. Procedure: a. Walk through each door indicated holding a tether and verify proper function of alarm system .</p> <p>Review of user guide for wander management transmitters, dated 11/2018, read in part, .Testing and Care transmitter testing .weekly testing - The following testing is required for all transmitters in use on residents. 1. Test the operation of transmitters using the transmitter tester. NOTE: Never take a resident to a door to test their transmitter .</p> <p>Part 2: (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 - Some</p>	<p>On 5/13/24 at 11:30 AM, an observation was made with RN A of all the exit doors and their locations. All exit doors were noted to have an additional pull tab alarm on the door handle. RN A was asked to ensure all the doors were working properly with this Surveyor. RN A was unable to engage door #5's alarm for 15 seconds and RN A was unable to have door #4's magnet release properly for the door to open. RN A stated that she would have the activities aide [CNA L] she if she could get the doors to work properly and have maintenance come and look at the doors to see if they were functioning properly.</p> <p>On 5/13/24 at 12:15 PM, an interview was conducted with RN A and was asked why the tab alarms were located on the front lobby entrance door and all the fire doors and replied, We added them after [R2's name] second elopement as an added precaution.</p> <p>On 5/13/24 at 1:00 PM, an observation was made of CNA L checking door #5 and it was noted that door #5 was very difficult to engage and open after the 15 second hold. CNA L was observed to add substantial force to door #5 to have it engage and open. CNA L was asked why she did not have maintenance check the function of the door and replied, I guess I just learned to deal with it and that is how the door was and I knew how to open it because I check it all the time.</p> <p>On 5/13/24 at 1:10 PM, an observation was made of CNA L checking door #4 and it was noted that door #4 was difficult to open and CNA L had to manipulate the door to get the magnet to release.</p> <p>On 5/13/24 at 1:20 PM, the Maintenance Supervisor (MS) I was observed checking door #5 and could not get the door to engage. CNA L had to show MS I how to open the door. During this time MS I had the two other maintenance crew members go and double check all the doors for functionality.</p> <p>Review of facility document titled, Daily Door Alarm Check, dated April 1 through April 30, 2024, revealed that door #11 had not been check for the entire month, door #9 had written info stating that the tether alarm not working on days 10, 17, 18, 19, 20, 21, 22, and 23, door #8 had written info stating that the RT [right] side of door not working prop. [properly], and lacked any door check for 4/19/24.</p> <p>Review of facility document titled, Daily Door Alarm Check, dated March 1 through March 31, 2024, revealed that door #11 had not been checked for the entire month and lacked any door checks on 3/24/24.</p> <p>Review of facility documents identified as, Work Orders, dated 4/11/24, 4/17/24, 4/18/24, 4/20/24, and 4/22/24, all revealed ticket submissions as high priority and indicated that the tether [Wanderguard] alarm was not working.</p> <p>On 5/14/24 at 9:00 AM, an observation was made with the DON of door #8. The DON and this Surveyor attempted to walk through door #8 when it would not engage. The DON called maintenance. Maintenance staff R came and had to adjust door #8 with a tool before he was able to get the door to engage, alarm, and open.</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 - Some</p>	<p>On 5/14/24 at 11:15 AM, an interview was conducted with MS I, and was asked to provide copies of monthly fire drills. Copies were provided and reviewed. MS I was asked if he was conducting monthly fire drills then why were door #'s 4, 5, and 8 still not functioning properly and why door #11 was not found to be engaged until after R2 had eloped out that door and replied, Honestly, I cannot answer that. MS I was then asked about work orders and priority levels and replied, There is no policy on how fast they get completed. I am working on a process to get these completed sooner and ensure the doors are working properly. It has been a process.</p> <p>Review of policy titled, Door Alarms, dated 5/24, read in part, Purpose: Define procedure for use of door alarms to prevent elopement .4. Daily the Activity Aide will make checks on each door alarm system .5. Procedure: a. Walk through each door indicated holding a tether and verify proper function of alarm system . c. Implement second security system by applying a pull alarm to the door until system is deemed fully functional .</p> <p>Review of policy titled, Door, Locking System, dated 12/06/2022, read in part, Purpose: To ensure the safety of all residents through the proper usage of the Locking Door System .Procedure: 1. The locking door system needs to be engaged at all times .</p> <p>Part 3:</p> <p>Resident #8 (R8)</p> <p>On 5/13/24 at 12:56 PM, an observation was made of R8 sitting in her recliner with her front wheeled walker in front of her. R8's fall mat was on the floor in her room next to her bed and R8's call light was tucked underneath her pillow on her bed and out of her reach.</p> <p>On 5/13/24 at 1:00 PM, an interview was conducted with the DON, and was asked if the floor mat should be on the floor if R8 was not in bed and replied, No, that is a trip hazard. The DON immediately removed the mat from its place.</p> <p>Review of R8's care plan, printed on 5/13/24, read in part, .I am at risk for falls related my Morse Fall Scale score of 75, which is considered high .Interventions .Be sure that my call light is within reach .I require a safe environment with: even floors free from spills and/or clutter .</p> <p>Resident #1 (R1)</p> <p>On 5/13/24 at 1:15 PM, an observation was made of R1's room. R1 was not in her room, but it was noted that her floor mat was left on the floor next to her bed.</p> <p>On 5/14/24 at 8:30 AM, an observation was made of R1 sitting in her room in her wheelchair. R1's fall mat was observed on the floor in her room and her call light was pinned on an electrical cord on the electrical outlet and was out of her reach.</p> <p>Review of R1's care plan, date printed 5/13/24, read in part, .Focus: I am at risk for falls r/t [related to] Gait/balance problems and dementia .Interventions .Ensure that my call light is within reach .landing strip at bedside .The resident needs a safe environment with: even floors free from spills and/or clutter .</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 - Some</p>	<p>On 5/14/24 at 8:35 AM, an interview was conducted with CNA H, and was asked if he thought R1 could reach her call light safely and with ease and replied, Well her floor mat should not be on the floor if she is not in bed and her call light is out of her reach. I feel it would be difficult for her to reach it in her wheelchair because she would have to go over the mat and might get caught of tip over. I will pick the mat up and get her the call light in case she needs anything.</p> <p>Review of policy titled, Standards of Care, dated 4/30/24, read in part, General Standards of Care .7. Keep rooms free of clutter and pathways clear and keep areas well-lit to help prevent falls .10. Call light within reach at all times .</p> <p>Part 4:</p> <p>Review of Intake #MI00143451's Incident Summary, dated 3/13/24 at 4:30 PM, read in part, .Resident [R1] was checked during rounds and discovered laying on her left side with leg up against the radiator. Charge nurse was immediately notified, reddened area was assessed and per documentation measured 80x54 cm [centimeters] with an open area in middle 21x32 cm w/o [without] any drainage .</p> <p>Review of Investigation Summary, dated 3/16/24 at 11:16 AM, read in part, .Root cause findings were: Bed was placed close to register d/t [due to] not having a policy in place for bed placement .</p> <p>Review of R1's wound picture, dated 3/13/24, revealed a left lower leg with redness and register marks indented in the skin with an open area in the center.</p> <p>Review of witness statement by CNA H, dated 3/13/24, read in part, .found resident [R1] in her room [ROOM NUMBER] on 3/13/24 at 4:30 AM in bed with leg on floor resting on the heater. When I moved her leg back up on the bed I noticed she had a burn from the heater .</p> <p>On 5/14/24 at 1:45 PM, an interview was conducted with CNA H, and was asked about his witness statement and bed placement for R1 during the incident and replied, Yes, the witness statement is accurate. CNA H showed this Surveyor how the bed was positioned for R1. CNA H stated that the bed was up close to the register and there was less than an inch between the bed and the register. CNA H further explained that R1's injury was about the size of a quarter to a fifth cent piece and that it had a blister in the middle. He was called in early and got to the facility around 3:00 AM and got report then did rounds and found R1 with her leg on the register around 4:30 AM. CNA H stated he worked at the facility back in September and did not recall any beds being up against or close to the registers and thought the policy had changed.</p> <p>On 5/14/23 at 2:15 PM, an observation was made of R1's room and her register. R1's register measured approximately 3.5 inches wide. CNA H had described R1's bed to be approximately one inch away from the register at the time the incident on 3/13/24 when she sustained a skin injury on her left lower leg from her register.</p> <p>Review of wound evaluation, dated 3/13/24 at 10:28 AM, read in part, .Front Left Lateral Lower Leg . In-House acquired .(lacked measurements) .</p> <p>Review of R1's care plan, date printed 5/14/24, read in part, .I have sustained a burn on my left lateral shin .</p> <p>(continued on next page)</p>		

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