

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>414120</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>6/18/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SKLD LEONARD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 LEONARD ST N E GRAND RAPIDS, MI 49505</b>
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F0000 SS=	INITIAL COMMENTS  SKLD Leonard was surveyed for an Abbreviated survey from 6/17/25-6/18/25.  Intake #MI00151183, MI00153606 & MI00151905  Census=62	F0000		
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:  This citation pertains to intake #MI00151905  Based on interview, and record review, the facility failed to provide adequate supervision in 1 resident (Resident #101) of 3 residents, reviewed for elopement, when Resident #101, who was actively exit seeking and a high fall risk, exited the facility unattended on 3/27/25 and descended 16 concrete steps to a parking lot, resulting in the potential for serious injury and/or harm.  Findings include:  Review of an "Admission Record" revealed Resident #101 was originally admitted to the facility on 4/13/22, with pertinent diagnoses which included: repeated falls, delusional disorder, parkinson's disease, and alzheimer's	F0689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/30/2025

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.

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	<p>disease.</p> <p>Review of Resident #101's "Wandering risk scale" assessment dated 1/30/25 indicated a high risk to wander.</p> <p>Review of Resident #101's "Care Plan" revealed, "...elopement risk r/t (related to) delusion at times when resident is confused due to lewy bodies (a gradual decline in mental abilities). Created on 2/24/2023...Interventions: May wander or attempt to leave facility unattended: triggers for wandering/elopeing are thinking that people are trying to get her, or violence is occurring outside. De-escalated by redirection, speaking to her about things, active listening. Created on 8/30/2024, Distract resident when increased wandering by offering pleasant diversions, structured activities, food, conversation, television, book, etc. per resident preferences. Created on: 2/24/2023, Encourage rest periods as tolerated if fatigue or weakness observed with wander and/or exit seeking behavior. Created on: 2/24/2023, Provide structured activities; toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes, etc. to identify personal space. Created on: 2/24/2023, Provide visual reminders and/or deterrents to high risk exit locations per facility protocol. Created on: 8/30/2024..."</p> <p>Review of the Facility Reported Incident (FRI) dated 3/27/25 revealed, "...Resident (Resident #101) exited the facility unsupervised at 5:10 AM. She exited the building through the left exit doors in the main dining room...Interviews/Investigation Timeline: 2:30 AM Resident was wandering hallways looking for family. Resident had been testing doors in the front lobby but was able to be redirected. Resident awoke at 3:20 AM asking nursing staff to bring her to her sister's house and stating that</p>				

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	<p>she "wants to go home". Gave PRN (as needed) pain medication for c/o (complaints of) leg pain and PRN Ativan for anxiousness and her urgent requests to leave. Resident drank 180 cc med pass (nutritional supplement). Ambulated thru-out facility and resident hallways. Roughly 5:00 AM resident was laid back in bed and appeared to be asleep. At roughly 5:10 AM the dining room exit door began alarming. Staff responded and observed (Resident #101) at the bottom of the stairs outside leading in to the parking lot. Upon further investigation and interviews it was determined that (Resident #101) had been having exit seeking behaviors since 2:30 AM. She had been noted to be pushing on doors in the front lobby and dining room...During the time when staff were doing rounds (Resident #101) had exited her room, walked down 200 hall and into the common area, proceeded to open the doors to the dining room and exited through the back left exit door...down 16 stairs to the parking lot...staff were able to get her while she was in the parking lot..."</p> <p>During an observation on 6/17/25 at 9:50 AM of the facility floor plan. Observed 3 halls with resident rooms and 1 hall with offices that lead to the lobby and the dining room. At the far end of the dining room, observed a fire exit that lead to 5 steep concrete stairs, a platform, then a turn with 5 additional steep concrete stairs, then another platform and ended with 5 wide steps that led to a parking lot full of cars.</p> <p>In an interview on 6/17/25 at 11:24 AM, Certified Nursing Assistant (CNA) "F" reported that she was not assigned to Resident #101's hall but at approximately 4:00 AM on 3/27/25 she heard the main dining room door alarming CNA "F" reported that when she got to the door Resident #101 was observed in the parking lot. CNA "F" reported that she called for more help and headed out the door to get the resident. CNA "F" reported</p>				

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	<p>that it was very cold outside that night and Resident #101 did not have her walker. CNA "F" reported that Resident #101 had been "ramping up" and exit seeking more frequently but was not assigned to any increased supervision.</p> <p>In an interview on 6/17/25 at 2:03 PM, Registered Nurse (RN) "C" reported that Resident #101 was a high fall risk and had been agitated, wandering and exit seeking for 2 days prior to her elopement on 3/27/25. RN "C" reported that Resident #101 had been testing doors and more agitated than usual. RN "C" reported that the facility was short a nurse on 3/27/25 therefore RN "C" and Licensed Practical Nurse (LPN) "C" were sharing Resident #101's hall (200) but were both on other halls during the elopement. The CNA's had a similar assignment and were on other halls during the elopement. RN "C" reported that staff had closed the resident's room door and closed the double doors to the main lobby/dining room in an attempt to stop Resident #101 from leaving the unit unsupervised. RN "C" reported that she had heard the door alarm going off for a couple minutes between 4:30-5:30 AM but was in a room doing wound care; when she came out of the room she did not see any staff. RN "C" went to the nurse's station and the "board" was showing that the main dining room door was alarming. RN "C" made her way down the administration hall, and through the dining room where she saw CNA "F" trying to open the exit door. RN "C" reported that Resident #101 was already walking across the parking lot when they first saw her; she had made it down 3 flights of stairs. RN "C" reported that Resident #101 was unsteady on her feet and frequently fell. RN "C" reported that staff had not implemented an increased supervision intervention on 3/27/25 when the resident was exit seeking.</p> <p>Multiple attempts were made to contact LPN "D", with no return phone call prior to survey exit.</p>				

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	<p>In an interview on 6/18/25 at 7:59 AM, RN "K" reported that on 3/26/25 (day before elopement) Resident #101 was constantly trying to exit the facility and the door alarms were going off. RN "K" reported that Resident #101 was observed exiting the door at the end of 200 hall on 3/26/25 at approximately 4:00 AM, but was immediately redirected back to her room on 200 hall.</p> <p>In an interview on 6/18/25 at 9:01 AM, CNA "M" reported that she was in a room on 300 hall with another CNA on 3/27/25 when Resident #101 eloped from the facility. CNA "M" reported that Resident #101 was wandering and exit seeking since about 10:00 PM that evening and constantly setting off the door alarm in the main lobby. CNA "M" reported that staff had closed the double doors to the lobby/main dining area in an attempt to stop the resident from exit seeking. CNA "M" did not hear a door alarm or know about the elopement until she came out of the room she was in with CNA "G".</p> <p>In an interview on 6/18/25 at 1:17 AM, CNA "L" reported that she was not working on Resident #101's hall the night of her elopement but reported the resident was roaming the halls with her walker, talking about someone coming to pick her up and had extra clothes with her. CNA "L" reported that she was charting on 100 hall and remembered hearing a door alarm that morning. CNA "L" did not respond to the door alarm.</p> <p>In an interview on 6/18/25 at 11:30 AM, Director of Nursing (DON) "B" reported that Resident #101 had a history of exit seeking, requested help opening doors, pushed on doors, wandered, and would look for a train station. DON "B" reported that Resident #101 had been actively exit seeking, and had exited the 200 hall door the day before around the same time. DON "B" reported on</p>				

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	<p>3/27/25 when the resident was exit seeking, staff responded by administering anti-anxiety and pain medication, and thought that the resident was resting in bed until the elopement occurred. DON "B" reported that he would have expected staff to increase supervision of Resident #101 and that did not happen. Additionally, DON "B" reported that Resident #101 was a very high fall risk, had most recently fallen on 3/24/25 and should have had increased supervision.</p> <p>In an interview on 6/18/25 at 1:30 PM, Director of Therapy (DOT) "P" reported that Resident #101 was not safe to ambulate unsupervised, was very unsteady, had a shuffled gait, and a history of falls. DOT "P" reported that Resident #101's last therapy recommendations were supervised to touching assistance for walking.</p> <p>Review of Resident #101's "Physical Therapy Discharge Summary" dated 10/23/2024 revealed, "...Ambulation: Walk 10 feet...Walk 50 feet with two turns...Walking 10 feet on uneven surfaces-supervision or touching assistance..."</p> <p>Review of Resident #101's "Fall Reports" indicated that she had 6 unwitnessed falls between 2/13/25 and 3/24/25.</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included education with all staff on increasing supervision for residents that are actively exit seeking, reviewing all residents at risk for elopement, and continued audits to ensure all residents were accurately assessed and monitoring was in place. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>				