STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235214	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00146628, MI00146773, MI00146696 Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal abuse and physical abuse by a resident for four (R605, R606, R611, and R609) of 12 residents reviewed for abuse, resulting in R605 being slapped by R606 after R605 called R606 a derogatory name, R605 being pushed by R611 after R605 called R611 a derogatory name, and R609 being hit with a shoe by R610. Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed an allegation that R606 slapped R605 on 8/15/24. On 11/12/24 and 11/13/24, an unannounced investigation was conducted onsite at the facility. A review of R605's clinical record revealed R605 was admitted into the facility on [DATE], readmitted on [DATE], and discharged on [DATE] with diagnoses that included: dementia, traumatic brain injury, bipolar disorder, and post traumatic stress disorder (PTSD). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R605 had severely impaired cognition and no behaviors, including wandering. A review of a Nursing Progress Note dated 7/26/24 revealed R605 experienced some behavioral issues. A review of the IDT (interdisciplinary team) Review Note dated 7/30/24 revealed R605 has some increased agitation. It was documented throughout the month of July 2024 that R605 wandered the hallways. A review of a Nursing: Infection Note dated 8/14/24 revealed R605 continues to walk through the halls as normal but seems more agitated and talkative than normal. A review of a Nursing Progress Note dated 8/15/24 revealed, Co-worker approached writer that resident (R605) was slapped in her right face by another resident in hallway .redness noted at spot behind right ear . (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a Behavior Notes dated 8/15/24 revealed, .after incident writer observed resident (R605) still becoming verbally aggressive towards other residents .resident was wandering the hallways following behind another resident . A review of R606's clinical record revealed R606 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included: Wernicke's encephalopathy and adjustment disorder. A review of a MDS assessment dated [DATE] revealed R606 had intact cognition and no behaviors. A review of an Incident Note dated 8/15/24 revealed, Writer was informed by care staff that resident (R606) slapped another resident (R605) in the face. Writer and Social Worker interviewed resident (R606) who stated she slapped resident (R605) because she called her out her name as she was passing by in her wheelchair on her way to the dining room . A review of a second Incident Note dated 8/15/24 revealed R606 was taken into policy custody. A review of a 5 Day Investigation Summary dated 8/15/24, conducted by the facility, revealed Certified Nursing Assistant (CNA) 'E' heard a loud slap and saw R606 in a wheelchair in front of R605 and R605 was holding her face. R606 said that R605 called her a fat bitch. R606 was arrested by the local police. It was documented R606 was interviewed as part of the investigation and stated, She called me a 'fat bitch' so I slapped her, and I will do it again, she knows what she is doing!' The investigation revealed the facility did validate that abuse occurred when (R606) slapped (R605). It was noted that R606 was arrested and R605 is a long term resident and has had no further concerns and continues her activities of daily living without incident. There was no documentation of any additional interventions for R605 who used derogatory language toward R606. On 11/12/24 at 2:35 PM, an interview was conducted with CNA 'E'. CNA 'E' reported hearing a smack and when she turned around R606 and R605 were face to face in the hallway and R605 was holding her face. CNA 'E' said R605 always says things to everyone. When queried about what kind of things R605 said, CNA 'E' reported R605 called people out their names in passing. CNA 'E' explained R606 reported R605 called her a fat bitch and that was why she slapped her. Further review of R605's clinical record revealed on 8/17/24 R605 tapped another resident on the top of the head and on 8/18/24 another resident reported that R605 hit her on the forehead on 8/16/24. A review of an investigation into the allegation from 8/18/24 revealed abuse was not substantiated at that time, but R605 was placed on 1:1 supervision indefinitely. A review of a FRI submitted to the SA on 8/27/24 revealed an allegation that R611 hit R605. Further review of R605's progress notes revealed R605 was on 15 minute checks on 8/20/24, not 1:1 supervision. R605 was seen by the medical practitioner on 8/20/24 for increased agitation and her antipsychotic medication dose was increased. On 8/21/24, it was documented in an IDT Review Note that R605 was on a 1:1 for safety. A Nursing Progress Note dated 8/23/24 noted R605 continues 15-minute checks for safety and is on a 1:1. On 8/24/25 and 8/25/24, it was documented R605 was on 15-minute checks. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a Nursing Progress Note dated 8/27/24 at 11:33 AM revealed Writer observed resident walking past another resident (R611) and was pushed on her back .Resident is on 1:1 monitoring . A second Nursing Progress note dated 8/27/24 revealed, .Immediate intervention implemented: resident placed on 1:1 supervision . It should be noted that R605 was supposed to be on 1:1 supervision since 8/18/24, per the facility's investigation. On 11/12/24 at 12:45 PM, an interview was conducted with Licensed Practical Nurse (LPN) 'F' via the telephone. LPN 'F' reported R605 frequently wandered the hallways and whispered stuff to the other residents. When queried about what R605 said to other residents, LPN 'F' reported it was usually fat bitch or bitch and then she continued walking. On 11/12/24 at approximately 4:10 PM, R611 was observed in her room. R611 talked excessively about Jesus, her mother, and many unrelated topics, then proceeded to follow the surveyor throughout the facility at close range. A review of R611's clinical record revealed R611 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, PTSD, dementia, and paranoid personality disorder. A review of a MDS assessment dated [DATE] revealed R611 had severely impaired cognition and physical and verbal behaviors. A review of R611's progress notes revealed a history of verbal altercations with other residents. A review of a Nursing Progress Note dated 8/27/24 revealed, Writer observed (R605) walking past (R611) and (R611) pushing (R605). (R611) stated, 'Ain't nobody going to be walking past me calling me a Bitch, yeah I pushed her and my family will finish her off. A second progress note from 8/27/24 noted R611 was petitioned to the hospital for a psychological evaluation due to physical aggression. A review of a 5 Day Investigation Summary conducted by the facility dated 8/27/24 revealed, Registered Nurse (RN) 'J' observed R611 push R605 in the dining room. It was noted that R611 walked by R605 and R605 called R611 a bitch. The investigation revealed R605 had a documented and care planned behavior regarding calling people out of their name. It was documented as a result R611 got upset and pushed R611. The investigation further noted that R611 had a history of combative behavior. On 11/13/24 at 1:31 PM, an interview was conducted with Scheduler 'K'. When queried about the process for staffing when a resident required 1:1 supervision, Scheduler 'K' reported the unit manager or Director of Nursing (DON) let her know if someone needed to be scheduled for 1:1 supervision, then she sent out a request for staff to pick up that shift. Scheduler 'K' reported the staff person assigned for 1:1 supervision would be reflected on the schedule and/or the assignment sheet for that shift. At that time, Scheduler 'K' provided all schedules and assignment sheets from 8/18/24 through 8/27/24. A review of the scheduled and assignment sheets from 8/18/24 through 8/27/24 revealed no assigned staff for 1:1 supervision for R605 on 8/18/24, 8/19/24, 8/20/24, 8/21/24, 8/22/24, 8/23/24, 8/24/24, and 8/25/24. On 8/26/24 and 8/17/24 there was one CNA assigned to two different residents (one who was R605) for 1:1 supervision during the day shift and afternoon shift. It should be noted that it was not 1:1 supervision if assigned to two residents at the same time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 2:32 PM, an interview was conducted with RN 'J' via the telephone. RN 'J' reported R605 was walking around the building like she typically did and walked past R611. RN 'J' reported they did not remember if R605 said anything to R611, but R605 often mumbled things under her breathe saying 'fat bitch' and stuff. RN 'J' witnessed R611 push R605. When queried about whether R605 was on 1:1 supervision, RN 'J' reported they could not recall, but the after the incident R605 was put on 1:1 supervision and R611 was sent to the hospital. On 11/13/24 at 2:40 PM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. When queried about what was done to prevent R605's verbally abusive behaviors after she called R606 a fat bitch on 8/15/24 which resulted in R606 slapping R605, the Administrator reported R606 was arrested and the staff were told to watch R605 more closely and she was referred for a psychiatric evaluation. The Administrator stated, (R605)'s behaviors are the same thing all the time so they just have to watch her. When queried about why 1:1 supervision was not implemented as mentioned on the investigation conducted by the facility on 8/18/24 after another resident alleged being hit by R605, the Administrator stated, We did our best and explained they were unable to maintain 1:1 supervision due to a system breakdown and not having enough staff so they did their best with 15 and 30 minute checks. When queried about whether there was documented evidence of the 15 and 30 minute checks, the Administrator reported some may be scanned into the medical record but they do not have documentation for every day. A review of the 15 Minute Check Sheets available in the clinical record revealed they were completed on 8/22/24 after 6:45 PM and on 8/23/24. No additional information was provided prior to the end of the survey. On 11/13/24 at 3:39 PM, the Administrator was asked to provide any notes from the contracted behavioral health agency from 8/15/24 and 8/27/24, as a referral to behavioral health was reported as an intervention for R605 after the 8/15/24 incident to prevent further verbal abuse from occurring. According to the notes provided by the facility, R605 was not evaluated by behavioral health until 8/29/24. A review of a facility policy titled, Abuse, Neglect and Exploitation, reviewed on 3/13/24, revealed, in part, the following: .The facility will identify by ongoing assessment, care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict . 47283 A facility submitted investigation report dated 8/22/24 revealed resident to resident physical abuse. The report revealed a on 8/22/24, at 1:40 PM, a facility staff member witnessed R610 standing over R609's bed, hitting R609 with a shoe. The facility investigation report further read I told him to stop and went and got the nurse. Action taken section of the document revealed R610 was moved to a different room. R609 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed R609 was admitted on [DATE]. R609's admitting diagnoses included dementia, malnutrition, mood disturbance, glaucoma, and anxiety. Based on the Minimum Data Set (MDS) assessment dated [DATE], R609 had Brief Interview for Mental Status (BIMS) score of 3/15, indicative severe cognitive impairment. R609 also had severe vision impairment and moderate hearing impairment. R609 needed moderate to extensive staff assistance with their mobility and Activities of Daily Living (ADLs) such as dressing, bathing etc. An initial observation was completed on 11/12/24 at approximately 10:20 AM. R609 was observed in their bed with a sheet over their head. Resident responded when called their name the second time, louder. R609 reported that they did not have anything to eat and needed a cigarette. Review of R609's progress notes revealed a late entry nursing note dated 8/22/24 at 14:39 (2:39 PM) read in part, housekeeper observed resident being hit with a shoe on the lower part of his leg by his roommate . Resident unable to explain what happened due to impaired cognition . Review of R609's care plan revealed that R609 liked to watch television and listening to music while and they had moderate hearing impairment. The care plan also revealed an intervention that read, be conscious of position when in groups, activities, dining room to promote proper communication with others and remove me from highly stimulated environments due to their communication problem related hearing deficit. R610 R610 was also a long-term resident, admitted to the facility on [DATE]. R610's admitting diagnoses included dementia with behavioral issues, alcohol abuse, anxiety, depression, insomnia and heart failure. Based on the MDS assessment dated [DATE], R610 had a BIMS score of 6/15 indicative of severe cognitive impairment. R610 was discharged from the facility on 10/31/24. Review of R610's Electronic Medical Record (EMR) revealed that R610 had a history of behavior problems. R610's admission/census records revealed their room was changed at six different times between 4/9/24 and 8/22/24. Review of nursing progress notes revealed a note dated 8/9/24 at 13:48 that read, Resident moved back to 110-2 due to not getting along with 120-2 resident, received resident in 110-2 and stated he like 110 . A progress dated 8/22/24 at 17:21 (5:21 PM) read in part, Resident got upset his roommate was singing and hit his roommate with a shoe. Resident did deny hitting resident but admitted he did want him to stop singing. Review of R610's care plan revealed that R610 had history of behaviors that included altercation with roommate, calling other residents with inappropriate names, and aggressive/combative behaviors. A care plan that was initiated on 4/11/24 read in part, I have a history of hitting and yelling at peers. I have a history of throwing things at peers . Review of psychologist visit note dated 7/22/24 read in part, staff requested he be seen due to a resident-to-resident incident. This was an incident prior to R610 being moved into R609's room which was semiprivate (two beds) room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with housekeeper (HK) L was completed on 11/12/24 at approximately 9:30 AM. They were queried about the incident between R610 and R609 that they had witnessed. HK L reported that they remembered the incident and added that that they were outside R609/R610's room and they were getting ready to go into the room. They observed R610 standing next to R609's bed and they were hitting them with a tennis shoe. When queried further they added that R609 cannot see and cannot speak clearly and they were not able to do anything. HK L reported that they had to ask them to stop and had reported the incident to the nurse and got assistance. An interview with facility administrator was completed on 11/13/24 at approximately 2:45 PM. During the interview they were notified of the abuse concern related to R610 hitting R609 with a shoe. They reported that they understood the concern and when queried why R610 was moved into R609's room when they had a history of combative/aggressive behaviors and not getting along with their roommates and had multiple room changes in the last few months. The Administrator reported that they tried to do their best with their open rooms and they were looking for placement. No further explanation was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on interview, and record review, the facility failed to thoroughly investigate an allegation of resident to resident physical abuse for two (R605 and R608) of 12 residents reviewed for abuse. Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed R608 alleged R605 hit her in the head on 8/16/24. On 11/12/24 at 10:50 AM, an interview was attempted with R608. R608 was difficult to understand and did not want to talk. A review of R608's clinical record revealed R608 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Multiple Sclerosis. A review of R608's Minimum Data Set (MDS) assessment dated [DATE] revealed R608 had intact cognition with no behaviors. A review of R608's progress notes revealed a Nursing Progress Note dated 8/18/24 that read, Resident came to nursing station and told assigned nurse that another resident punched her in the head two days ago . This note was written by Licensed Practical Nurse (LPN) 'F'. A review of a 5 Day Investigation Summary written by the facility revealed, On Sunday, August 18, 2024, at approximately 1:10 PM (R608) reported to (LPN 'F') that a resident hit her on Friday. This writer interviewed (R608) and she states that she did not know the name of the resident that hit her, but she knew what she looks like. R608 was able to identify the resident as R605. The writer of the investigation asked R608 why she did not report it when it happened and R608 said she reported it to a Certified Nursing Assistant (CNA). Per the investigation, that CNA did not work during that time frame. R608 said R605 called her a fat bitch and hit her in the head. The incident was not witnessed. In conclusion, the facility documented abuse was not substantiated, but they were taking R608's word that she was hit. A review of R605's clinical record revealed R605 was admitted into the facility on [DATE], readmitted on [DATE], and discharged on [DATE] with diagnoses that included: dementia, traumatic brain injury, bipolar disorder, and post traumatic stress disorder (PTSD). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R605 had severely impaired cognition and no behaviors, including wandering. A review of an investigation conducted by the facility revealed on 8/15/24, R605 called another resident a fat bitch which resulted in that resident slapping R605. On 11/12/24 at 12:45 PM, an interview was conducted with LPN 'F'. LPN 'F' reported she did not witness R605 hit R608, but R605 had a history of whispering fat bitch when she walks past other residents. Further review of the investigation revealed no other staff other than LPN 'F' was interviewed and no residents were interviewed to determine if anyone else had been verbally or physically abused by R605. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 2:40 PM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. When queried about whether she interviewed any other residents to determine if anyone else was hit or affected by R605's verbal behaviors, the Administrator reported she did not interview anyone other than LPN 'F'. A review of a facility policy titled, Abuse, Neglect, and Exploitation, reviewed on 3/13/24, revealed, in part, the following, .Investigations may include but not limited to .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Focusing the investigation on determining if abuse .has occurred, the extent, and cause . Providing complete and thorough documentation of the investigation .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to implement care planned interventions for bed mobility and toileting and develop a care plan to address combative behaviors and hearing deficits for one (R601) of seven residents reviewed for accidents, resulting in a skin tear to the left hand. Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) on 8/5/24 revealed an allegation that a man twisted R601's arm on 8/3/24. The alleged perpetrator was noted to be Certified Nursing Assistant (CNA) 'H'. On 11/12/24 at 9:50 AM and 10:55 AM, R601 was observed sleeping. At 10:55 AM, R601's roommate was interviewed and they reported R601 yells a lot. A review of R601's clinical record revealed R601 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, macular degeneration, and dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R601 had severely impaired cognition, no behaviors, and required substantial/maximum assistance for bed mobility and toileting hygiene. R601 received hospice services. A review of a Nursing Progress Note dated 8/3/24 at 7:52 AM, written by Licensed Practical Nurse (LPN) 'F', revealed, After getting report from previous nurse, writer was doing rounds on residents, resident was received in bed with a skin tear .when asked how it happened resident stated, 'one of your friends did it'. Resident was complaining of pain and saying 'Ouch' . A review of a Hospice Progress Note dated 8/3/24 at 2:12 PM, written by Registered Nurse (RN) 'G' revealed, Staff nurse notified on call regarding skin tear .Skin tear present on the back of the left hand/wrist; measuring 3 cm (centimeters) x (by) 2 cm x 0.1 cm .Patient skin is fragile .Patient is also known to be combative during ADL (activities of daily living) care .Patient states that a man twisted his arm during the night time . A review of a 5 Day Investigation Summary conducted by the facility revealed a statement from CNA 'H' that documented, At 6:40 AM I entered (R601) room .I asked (R601) 'Can I get you cleaned up for breakfast. He stated yes. I proceeded to clean (R601). As I turned (R601), he stated that's enough and stated swing <sic>. I told (R601) we are almost done. I put his brief on and as I turned him on his back, he really started swinging again. I grabbed his hand and placed them to his chest. I proceeded to finish by closing his brief, then I left his hands go. When I left his room, I did not see a skin tear . The investigation noted R601 had a history of being combative with care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 11:05 AM, an interview was conducted with CNA 'H' on the telephone. When queried about what happened with R601 on 8/3/24, CNA 'H' reported R601 was blind and hard of hearing and if it took too long providing care, he would start fighting you. CNA 'H' reported he would have to leave and re-approach R601 when he did that. When queried about the statement of holding R601's hands to his chest while finishing care, CNA 'H' did not offer a response. CNA 'H' reported he saw the skin tear the following day after he was told about it and stated, Someone had to literally grab this man to cause that. When queried about how many staff members R601 required when turning in bed or receiving a brief change, CNA 'H' stated, His Kardex says two person assist but really he is a one person assist. When you are as big as I am, I can handle him by myself. CNA H' reported he did not notice a skin tear after providing care. On 11/12/24 at 12:32 PM, an interview was conducted with LPN 'F' via the telephone. LPN 'F' reported that upon starting her shift on 8/3/24, R601's left hand was actively bleeding with a skin tear. LPN 'F' said it was not reported to her at shift change. LPN 'F' explained R601 was blind and hard of hearing and was often combative with care. It was further reported staff needed to explain what they were doing to R601 and to re-approach and notify the nurse if R601 became combative during care. When queried about the level of assistance R601 required, LPN 'F' stated, My aides can usually handle him with one person. On 11/12/24 at 11:17 AM, an interview was conducted with RN 'G' who was a contracted hospice nurse. RN 'G' reported R601 was combative during care and had fragile skin. RN 'G' reported due to his behaviors, R601 required two people to change his brief so they could get it done quickly and especially when he was combative. A review of R601's care plans revealed the following: A care plan initiated on 9/28/21 that read, I have an ADL Self Care Performance Deficit r/t (related to) Activity Intolerance, macular degeneration. I am combative during care at times . An intervention initiated on 5/5/22 and last revised on 7/12/22 that noted, BED MOBILITY: I require assist of 2 staff to turn and reposition . An intervention initiated on 9/28/21 and revised on 2/2/24 noted, TOILETING- I require extensive assistance by 2 staff for toileting. I am incontinent of Bowel/bladder provide peri care after each incontinent episode . A care plan initiated on 3/19/24 documented, MOOD/BEHAVIOR: .I have a hx (history) of yelling out. I am legally blind . The care plan was revised on 8/6/24, three days after R601 sustained a skin tear to the left hand. The revision included .I am very HOH (Hard of hearing) .I sometimes become combative with care . It was not until 8/6/24 that an intervention was put in place to address R601's hearing deficit, at which time the intervention initiated was Please take your (time) talking to me, talk loud and clear and make sure I understand (you) before providing care . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 12:06 PM, an interview was conducted with the DON. The DON reported CNAs should refer to the Kardex, which is derived from the care plan, to confirm the level of assistance residents required. When queried about who was able to determine whether a lesser level of assistance could be used for care, the DON reported the resident had to be assessed and a CNA could not determine it. When queried about what a CNA should do if a resident became combative during care, the DON reported the CNA would make sure the resident was safe, go get another staff member, and re-approach. When queried about R601, the DON reported if care planned for two person assistance, two person assistance should be used. When queried about whether it was appropriate to hold R601's hands to his chest while completing care while combative, the DON reported another staff member should have been brought in to assist.

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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** 47283 This citation pertains to Intake: MI00146570 Based on observation, interview, and record review, facility failed to provide supervision needed for one (R607) of five residents reviewed for with elopement. This deficient practice resulted in R607 with severe cognitive impairment exiting the facility unbeknownst to facility staff with potential for serious injury from the resident being outside and unsupervised, with access to a five a lane road. R607 Record review revealed R607 was a long-term resident of the facility, originally admitted to the facility on [DATE]. R607's admitting diagnoses included dementia, mood disturbance, anxiety, stroke, muscle weakness, history falls, and malnutrition. Based on the Minimum Data Set (MDS) assessment dated [DATE], R607 had a Brief Interview for Mental Status (BIMS) score of 6/15, indicative of severe cognitive impairment. R607 needed staff assistance with their mobility and Activities of Daily Living (ADLs) such as bathing, dressing, etc. due to their physical and cognitive impairment. R607 was using a wheelchair for their mobility. R607 had a guardian who were handling their medical and financial decisions. An initial observation was made on 11/12/24 at approximately 9:10 AM. R607 was observed sitting in their wheelchair outside of their room with their eyes closed. R607 was unable to provide any information on the incident. Later that day a follow up observation was completed at approximately 12:15 PM. R607 was observed in the 2nd floor dining room eating lunch. At approximately 12:30 PM, R607 was observed coming out of the elevator with no staff member. R607 got out of the elevator and a staff member directed them towards their room. R607 wheeled towards their room and a Certified Nursing Assistant (CNA) directed them to the room. R607 got next to the bed and before the CNA went into the room, R607 got out of their wheelchair and got into the bed; did not lock the wheelchair brakes and performed the task in an unsafe manner. Review of the investigation report submitted to the State Agency revealed that on 8/14/24, R607 eloped from the facility through the facility's front door and was observed near the bus stop at 8:45 PM. The report read that R607 was outside of the facility for approximately 5 minutes and the front had an egress alarm with 15 seconds delay and was alarmed. However, the investigation report did not reveal that staff did not respond to the alarm and were unaware that R607 exited the facility. R607 was observed outside of the facility, near the bus stop, in their wheelchair while Registered Nurse (RN) J was leaving the facility after their shift. The report revealed that RN J assisted R607 back to the facility. The report also read the facility is in the process of purchasing a wander guard system to ensure resident safety. Review of the facility investigation report did not include the witness statements from the nurse and CNA assigned to care for R607 on 8/14/24 and did not reveal a root cause analysis for the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An initial observation of the facility door set up on 11/12/24 at approximately 11:30 AM revealed the two sets of doors with a door closing mechanism. The first set of doors from the hallway to a small vestibule (approximately 10 feet) and 2nd set of doors were the exit doors from the vestibule out of the facility. The first set of doors did not have alarms and the 2nd set of doors had an egress system with a local alarm to the door, that was not connected to any of their other alarm system in the facility. On 11/12/24 at approximately 3 PM the front door alarm system was tested with maintenance manager (MM) N. They were queried about the alarm on the door. They reported that door had an egress system with a 15 second delay and the door would open after 15 seconds and the alarm sounds so staff could respond. MM N pushed on the egress bar on the door and activated the alarm. The alarm was sounding at the door and had a low volume. MM N was queried if the alarm was connected to any other system as it was not audible enough and how their staff were able to hear past another set of double doors in the hallways or the units. MM N agreed the volume was low and added that the staff needed to be near the receptionist desk for them to hear the alarm. The receptionist was located approximately 10-15 feet from the door alarm. This surveyor walked to the receptionist desk when the alarm was still sounding and the alarm was barely audible and was not audible past the desk. On 11/13/24, at approximately 8:49 AM, this surveyor activated the front door alarm and exited the facility and alarm was sounding. There were no staff members in the nurse's station or the hallway. The Receptionist shift had not started (shift 10 AM - 6 PM). The Unit manager office and administrator offices were approximately 15-20 feet away from the receptionist desk. The Surveyor walked to the bus stop where R607 was observed. The bus stop was approximately 250-300 feet away (with a short route from the North side of the facility and approximately 800-900 feet away from South side of the from the facility) and returned to the front door at approximately 8:53 AM. The door alarm was still going off and there were no staff members at the door. This surveyor walked to the south end of the facility to the sidewalk and walked back to the front door at 8:55 AM and the alarm was not sounding. No staff member was observed at the door and no staff member came out to check if any residents had exited through door. A staff member who was entering the facility from outside assisted the surveyor to get inside. Review of R607's practitioner's progress notes dated 8/11/24, 8/4/24, 7/31/24, 7/29/24 and 7/24/24 revealed that their barriers to R607's progress were safety management, fall risks, and cognitive status. A nursing progress note dated 8/14/24 at 20:45 (8:45 PM) read in part, Resident observed in wheelchair by staff nurse. Nurse returned resident to facility. Resident stated that he pushed past the door by holding for 15 seconds and left. Review of R607's elopement assessment dated [DATE] revealed that they were not at risk for elopement, despite the assessment revealed the following risk factors that were marked as YES for Delirium, Restlessness , Behavioral symptoms that included: entering other resident rooms, experiences delusions, exhibits confusion, fear and or/disorientation, has short attention span, wanders, shows excessive motor activity, independent with mobility, with diagnoses of dementia, depression, and anxiety. Further review of elopement assessment history revealed that R607 was at risk for elopement on 8/29/23. Elopement assessments completed on 12/20/23 and 3/20/24 read no history of elopement. Review of elopement incident report provided by the facility read increased agitation and resident verbalized that he would continue to exit seek when opportunity present itself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R607's care plan revealed that an intervention dated 7/26/23 and 8/29/23 read, Resident at risk for elopement. Resident is always supervising (sic) by staff and check his location at all times. No aim to go anywhere. Place information in the elopement book per policy. An initial interview was completed with CNA M on 11/12/24 at approximately 12:35 PM. CNA M was assigned to care for R607 that shift. They were queried about R607 and their routine. CNA M reported they had to watch R607 closely as they have a history of exit seeking. CNA M showed the door to the courtyard at the end of the hall and reported R607 tried to push the door open. When they were queried if that was a new behavior, they reported that it was not a new behavior. When queried how they had monitored them they reported that were trying to keep a close watch on R607, but it was hard on weekends and afternoon shifts when they did not have the additional staff and or the receptionist to monitor the front door. CNA M also reported that it would help R607 to have a wander alert bracelet. When queried why they did not have one they reported that the facility did not have the set up. An interview with MM N was completed on 11/12/24 at approximately 2:45 PM. They reported that they had been at the facility since June 2024. They were queried if they were aware of the elopement for R607. They were notified after the event and they had checked the doors to made sure that they were working. They reported that staff should monitor the doors closely if not, elopement can happen. When queried how they were monitoring the doors, they reported that they had a receptionist during the day (from 10 AM to 6 PM) to monitor the doors on weekdays. When queried how the staff were monitoring the doors after 6 PM and on weekends when they did not have a receptionist, they reported the nursing staff were expected to monitor. They also added that the facility was planning to hire another staff member to monitor the doors for after hours and weekends after the incident and they did not know what happened. An interview with Registered Nurse (RN) J was completed on 11/12/24 at approximately 1 PM. They were queried about the incident. RN J reported that they were leaving the facility after their shift, (approximately 8:45 PM) and they were pulling out from the facility to the main street; they saw R607 in their wheelchair going towards the bus stop. They had parked their car and assisted the resident. When RN J asked where they were going, R607 replied that they were going to see their family in Florida. RN J added that they remember asking R607 how they had gotten out and R607 did not say how they had gotten out. When queried, RN J added that they used the main door when they exited the facility and the door alarm was not going off. An interview with CNA O who was assigned to care for R607 on 8/14/24 during the shift of the elopement incident was completed on 11/12/24 at approximately 2:05 PM. They were queried about the incident for R607. They reported they were a full-time staff member at one of their sister facilities and they were helping out at this location temporarily. They were not familiar with the R607 as that was their first day working with them as they usually worked on the 2nd floor. CNA O reported that they saw R607 in the hallway in their wheelchair when they were trying to get some linen for another resident about 4 minutes later, R607 was brought back to the facility by RN J. When queried how did they know it was exactly 4 minutes and how R607 could have wheeled all the way to the exit door, opened 2 sets of doors (including one egress door), wheeled on the ramp in the exit, in the uneven parking lot to the bus-stop and was brought back in 4 minutes? CNA O' did not provide any further explanation. CNA O reported that they did not know how R607 got out the facility and they did not hear the door alarm. They also added that they had provided their statement to their charge nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Licensed Practical Nurse (LPN) P was completed on 11/12/24 at approximately 5:30 PM. LPN P no longer worked for the facility per facility administrator. LPN P was assigned to care for R607 during the shift of incident on 8/14/24. They were queried about the incident and they had reported that R607 was gone for 4 minutes. When they were queried about the time frame they reported that it was hypothetical. They were asked how R607 wheeled all the way to the exit door, opened 2 sets of doors (including one egress door) wheeled on the ramp in the exit, in the uneven parking lot to the bus-stop and was brought back in 4 minutes. LPN P reported that it may be different for everyone and did not provide any further explanation. They also added that their assignment was changed that night was their first time working with R607. When queried about the door alarm, they reported that door alarm was too low and how were they supposed to hear that alarm when they were providing care for their residents. An interview with Unit Manager (UM) Q was completed on 11/12/24 at approximately 3:35 PM. They reported they were notified of the incident the day after, during a meeting. They reported that they spoke with R607 and they did not remember how they had gotten out. They were queried about their expectations for the staff with the current system. They reported that their expectation is to fix the system to make it louder like a panic alarm so staff could respond timely. They also confirmed they did not have a receptionist or staff member assigned to monitor the doors after hours and on weekends. An initial interview with the facility administrator was completed on 11/12/24 at approximately 3:55 PM. The administrator was queried about R607's elopement incident. They reported that they did not realize that R607 was an elopement risk and they found out during the investigation after the incident that the resident was exhibiting exit seeking behaviors. They added that R607 pushed the door and exited through the main door. The approximate time frame was between 10-15 minutes. When queried if they interviewed all their staff to investigate if staff members (who had worked that shift) heard the alarm and how they responded. The administrator reported that only had statements from the CNA and LPN who were assigned and they were lost during the leadership transition. They had included notes under their summary. The investigation did not include any interviews from any staff members. The administrator was queried if they had found out who turned the alarm off and why the staff did not follow their facility protocol and they did not provide any further explanation. When queried about the investigation summary (submitted to state agency) that read the facility was in the process of purchasing a wander guard system to ensure resident safety. The administrator reported that they received and quote in August that included doors and they had requested their corporation to add the elevators and they were waiting for approval. When queried about the existing alarm that was not loud enough for their staff, they added that they understood the concern. They confirmed that they did not have a receptionist or designated staff member to monitor the door on after hours and weekends. Their expectation for their staff is to provide better supervision and follow the facility protocol and did not explain any further how with their current staffing. An interview with RN R and LPN S was completed on 11/13/24 at approximately 7:35 AM. RN R and LPN Q worked afternoon/mid-night shifts (7 PM-7 AM). They were queried how they were monitoring the residents who were at risk on after hours. They reported that they had a resident monitoring the door between 6 PM - 8 PM. They tried to do their best to monitor the door when they had time in between the care and tried to sit in the front when they could monitor the door. When queried about the front door alarm, they reported if they could hear the alarm they would respond and follow their facility protocol. LPN S added that front door needed some updates and everyone was aware of the concern. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 an interview was completed with Director of Nursing (DON) at approximately 11:20 AM. They reported that they had started at the facility after the incident. They were not involved in educating the staff. The DON was notified of the observations of the front door alarm that was not audible, staff interviews and surveyor was able to get out of the facility and staff did not respond timely and did not follow their protocol. The DON reported that they were aware the front door alarm was not loud enough to alert their staff and they had tested it and they understood the concerns. On 11/13/24 a follow up interview was completed with the facility administrator at approximately 2:45 PM. They were notified of the observations that staff did not respond to the door alarm when the surveyor exited through the front door,the administrator reported that they were notified by their team and added that they did not hear the alarm and agreed with concerns. They also reported that the facility would have the secure care monitoring system by January 2025. Review of the facility provided document titled Elopements and Wandering with a recent revision date of 5/24 read in part, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Policy Explanation and Compliance Guidelines: 1. Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed or aimless. 2. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. 3. The facility may be equipped with door locks and/or alarms to help avoid elopements. 4. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 5. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 6. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. (continued on next page)

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