STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235357	A. Building B. Wing	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Physical Rehab Ctr of Belding	414 E State St Belding, MI 48809

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 This citation pertains to intake MI00140722. Based on interview, observation, and record review, the facility failed to ensure elopement interventions were implemented for 2 of 3 residents (Resident #54 and Resident #57) reviewed for elopement. This deficient practice placed Resident #54 (R54) and Resident #57 (R57) at risk for elopement when prevention interventions were not in place and monitored. Finding include: The facility provided a policy for Elopements and Wandering Residents dated 3/2/08 and last revised on 4/2023 for review. The policy reflected, 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 personal centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility provided a policy for the [Name of elopement guard] System (a system that alerts staff of a resident attempting to leave the building) dated 3/13/18 and last revised date of 6/2023 for review. The policy reflected, The purpose is to prevent residents from exiting the premises or a safe area without authorization . c. Once a device is needed for a resident: a. Staff is to assess location and function of the [Name of elopement] guard unit daily (by visually seeing the blinking light/where its located) and document in the EHR (electronic health record). b. The care plan is to include function and placement location. c. The elopement book is to be updated to include resident information. R54 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R54 was readmitted to the facility on [DATE] with diagnosis of (but not limited to) frontotemporal neurocognitive disorder (problems with memory), diabetes, and high blood pressure. Brief Interview for Mental Status (BIMS) reflected that R54 had moderate cognitive impairment. R54 had a guardian for all medical decision making. According to the room census record, R54 resided in the secured memory care unit until 9/16/23 when he was moved off the unit to a regular room in the skilled nursing facility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress note dated 9/25/23 at 3:13 AM reflected, Resident observed wandering the hall then pushing against the door to the courtyard setting off the door alarm. Resident redirected and distracted from wandering behaviors. The Elopement Risk assessment dated [DATE] revealed that R54 was at risk for elopement and wore a [name of elopement system] bracelet (a bracelet that alerts staff when the resident enters through area's such as doors to the outside). According to the elopement care plan dated 11/4/22, the interventions were reviewed and did not reflect the intervention of an elopement device system. Record review of the Certified Nurse Assistant (CNA)'s Task charting reflected that the CNA's were checking for the placement and functioning of the elopement device unit every shift. During an interview on 11/15/23 at approximately 10:00 AM, CNA B stated the CNA's responsibility regarding the elopement devices was to ensure the device is in place on the resident and that the CNA's do not ensure the functionality of the unit. CNA B stated the nurses do the function checks. Record review revealed no evidence that the nurses were checking the function and documenting this daily in the EHR as the policy indicated. The facility provided an Incident Report dated 10/26/23 for review. The investigation section of the report reflected that R54 had pulled the fire alarm (freeing all door locks) and was able to exit the building unsupervised. R54 was found moments later outside on the ground. R54 was subsequently moved back to the secured memory unit after the incident. R57 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R57 was admitted to the facility on [DATE] with diagnosis of (but not limited to) dementia (problems with memory) delusional disorder, and diabetes. Brief Interview for Mental Status (BIMS) reflected that R54 had moderate cognitive impairment. R54 had a guardian for all medical decision making. According to the Elopement Risk assessment dated [DATE], R57 was at risk for elopement. During an observation and interview on 11/15/23 at approximately 2:00 PM, the Unit Manager (UM) A and this Surveyor observed R57's picture and information in the Elopement binder kept at the nurse's desk. The UM A stated R57 is at risk for elopement and wears a [Name of elopement system]. The UM A and this Surveyor went to R57's room and observed him seated on his bed. The UM A asked R57 if she could check his [name of elopement system] bracelet and R57 extended his left arm. The UM A stated the nurse is responsible to check the functioning of the unit by observing it for the flashing red light and documenting it in the EHR. During an interview on 11/15/23 at 12:10 PM, CNA C stated that she was assigned to R57 today and stated that she checked his [Name of elopement system] placement this morning. When asked who checks for the unit to ensure it is functioning, CNA C stated, The nurses do. We just make sure it is on them. (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 the EHR showed no documentation that the CNA's were checking the placement every shift or that the nurses were checking the functioning of it daily. The Risk for Elopement care plan dated 3/14/20 reflected, R57 was at risk for wandering and elopement. The [Name of elopement] system was not listed as an intervention. During an interview and record review on 11/15/23 at 2:30 PM, the Director of Nursing (DON) and the UM A reviewed the policy for the [name of elopement] systems. They stated that the staff would obtain an order from the physician, place it on the resident, place the intervention on the Risk for Elopement care plan, noting where it was placed on the resident or wheelchair, create a Task to have the CNA check the placement every shift and have the nurse check that it functions daily and document it on the treatment administration record. During a record review the DON and the UM A checked R54's Risk for Elopement Care plan and reviewed the EHR for daily [Name of elopement system] function checks but neither was located in the EHR. The DON and UM A were asked to review R57's care plan and EHR for documentation of the location of the [Name of elopement system] placement checks every shift and function checks daily but were unable to locate them being done in R57's EHR.