STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 This citation pertains to intake #MI00142783 Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, homelike environment, as evidenced by offensive odors, overflow of garbage, soiled floors, soiled and broken equipment resulting in the potential to affect all 103 residents (including R902, R903). Findings included: A complaint was filed with the State Agency that alleged issues pertaining to the cleanliness of the facility. On 3/25/24 at approximately 8:15 AM, the facility was entered from west entrance and a strong foul odor of urine and feces was noted. The flooring in the common area from the main entrance and down central hallway towards the east unit was observed sticky, and visibly soiled. Medical exam gloves were observed at the main entrance balled up on the floor in front of nurse's station, and condiment wrappers were noted on floor throughout. On 3/25/24 at 09:28 AM, this surveyor entered the room of R903, and an odor of spoiled milk was noted. R903 was observed lying in bed eating from the bedside tray table. The tabletop was observed with dried food matter around the food tray from which the resident was eating. Underneath the bed, condiment wrappers, a plastic cup lid, piles of food crumbs were observed. Observation of room R902 presented visibly soiled areas on floor around residents' bed. Clothing and shoes were scattered on the floor surrounded by condiment wrappers and food crumbs. Trash receptacle next to bed was overflowing with garbage. Further observation of the [NAME] Unit revealed multiple resident rooms and common hallways having unsanitary floors and garbage overflow from trash receptacles, debris, and food on floors. A strong urine odor was noted throughout the common hallway with the strongest potency noted in the vicinity of the [NAME] shower room and room [ROOM NUMBER]. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/24 at 10:00AM, the [NAME] Unit shower room was observed with three soiled utility towels laying on the floor next to the entrance of the walk-in shower. A sharps container on the left wall was identified overflowing and four blue disposable razors with hair were hanging out from the top. Within the shower room, another room was identified for toileting. When the door was opened, a sour food odor was noted. The trash bin next to the toilet was inspected and revealed a brown and black colored banana peel. An empty hand soap container was noted on the back of the toilet, the hand soap wall mount was broken, no paper towel was available, and dried urine was noted on the toilet seat, and around base on the floor. On 3/25/2023 at 10:20AM,, after observing the west shower room, an interview with housekeeper C was conducted. When asked who was responsible for changing out sharp containers, housekeeper C replied, Not sure who does it or who has the keys to change it. This surveyor then inquired to Register Nurse (RN) Regional Clinical Director A who observed the shower room and stated he would take care of replacing the sharps container. The Central Unit Shower on the first floor was observed cluttered with a scale, Hoyer lift, shower chair and shower bed. Within the shower room, another room was identified for toileting. Observed behind the toilet on the corner wall, dried brown matter in a splash pattern was noted. A screen frame was behind the toilet laying on top of dried matter. An empty hand soap container was on the back of the toilet, the hand soap wall mount was broken, no paper towel was available, and dried urine was noted on the toilet seat, and around base on the floor. On 3/25/24 at 10:35AM, an interview was conducted with housekeeper C who indicated she was originally hired to be the laundry aide, but due to being short staffed, currently works as a housekeeper. Housekeeper C stated there should be two housekeepers for each floor of the facility. Further conversation revealed there was no housekeeper over the weekend and when housekeeper C arrived to work this morning, the central shower room required much attention due to multiple soiled briefs left in the shower, and further stated, the facility was a mess. On 3/25/24 at 10:40AM, the common area in front of the nurse's station and administration door, a moderate puddle of liquid was identified. Residents were observed walking in the common area and staff was noted making multiple passes by puddle. The facility activity room at end of the East unit was entered and a rotten food odor from a large trash receptacle was noted. The trash receptacle was observed filled to the top with empty soda cans, chips and candy wrappers and uneaten food. Small flies were noted swarming the area. On 3/25/24 at 2:30 PM, while passing by the [NAME] shower room, this surveyor slipped on what appeared to be a flattened piece of bread surrounded by a red colored substance. On 3/26/24 at 9:35AM, an observation was conducted on the second floor revealed a strong odor of urine was noted in common areas and in proximity of residents eating breakfast. The flooring in the common area was observed with sticky, visibly soiled matter, and trash receptacles observed in resident rooms were overflowing, condiment wrappers and tissues were noted on the floors throughout. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/24 at 9:45AM, an interview was conducted with housekeeper B who indicated housekeepers only work the day shift at the facility and she is the only housekeeper for the entire second floor and the facility has been short staffed for a while and the job is hard to do alone. The housekeeper was inquired if there is need for housekeeping concerns on the off hours, who is responsible and explained with uncertainty maybe the nurse assistant? Housekeeper B was inquired about the strong urine odor in the locked unit and stated, It smells like that most times because they have dementia. They will pull down their pants and just go (to the bathroom) anywhere. Documentation was requested from the facility regarding work orders, cleaning schedules, and policies for storage and cleaning. The Nursing Home Administrator responded by email on 3/26/24 at 3:58 PM .We have not located any work orders for the shower rooms. There are no tracking sheets specifically for cleaning the shower rooms or a policy on storage . A request to interview the facility environment manager was made to the Nursing Home Administartor (NHA), but was told they were unavailable and not at the facility.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48680 This Citation pertains to Intake MI00143498, MI00143298,and MI00143618. This citation has two deficient practice statements (DPS). DPS #1 Based on observation, interview, and record review, the facility failed to protect Resident #902/(R902) and R906's right to be free from physical abuse from R911. Findings include: The facility reported two resident to resident incidents (R911 verses R902, and R911 verses 906) to the state agency. On 3/25/24 an onsite investigation was conducted. On 3/25/24 at 10:30 AM, R906 was observed in activities located on the second floor in the dinning room. On 3/25/24 at 11:00 AM, R911 was observed in the room with a visitor. R911 was asked was it okay to interview them while they had guest, R911 stated yes. R911 was interviewed about the incident that occurred between R906 as to what had happened. R911 explaineded that R906 did pull me out of my chair but it was because R911 said something to R906 which caused them to react in the way that they did. R911 repeated that the incident was their (R911) fault and that R906's relationship with each other is good and that they didn't want any problems. R911 stated that they are good friends and that he loved R906 and wanted to let bye [NAME] be bye [NAME] and that a situation like this will never happen again. On 3/25/24 at 12:05 PM, R906 was observed in their room sitting in a chair by the window. R906 was asked what happened between them and R911. R906 shrugged their shoulders and stated nothing happened and questioned what was asked. On 3/26/24 at 1:30PM, the Director of Nursing(DON) and [NAME] Registered Nurse (RRN) were interviewed and asked at the time who was the administrator. They mentioned that it was a corporate Administrator and at that time he was out of the building but could be reached via phone or email. They were then asked, in his absence who oversaw and investigated for the abuse allegations that occurred. The RRN stated that the corporate administrator was still in charge of overseeing these allegations although he was not physically in house. The DON and RRN stated, We have tried several things, but this is their relationship, and we can't keep them from sneaking to see each other or restricting their interactions. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/24 at 10:00 AM, R906 was interviewed and asked if they recalled the incident that happened between them and R911. R906 explained that R911 tried to hit her but missed so she grabbed them and staff was there to get him (away). On 3/27/24 at 10:15 AM, The DON and RRN were asked if they considered these Facility Reported Incidents (FRI) to have been substantiated as abuse. They both stated, Yes, after our investigations. No additional information was provided by the exit of the survey DPS 2 Based on observations, interviews and record review the facility failed to ensure that one(R906) resident was free from misappropriation of funds by a staff member resulting in the resident missing 40 dollars. Findings include: On 3/25/24 at 12:00 PM, R906 was asked what happened between them and Certified Nurse Assistant(CNA) J. R906 shrugged their shoulders and stated they did not remember or recall the situation. On 3/25/24 at 1:00PM, CNA J was called and interviewed. CNA J was asked what occurred on the morning of 2/29/24. CNA J explained that when he came onto his shift he started by placing his items in the dining room on the first floor in the hall way with room [ROOM NUMBER]. CNA J reported he came in made rounds, gave a few baths and when he finished around one in the morning, he sat in the dining room for a break, got back up and completed another round just to check and change the residents he knew to be frequent urinators. He stated he went back into the dinning room after the round was completed and noticed his backpack was missing around 4 am. He stated he then went to ask his nurse if he has seen the bag at which the nurse stated no. CNA J stated he started to look in the rooms that he had recently gone in to ensure that he did not accidently take it into one of the resident's room. He stated he went into room [ROOM NUMBER], and asked R906 if they had seen his bag and R906 replied to him insinuating another resident had taken his items. CNA J then called the DON around 5:30 in the morning for guidance because he was missing his book bag which contained important documents, cash with lots of spare change, cell phone, watch and several other things, however he stated she replied to him saying that she was in clinical and that he should call corporate administration. He stated he called that number several times with no answer. CNA J stated that he then entered into the other Resident's room with Nurse K present the entire time and asked the Resident where was his bag/items and the Resident stated, I don't have your stuff. CNA J then went back to R906's room and looked in the closet and found his backpack. The cell phone was in the dresser drawer, his papers at the top of the closet and in her bottom drawer a tin cookie can and once he opened it he found 105 dollars. He then showed the nurse all the items he claimed to be his and retrieved them back from the resident. After that, CNAJ stated that resident 906 was going to call the police so he stated that he waited at the facility for about an hour and no one showed up so he left because he stated he worked a second job and could not be super late to it. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 1:36 PM, the RR and the DON were interviewed and asked how they substantiated these allegations of abuse. They replied, Because [CNA J] did go to the resident's room and find his items, but how does he know the money was his, he stated that he had 150 something dollars and only 105 was retrieved? Additionallt, the facility knows that R906 does steal and lie all the time and is accused all the time, we can't say that she did not have 40 dollars that she claimed was missing and the money in the can was probably CNA J but the resident stated she was missing 40 dollars so we took it serious. This is why we concluded that it was abuse. The RR and DON were then asked, when CNAJ reached out at 5 in the morning, how come he didn't receive the guidance on what to do? The DON replied, I gave him the corporate administration number, but he could have waited around for us. There was no additional information provided by the exit of the survey.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 This citation pertains to intake #MI00142342 Based on observation, interview, and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act, for abuse between two residents (R902, R903) of eleven reviewed for abuse resulting in the potential for unidentified or continued abuse. Findings include: A Facility Reported Incident (FRI) was received by the State Agency that included allegations of two residents involved with verbal sexual requests. Clinical record review revealed R903 was admitted into the facility on [DATE] with medical diagnoses of morbid obesity, diabetes, schizoaffective disorder, and bipolar. Brief Interview for Mental Status (BIMS) score dated 1/12/24, totaled 14 indicating R903 was cognitively intact. On 3/25/24 at 11:40 AM, R903 was interviewed and stated that her and R902 are friends and sometimes visit with each other. When inquired of the alleged incident regarding sexual requests, R903 rolled her eyes, turned her head away from this surveyor, and said I am tired of talking about that, is that all you want? This surveyor concluded by asking if she felt safe around R902 and she replied she felt safe. A clinical record review of R902 revealed they were admitted to the facility on [DATE] with medical diagnoses of encephalopathy (disease in brain that causes confusion), Alzheimer, dementia, behavior, and psychotic disturbances. R902's BIMS score total was eight, indicating moderate cognitive impairment. On 3/25/24 at 9:24 AM, an interview was attempted regarding the reported incident. R902 was observed lying in bed facing the door. Inquired how the facility and staff were treating him and he replied, They are treating me fine and further stated I respect the female. Based on verbal response and respect for dignity, further questioning with R902 was concluded. Record review of the FRI (Facility Reported Incident) paperwork provided from the facility, revealed the alleged incident occurred on January 11, 2024, and was not reported to the State Agency until February 20, 2024. On 3/25/24 at 12:10 PM, an interview with Registered Nurse (RN) Regional Clinical Director A indicated he was notified the facility had outstanding FRI's from January 2024 that were not complete. RN A confirmed the FRI reviewed by this surveyor was not submitted to the State Agency per guidelines. Review of the facilities Abuse, Neglect, Exploitation Policy Implemented 1/28/02 Revised 6/23 VII. Reporting/Response reads, .Reporting of all alleged violations to the State Agency not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .

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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** 48680 This Citation pertains to intake MI00143318 and MI00143312. Based on observations, interviews, and record review the facility failed thoroughly investigate allegations of R905's stolen money from R906 and the verbal abuse allegations from R907 by a staff member. Findings include: On 3/25/24 at 10:26AM, an interview was conducted with R907. He was asked what happened on the morning of 2/29/24 with Certified Nursing Assistant (CNA)J, R907 replied, [CNA J] came in my room, I had just woke up and he asked 'Where my sh*t, give me my stuff back. [R906] told me you took my sh*t.' I told [CNAJ] that I just woke up and I did not know what he was talking about, [CNAJ] must have known I just woke up and could tell that so he left out my room went back to [R906]'s room and just started finding all his items, [R906] had that man's backpack , his phone, his money all his stuff. But [R906] stays, stealing people's items but plays crazy when it comes up missing or they question [R906] about their missing items. [R906] stole 75 dollars from another resident (R905). The only reason I reported the incident to the facility because my mother wanted me to, but I did not feel threatened or anything from [CNAJ]. I knew he would not harm me he was just looking for his items. On 3/25/24 at 1:00PM, CNA J was called and interviewed. CNA J was asked what occurred on the morning of 2/29/24. CNA J stated that, when he came onto his shift, he started by placing his items in the dining room on the first floor in the hall way with room [ROOM NUMBER]. CNA J stated he came in made rounds, gave a few baths and when he finished around 1 in the morning. He sat in the dining room for a break. CNA J got back up and completed another round just to check and change the residents he knew to be frequent urinators. He stated he went back into the dining room after the round was completed and noticed the backpack was missing around 4 am. He stated he then went to ask his nurse if he has seen the bag at which the nurse stated no. CNA J stated he started to look in the rooms that he had recently gone too to ensure that he did not accidentally take it into one of the resident's rooms. He stated he went into room [ROOM NUMBER], and asked R906 if they had seen his bag and R906 replied to him like R907 had taken his items. CNA J then called the DON around 5:30 in the morning for guidance because he was missing his book bag which contained important documents, cash with lots of spear change, cell phone, watch and several other things, however he stated she replied to him saying that she was in a clinical (meeting) and that he should call corporate administration. He stated he called that number several times with no answer. CNA J stated that he then entered into R907's room with Nurse K present the entire time and asked R907 where was his bag/items and R907 stated I don't have your stuff. CNA J then went back to R906 room and looked in the closet and found his backpack, the cell phone was in the dresser drawer, his papers at the top of the closet and in her bottom drawer a tin cookie can and once he opened it he found 105 dollars. He then showed the nurse all the items he claimed to be his and retrieved them back from the resident. After that, CNAJ stated that R906 was going to call the police so he stated that he waited at the facility for about an hour and no one showed up so he left because he stated he worked a second job and could not be super late to it. CNAJ was asked did he ever use profane language with R907, CNA J stated, No I just asked if he had my items , the nurse was in the room the entire time I talked to the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 9:12 AM, R907 was interviewed again and asked how did CNA J approach them that morning and did the CNA J really curse at them. R906 replied, Naw he aint cuss at me but his body language was tense and aggressive but I aint feel threatened or afraid I knew he was looking for his sh*t, I knew that he wasn't gonna do anything to me and the only reason I reported it because my mother came up here and she made me but other than that he cool he took care of me. I didn't want him to get fired or anything because I didn't feel threatened. [CNA J] also apologize for the confusion as well. On 3/26/24 at 12:00 PM , Nurse K was called and interviewed and asked what happened between R907 and CNA J. Nurse K replied, Nothing, [CNAJ] just asked R907 where his stuff was, I was inside the room the entire time. Nurse K was asked if CNAJ ever cursed or used profane language with R906, Nurse K replied, No he did not, if it was a hostile situation I would have immediately separated the two and called whatever authority that was needed. Further interview revealed, Did CNAJ reached out to management before retrieving his items. Nurse K stated, Yes, he called he Director of Nursing (DON) but I am not for sure the conversation that was held between the two this was around 5 in the morning. On 3/26/24 at 12:30PM , the [NAME] Registered Nurse(RR) was interviewed and asked who was the abuse coordinator at the time of the incident. RR stated the corporate administrator, he was made aware and could be reached via phone. RR was asked what was the conclusion from this investigation and explained CNA J was suspended pending investigation. On 3/27/24 at 7:36 AM Nurse K was interviewed in person and asked did the Director of Nursing (DON) interview him? He stated, She had me write my statement down on a piece of paper. Nurse K was asked did the DON ask you what actually happened in the situation? He stated, She just had me write it down. Upon further interview, Nurse K was asked if administration would have actually asked him what happened what would you have told them? Nurse K stated, I would have told them that nothing happened between [CNAJ] and [R907] he just asked the resident a question, and that [CNA J] retrieved his items from [R906]'s room. Nurse K was asked where employees to put their personal items and stated, We normally put our items in this conference room or in the dining rooms I think there may be a locker room in the basement but I am not sure if it is being used or occupied. On 3/27/24 at 11:00AM, the DON was interviewed, and asked what did R907's mother report? The DON replied, I didn't even know that [R907] was approached by [CNA J] until two days later and I gave his mother a concern form so [R907] must have filled it out for her. The DON was asked what Nurse K had reported and stated she asked him what happened and to write a statement. The DON was then asked if Nurse K was interviewed and stated that there was no verbal threats made and was a witness in the room the entire time. The DON replied again that R907 stated they felt threatened so the facility reported it. The DON was asked who investigated the allegations and replied, The corporate administrator was notified. I didn't do the investigation. The DON was then asked about R905's money that was stolen by R906. The DON stated she didn't know what happen with that situation but they do know R906 does take things, and that she never physically seen the wallet herself but R905 was noted to have a wallet. The DON was then asked since R905 states that his money was stolen and he did have a wallet would R905 be reimbursed funds? The DON stated that's a question for the administrator. On 3/27/24 at 11:40AM, the administrator was interviewed and asked what were they doing about the money that R905 claims as being stolen. The administrator stated we are going to give him a check to give them their money back. No additional information was provided by the exit of survey.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00143494. Based on interviews and record reviews the facility failed to follow the facility policies for a Leave Of Absence (LOA) and an Against Medical Advice (AMA) discharge for one (R913) of four residents reviewed for accidents. Findings include: Review of the progress notes revealed the following: A Nursing note dated 3/7/24 at 1:46 AM, documented in part . Resident received resting in bed and easily aroused. No s/s (signs/symptoms) of respiratory distress SOB (shortness of breath) observed. Resident denied pain or discomfort. Resident voiced no complaints or concerns . safety maintained . A Nursing note dated 3/7/24 at 11:03 PM, documented . Resident still out on LOA has not returned back to facility . This note was documented by Licensed Practical Nurse (LPN) D. Review of the facility Release of Responsibility for Leave of Absence forms requested for all of the facility residents for the month of March 2024 was reviewed and revealed no documentation of R913 to have signed out on LOA on 3/7/24. Review of a facility policy titled Leave of Absence revised 6/23 documented in part . A physician's order is required for any resident to leave the facility with or without supervision . The resident and/or person supervising the resident while on the leave of absence will sign the Release of Responsibility for Leave of Absence prior to leaving the building and again when returning to the facility . Review of R913's physician orders revealed no physician order implemented for the resident to be allowed to leave the facility on a LOA. On 3/25/24 at 3:22 PM, LPN D (the assigned nurse for R913 on 3/7/24 evening shift) was interviewed and asked if they had seen R913 on 3/7/24 on their shift and LPN D replied they had not seen the resident at all during their shift from 3 pm - 11 pm. LPN D was asked what report was given to them by the off going nurse (later identified as LPN F) when they came on duty on 3/7/24 and LPN D replied, the nurse reported that a search was done of R913's room and liquor was found and the resident flipped out and left on LOA. LPN D stated by about 7 PM they noticed the resident had not returned from LOA, which was unusual for R913 because they never stay out for more than a few hours for their LOA, so they notified the DON that R913 had not returned. LPN D was asked the DON's directive when they informed the DON that R913 had not returned, and LPN D stated the DON informed them to put a note in before they left if R913 had not returned by the end of their shift. LPN D stated the DON informed LPN D that R913 was their own responsible party, and it was okay. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nursing note dated 3/8/24 at 7:16 AM, documented in part . Resident still has not returned to facility from LOA during midnight shift. Writer received report from afternoon shift nurse that resident went out on LOA, but has not returned at any time during that shift as well . This note was documented by LPN E. On 3/26/24 at 9:28 AM, LPN E was interviewed and asked if they had seen R913 on their shift on 3/8/24 and LPN E replied they did not. LPN E confirmed the DON asked LPN E why they did not inform them that R913 had not returned from the LOA by midnight and LPN E stated they told the DON they documented a note in the resident's chart and the DON replied they should have been notified that R913 failed to return from their LOA by midnight. LPN E stated they know that R913 leaves the facility on LOA but R913 had always returned by their shift and would be in bed sleeping. Review of a Nursing note dated 3/8/24 at 5:01 PM, documented in part . Resident left the faciity on [DATE] at approximately 2:00pm on LOA. Resident has not return to the facility as of 3/8/24 12 am. The resident's brother and APS (adult protective services) were notified. The resident previously signed a <sic> AMA form prior to leaving the facility. There is no current record of the resident admission into a hospital . This note was documented by the Director of Nursing (DON). Review of a Nursing progress note dated 3/8/24 at 5:05 PM, documented . MD (medical doctor) was notified. This note was also documented by the DON. Review of the medical record revealed an incomplete Against Medical Advice (AMA) Form that documented in part . This is to certify that I, (R913's name) . am leaving (facility's name) on my own insistence and against the advice of my attending physician and this facility. I do not hold the facility, the facility employees, or the attending physician responsible for harm, injuries, or any decline in my medical condition that occurs as a result of my leaving this facility against medical approval. Acknowledgment of Information (Initial on the line) _____ I have been informed of the dangers/risks to my health and the consequences associated with my leaving this facility against the advice and approval of my physician (this line was not initialed by R913) _____ I fully understand the information that has been discussed and have been given the opportunity to ask questions (this line was not initialed by R913) _____ I accept the risks and consequences of my decision and hereby release the facility, the facility employees, and my attending physician (s) from all liability that may result from my leaving the facility and not following the medical advice of my attending physician(s) (this line was not initialed by R913) . The form contained the name of R913 signed on the resident signature section and dated 3-7-24 and the witness signature section contained the signature of the DON with no date documented. The AMA form was uploaded to the resident's medical record on 3/20/24. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 1:08 PM, the DON entered the conference room with Social Service Manager (SSM) H and stated SSM H is the one that provided the AMA form to R913 to sign. SSM H was asked to explain what happened with R913 on 3/7/24 and SSM H stated they were informed by a staff that (R913's name) was in their room acting irate. When asked what staff informed them of R913's behavior, SSM H stated they could not remember which staff informed them of R913's behavior. SSM H stated they went to R913's room to meet with them and R913 stated they wanted to leave. SSM H stated they provided the AMA form to R913, and they signed it. SSM H was asked if they educated the resident on the risks to their health if they left the facility and the benefits of staying in the facility and SSM H stated they did not. SSM H was asked if they notified the physician of the AMA, so the physician could educate the resident and SSM H stated they did not. SSM H was asked why they failed to document a note in the residents record regarding the irate behavior and the AMA and SSM H stated they were leaving out of the facility (to go home) and . just didn't document it in the medical record . SSM H stated before they left the facility, they provided the AMA form to the DON. The DON was then asked if they met with R913 to educate them and discuss the risks of leaving AMA, the benefits of staying in the facility and if they notified the physician of the AMA prior to R913 leaving the facility and the DON stated they did not meet with the resident and did not inform the physician of the AMA prior to R913 leaving the facility. The DON was asked why the nursing staff assigned to R913 on 3/7/24 and 3/8/24 were all under the impression that R913 was out on LOA, which one nurse had notified the DON of the resident to not have returned from LOA and for the DON to have given directive for the nurse to write a note if R913 had not returned on their shift and the DON stated they had completely forgot that they were given the AMA form by SSM H on 3/7/24. The DON was then asked why themselves had written a note on 3/8/24 initially documenting the resident was on LOA then in the next sentence documenting the resident had signed an AMA and the DON again replied they had forgotten. The DON and SSM H was asked who witnessed R913 leaving the facility and neither replied. Review of a facility policy titled Transfer and Discharge (including AMA) revised 06/23 documented in part . Discharge Against Medical Advice (AMA) . The resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. The physician should be notified and encouraged to speak with the resident . Documentation of this notification should be entered in the nurses' notes by the nursing department. The social service designee should document any discussions held with the resident/family in the social service progress notes, if present . Document accordingly . The facility staff failed to follow the facility's AMA and LOA policies. No further explanation or documentation was provided by the end of the survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00143335. Based on observation, interview, and record reviews the facility failed to revise the care plan for one (R908) of four residents reviewed for resident-to-resident abuse. Findings include: Review of a Facility Reported Incident (FRI) documented the following in part . resident (R908 initials) without warning pulled the hair of resident (R909 initials) . Although the facility can substantiate that the incident happened, we are unable to establish abuse as there was no intent to do harm . The report documented Certified Nursing Assistant (CNA) I witnessed the incident. This report was submitted by Regional Clinical Director (RCD) A On 3/25/24 at 10:14 AM, CNA I was interviewed and asked about the incident that involved R's 908 & 909 and CNA I stated the residents were in the community room and CNA I was in the community room monitoring the residents. CNA I stated they saw R908 walk by and just pulled the hair of R909. CNA I then reenacted the incident and showed the surveyor how R908 grabbed a fist load of R909's hair and pulled it. CNA I stated there was no verbal exchange or incidents between the two resident's that would have prepared them for what they witnessed R908 do. At 10:17 AM, R909 was observed sitting in their wheelchair in the community room, when asked R909 did not remember the incident. At 10:19 AM, R908 was observed lying in bed sleeping. With verbal prompts R908 opened their eyes but did not reply to any of the questions asked. Review of R908's medical record revealed R908 was admitted to the facility on [DATE] with diagnoses that included: dementia, hallucinations, and schizoaffective disorder. Review of R908's care plans revealed the following: A care plan titled I have potential to demonstrate physical behaviors (hitting, kicking, resistive to care, biting, slapping) r/t (related to) Dementia . Implemented on 12/28/21. A care plan titled I have a psychosocial well-being problem (actual or potential) r/t EXTREMELY AGGRESSIVE BEHAVIOR TOWARDS STAFF and CAUSES DISTURBANCE TO OTHER RESIDENTS . Revised 10/3/22. Further review of the care plans revealed no interventions implemented to prevent further resident to resident mistreatment. Review of the medical record revealed no documentation of the interdisciplinary team to have met to discuss R908's behavior after the incident and modify/implement care plan interventions to ensure the safety of other residents. On 3/25/24 at 12:14 PM, RCD A was interviewed and asked why there were no further discussions or interventions implemented to ensure other vulnerable residents are safe from R908's known behaviors and RCD A acknowledged the concern. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further explanation or documentation was provided by the end of the survey.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41415 This citation pertains to intake: MI00143494. Based on interviews and record reviews the facility failed to provide the necessary monitoring, supervision, and interventions for one (R913) resident with a known alcohol addiction of four residents reviewed for accidents. Findings include: Review of the medical record revealed R913 was admitted to the facility on [DATE] with diagnoses that included: dementia, dysphagia, and alcohol abuse. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 (which indicated intact cognition) and required staff assistance for all Activities of Daily Living (ADLs). Review of the preadmission hospital documentation provided to the facility upon R913's admission documented in part . REASON FOR VISIT: ETOH (alcohol) WITHNDRAWAL <SIC> . Review of a Nursing note dated 3/8/24 at 7:16 AM, documented in part . Resident still has not returned to facility from LOA during midnight shift. Writer received report from afternoon shift nurse that resident went out on LOA, but has not returned at any time during that shift as well . This note was documented by LPN E. On 3/26/24 at 9:28 AM, LPN E was interviewed and asked if they had seen R913 on their shift on 3/8/24 and LPN E replied they did not. LPN E confirmed the DON asked LPN E why they did not inform them that R913 had not returned from the LOA by midnight and LPN E stated they told the DON they documented a note in the resident's chart and the DON replied they should have been notified that R913 failed to return from their LOA by midnight. LPN E stated they know that R913 leaves the facility on LOA but R913 had always returned by their shift and would be in bed sleeping. LPN E stated they had been informed of incidents where R913 was intoxicated in the facility, however never observed it themselves. Further review of the progress notes revealed the following: On 3/6/24 at 8:25 PM, a Physician Assistant (PA) G documented in part . continues to go on LOA and staff suspects drinking alcohol . ETOH abuse - not interested in stopping . On 2/23/24 at 8:03 PM, PA G documented in part . seen at staff request, has been leaving facility and returning intoxicated. He had episode where he returned and was agitated, yelling at staff, and throwing objects in room. He was sent to ER (emergency room) for his and staff safety. He returned more coherent. He continues to go out and drink and staff is concerned for his safety . ETOH abuse - d/w (discussed with) him about safety concerns of him going out on LOA and drinking, returning nearly daily intoxicated. He understands risks and states he does not plan on stopping . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R913's care plans revealed no implementation of interventions for R913's risk of leaving the facility to satisfy their alcohol addiction, the implementation of diversion interventions for their alcohol addiction, appropriate resources/referrals for their alcohol addiction, signs, and symptoms of intoxication for the staff to identify/monitor and provide appropriate supervision after a return from a LOA when intoxication is suspected. Further review of the care plans revealed no goals implemented for their alcohol addiction while inpatient at the facility. On 3/26/24 at approximately 1:15 PM, the DON and Social Service Manager (SSM) H was interviewed and asked why supervision/monitoring interventions were not implemented for R913 who was known to leave the facility LOA to satisfy their alcohol addiction and the DON stated the team had discussed it at one of the morning meetings, however the DON and SSM H acknowledged that a care plan and interventions were never implemented to monitor/supervise R913's alcohol addiction and LOA returns. No further explanation or documentation was provided by the end of the survey.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 This citation pertains to Intake MI00143549. Based on observation, interview, and record review the facility failed to provide behavioral services for one resident (R911) with known tendencies for substance use disorder prior to admission, resulting in resident leaving facility and returning drunk and bring alcohol beverages to the facility. Findings include: On 3/25/24 at 11:01AM, R911 was observed in his room with a visitor (Family member L) whom wanted to ask a few questions regarding R911's safety. She asked why the facility allowed R911 to leave the facility knowing that they go to the gas station next door, get drunk and being that alcohol is the reason R911 is medically messed up. Family member L was asked how she knew that R911 was returning to the facility drunk or was drunk at the facility? Family member Lstated R911 called her, and she could tell by the way they were talking and the aggression that R911 had in their voice was that of when they were drunk. She also stated that R911 had a drinking buddy at the facility, but the friend recently passed away, but the two of them would go to the store and bring back beverages for anyone who had money, R911 would go get it for them. R911 was asked, were they able to sign themselves out to go to the store, buy alcoholic beverages and return to facility drunk? R911 stated, Yes, I used to do that but I don't anymore since they restricted my leave of absences (LOA), I have been doing good. Family member L went on to say that she was confused as to how they let R911 out knowing that R911 is here for alcohol abuse and still let him go out and get drunk every day. Family member L stated she brought it up with the facility why they allowed it and they replied to her stating that R911 is their own responsible party and was free to leave whenever they pleased. On 3/25/24 at 1:0PM, the Social worker was interviewed and asked what the facility offers for residents with known substance abuse? The Social worker replied, I talk to them, ask them what their plan is as far as wanting to receive help or not, offer treatment outside the facility. The Social worker was asked, for someone with a known alcohol addiction how would they keep them safe. Social worker replied, We haven't done any planning for inside the facility. We offer the outside treatments and classes if they would agree to participate. The Social Worker was asked about residents that are intoxicated at the facility. The Social worker L replied, I haven't done anything with residents that are intoxicated, residents are not allowed to drink inside of the facility, if are residents coming back from LOA intoxicated, I would refer them to psychiatric services who comes once a week. Social worker L was then asked what they had in place for R911 with his known admission diagnosis of alcohol abuse, Social worker L replied, I don't believe we have anything in place for him but we did take away the privilege of LOA. It should be noted that the Social Worker came back 20 minutes later to say that they did not restrict R911 LOA that they were still allowed to leave the facility as they pleased. On 3/26/24 at 2:17 PM, the Director of Nursing (DON) was interviewed and asked what they did for residents with known substance use disorders. DON replied to social work normally handles that area, they offer different programs, outside treatment and that the Social worker should have more information (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed that R911 was admitted to the facility on [DATE] with the diagnosis of alcohol dependence, alcohol abuse and muscle weakness. With a Brief interview for Mental status score of 15. A further review of the record revealed that on 2/25/24,3/2/24,3/9/24 and 3/11/24, where R911 was intoxicated at facility. There was no additional information provided by the exit of survey.