

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg Phy Rehab Ctr of Madison Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 31155 Dequindre Madison Heights, MI 48071	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568</p> <p>This citation pertains to Intake Number(s): MI00146275, MI00147309, MI000147562, and MI00147564.</p> <p>Based on observations, interviews and record review, the facility failed to protect the residents ' right to be free from physical abuse by a resident for five (R401, R402, R404, R405, and R407) of five residents reviewed for abuse, resulting in R401 punching R402 in the eye, R404 punching R407 in the face and R404 punching and kicking R405 (witnessed by R409) in the face on two separate occasions. Findings include:</p> <p>R401 and R402</p> <p>A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed an allegation that R401 hit R402.</p> <p>On 10/22/24 at 9:45 AM, an interview was conducted with R402. When queried about any altercations with other residents, R402 reported he had one altercation with another resident (R401) and said the other resident was kicked out because of it. R402 explained they were talking to a nurse at the nurse's station and was telling jokes. R401 was seated in a chair nearby. When R402 walked toward their room, R401 was upset and made a statement that the joke was not funny. R402 said something back to R401 and R401 punched me in the face. R402 pointed to their right eye to indicate where they were hit by R401. R402 reported R401 was not sent out of the facility right away, but eventually he left and did not come back. R402 stated, I'm so glad I don't have to deal with that anymore.</p> <p>A review of R402's clinical record revealed R402 was admitted into the facility on [DATE]. A review of R402's Minimum Data Set (MDS) assessment dated [DATE] revealed R402 had intact cognition.</p> <p>A review of R402's progress notes revealed a Nursing Progress Note dated 7/26/24, written by Licensed Practical Nurse (LPN) 'J' that documented, Resident (R402) was over at the Nursing Station were <sic> he told the male nurse a joke and they both laughed. (R401) was also sitting at the Nursing Station. He also heard the joke and said it was not funny. He got up and punched (R402) .(R402) complained that under his right eye is tender to the touch .MD (physician) .ordered an X-Ray of the facial [NAME] <sic> .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235187
		If continuation sheet Page 1 of 15

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of R401's clinical record revealed R401 was admitted into the facility on [DATE] with diagnoses that included: paranoid schizophrenia, bipolar disorder, and violent behavior. A review of R401's MDS assessment dated [DATE] revealed R401 had intact cognition and verbal and other behaviors with no physical behaviors.</p> <p>A review of R401's progress notes revealed multiple progress notes that documented behaviors including, hitting staff with a cane (5/13/24), threw a laptop computer on the floor (5/18/24), threatening language toward staff (5/19/24), talking to himself (5/25/24), swinging a cane and shouting (5/25/24), broke toilet seat (5/25/24), expressed agitation about being in facility (6/5/24, 6/8/24, 6/12/24, 7/5/24), hit staff with a coffee mug (6/14/24), combative with staff (6/18/24), threw a chair that hit a staff member and broke a telephone (7/5/24), and threw a chair and chased staff (7/18/24).</p> <p>A review of a Nursing Progress Note dated 7/25/24 at 5:56 PM revealed R401 wanted to go to the store and did not want staff to accompany him. R401 was loud and wanted to go to the hospital.</p> <p>A review of a Nursing Progress Note dated 7/25/24 at 10:28 PM revealed Resident was agitated and having behavior issues. He punched a fellow resident because he said what he said was not funny .</p> <p>A review of the facility's investigation into the resident to resident incident that occurred on 7/25/24 between R401 and R402 revealed an Investigation Summary that documented, .In conclusion, the alleged allegation of physical abuse was substantiated .</p> <p>On 10/23/24 at 1:08 PM, an interview was conducted with LPN 'J'. LPN 'J' explained they were bringing the medication cart back down the hall when they noticed an altercation between R401 and R402 and saw R401 hit R402. LPN 'J' reported the nurse who was at the nurse's station said R401 did not like a joke that R402 told the nurse.</p> <p>On 10/23/24 at 2:09 PM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. The Administrator confirmed that R401 hit R402 in the face, confirmed by a witness and that R401 was known to have aggressive behaviors. The Administrator reported R401 was petitioned to the hospital and was not permitted to return.</p> <p>39592</p> <p>R404 and R407</p> <p>A FRI was submitted to the State Agency (SA) that alleged in part, .9/9/24 . (R404) made contact with (R407) .</p> <p>On 10/22/24 at 9:47 AM and 11:00 AM, R407 was observed sleeping in their bed.</p> <p>On 10/22/24 at 12:33 PM, R407 was observed sitting on the side of their bed eating lunch. When asked about the incident with R404 on 9/9/24. R407 explained they did not remember the incident.</p> <p>Review of the clinical record revealed R407 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: chronic obstructive pulmonary disease, Alzheimer's disease and mood disorder with depressive features. According to the MDS assessment dated [DATE], R407 had moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R407's progress notes revealed a nursing note dated 9/9/24 at 2:58 PM by LPN D that read in part, Resident was involved in physical altercation with another resident. He was being transferred to another room and was physically assaulted by the resident who was occupying the room he was moving into .</p> <p>Review of the closed record revealed R404 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: major depressive disorder, delusional disorders and emotional lability (sudden changes in mood). According to the MDS assessment dated [DATE], R404 scored 6/15 indicating severely impaired cognition.</p> <p>Review of R404's progress notes revealed a nursing note by Unit Manager (UM) B dated 9/9/24 at 5:13 that read in part, Resident hit another resident on the side of his face because he did not want him as a roommate .</p> <p>On 10/22/24 at 1:37 PM, UM B was interviewed and asked about the altercation between R404 and R407 on 9/9/24. UM B explained they had moved R407 into R404's room and R404 was not happy about having a roommate . a staff member, Physical Therapy Assistant (PTA) C, witnessed R404 hit R407.</p> <p>On 10/22/24 at 1:42 PM, PTA C was interviewed and asked what he saw between R404 and R407 on 9/9/24. PTA C explained he was working with a resident across the hall from R404's room, he heard a yelling and looked across to the room and saw R404 swing his arm and punch R407 in the face.</p> <p>On 10/23/24 at 9:34 AM, Licensed Practical Nurse (LPN) D was interviewed and asked about the altercation between R404 and R407. LPN D explained R404 did not want a roommate, and when R407 was moved in, PTA C witnessed R404 punch R407 in the face . the police were called . R404 promised he would not do it again . they never put another roommate in with him.</p> <p>Review of a police report dated 9/9/24 at 1:21 PM read in part, 2 RESIDENTS FOUGHT, 1 PUNCHED THE OTHER IN THE FACE . AGGRESSOR (R404) .</p> <p>Review of R404's comprehensive care plan revealed no physical behavior care plan or interventions implemented after R404 was observed punching R407 in the face.</p> <p>R404 and R405</p> <p>Review of a FRI reported to the SA read in part, .9/16/24 . (R405) stood up out of his wheelchair and (R404) pushed (R404) back into his wheelchair .</p> <p>Review of a FRI reported to the SA read in part, .10/2/24 . (R405) reported to staff (R404) hit him in the face .</p> <p>On 10/22/24 at 9:40 AM, R405 was observed lying in bed. R405 was asked about R404. R405 explained he was hit twice by R404, one time he was in R409's room talking to her when R404 came in and hit him in the face (R405 pointed to an area just below his right eye), then another time he was in the hall talking to R409 when R404 came up and kicked him on the jaw (pointed to his jaw on the right side of his face).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record revealed R405 was admitted into the facility on [DATE] with diagnoses that included: Alzheimer's disease, major depressive disorder and diabetes. According to the MDS assessment dated [DATE], R405 had moderately impaired cognition.</p> <p>On 10/22/24 at 12:23 PM, R409 was observed lying in bed. R409 was asked if she knew about the incidents between R404 and R405. R409 explained there were two incidents, one in her room and one out in the hall. Both times R405 was talking with her and R404 came and hit and/or kicked R405. R409 was asked if she had not wanted either R404 or R405 in her room or talking to her. R409 explained she liked to talk to both residents, and did not mind either coming to see her.</p> <p>Review of the clinical record revealed R409 was admitted into the facility on [DATE] with diagnoses that included: diabetes, hypertension and heart disease. According to the MDS assessment dated [DATE], R409 had moderately impaired cognition.</p> <p>Review of R404's progress notes revealed a nursing note by LPN D dated 9/15/24 at 11:09 AM that read in part, Was notified by staff that Resident physically assaulted another resident (R405) .</p> <p>Review of a police report dated 9/15/24 at 9:44 AM read in part, .(R405) WAS FOUND BY (R404) FLIRTING WITH (R409). (R404) DID NOT LIKE THAT (R405) WAS FLIRTING WITH HER SO (R404) PUSHED (R405) BY HIS NECK BACK INTO HIS WHEEL CHAIR [sic]. THE TWO MEN WERE ADVISED TO SEPARATE. OFFICERS ADVISED THE STAFF TO KEEP THE TWO MEN SEPARATED .</p> <p>Review of R405's progress notes revealed a nursing note by LPN G dated 10/2/24 at 11:07 AM that read in part, .Resident sated he was in wheelchair talking to (R409) and (R404) walked up to him aggressively and stated she don't want you talking to her, you're bothering her. (R405) stated that he just saw (R404) kick his feet up and kick him in the face . Writer gave (R405) a Cold compress for face .</p> <p>Review of a police report dated 10/2/24 at 9:40 AM read in part, .I was dispatched to the listed location for an A&B (assault and battery) report. Resident (R405) states another resident, (R404) kicked him in the face during an argument. I observed a faint mark on (R405's) right cheek . I spoke to (R404), who stated he was upset because (R405) had been talking to another resident .</p> <p>On 10/22/24 at 2:45 PM, Certified Nursing Assistant (CNA) F was interviewed and asked if he knew about any altercation between R404 and R405. CNA F explained on 10/2/24 he heard R409 yelling in her room . R404 was walking down the hall and R405 was trying to get out his wheelchair and was yelling he was going to get R404 . asked R405 what was wrong, R405 said R404 kicked him in the face, R409 also said R404 kicked R405 in the face.</p> <p>On 10/23/24 at 9:34 AM, LPN D was interviewed and asked about the altercations between R404 and R405. LPN D explained there seemed to be a triangle centered around R409 between R404 and R405 . on 9/15/24, R405 was in R409's room and R404 did not like it and they got into an argument, then after the argument, R405 was by the nurse station and R404 walked up and put his hands on R405 and forced him back into his wheelchair . on 10/2/24, R404 kicked R404 in the face . did ask R409 if she had been bothered by R405, but R409 said she was not . R404 has since been discharged to another place and it has been quiet ever since.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R404's physical behavior care plan revealed the focus, goals and interventions were initiated on 10/2/24.</p> <p>On 10/23/24 at 1:47 PM, the Social Services Director (SSD) was interviewed and asked why R404's physical behavior care plan was not initiated until the third physical altercation with another resident on 10/2/24. The SSD explained she would look into it. No information was provided prior to the end of the survey.</p> <p>On 10/23/24 at 2:20 PM, the Administrator was interviewed and asked about R404's three physical altercations with other residents in less than a month. The Administrator confirmed there was an altercation between R404 and R407 on 9/9/24, and two altercations between R404 and R407, one on 9/15/24 and one on 10/2/24.</p> <p>Review of a facility policy titled, Abuse, Neglect and Exploitation revised 6/2023 read in part, .Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592</p> <p>This citation pertains to Intake Number(s): MI00146275, MI00147309, MI000147562, and MI00147564.</p> <p>Based on interview and record review, the facility failed to thoroughly investigate multiple incidents of resident to resident abuse, three perpetrated by one (R404) resident and one by another (R401) for five (R401, R402, R404, R405 and R407) of six residents reviewed for abuse, resulting in the potential for additional instances of abuse to go unidentified and not be thoroughly investigated. Findings include:</p> <p>Review of a facility policy titled, Abuse, Neglect and Exploitation revised 6/2023 read in part, .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 . Providing complete and thorough documentation of the investigation .</p> <p>R404 and R407</p> <p>A FRI was submitted to the SA that alleged in part, .9/9/24 . (R404) made contact with (R407) . Investigation Summary . (R407) reported (R404) was gathering his belongings to move his things to the other side of the room and when he lifted his arm while carrying something he struck him on his face . In conclusion, abuse was not substantiated .</p> <p>Review of the clinical record revealed R407 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: chronic obstructive pulmonary disease, Alzheimer's disease and mood disorder with depressive features. According to the Minimum Data Set (MDS) assessment dated [DATE], R407 had moderately impaired cognition.</p> <p>Review of the closed record revealed R404 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: major depressive disorder, delusional disorders and emotional lability (sudden changes in mood). According to the MDS assessment dated [DATE], R404 scored 6/15 indicating severely impaired cognition.</p> <p>Review of R404's progress notes revealed a nursing note by Unit Manager (UM) B dated 9/9/24 at 5:13 that read in part, Resident hit another resident on the side of his face because he did not want him as a roommate .</p> <p>On 10/22/24 at 1:37 PM, UM B was interviewed and asked about the altercation between R404 and R407 on 9/9/24. UM B explained they had moved R407 into R404's room and R404 was not happy about having a roommate . a staff member, Physical Therapy Assistant (PTA) C, witnessed R404 hit R407.</p> <p>On 10/22/24 at 1:42 PM, PTA C was interviewed and asked what he saw between R404 and R407 on 9/9/24. PTA C explained he was working with a resident across the hall from R404's room, he heard a yelling and looked across to the room and saw R404 swing his arm and punch R407 in the face. PTA C was asked if anyone at the facility had interviewed him about what he saw. PTA C explained the Administrator had interviewed him.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/23/24 at 2:20 PM, the Administrator was interviewed and asked about the investigation into the altercation between R404 and R407 on 9/9/24. The Administrator explained she did not substantiate abuse because R404 said he did not punch R407, and when she had interviewed both residents, their statements agreed. The Administrator was asked about PTA C witnessing R404 punch R407. The Administrator explained PTA C was across the hall and transferring a resident at the time of the incident. The Administrator was asked about the investigation into the altercation between R404 and R405 on 9/15/24. The Administrator explained she thought there might have been some staff interviews, but was not sure. The Administrator was asked about the investigation into the altercation between R404 and R405 on 10/2/24. The Administrator explained there were no witnesses to that altercation, but she had substantiated abuse because R404 said he had hit R405. The Administrator was asked if she had interviewed R409 after the altercations on 9/15/24 or 10/2/24. The Administrator explained R409 had not witnessed anything. When informed R409 had witnessed both of the altercations, the Administrator had no reply. The Administrator was asked if any other residents in the facility had been interviewed after the altercations on 9/9/24, 9/15/24 and 10/2/24 to see if there were any other incidents involving R404 and any other resident. The Administrator explained she had not interviewed any of the residents in the facility.</p> <p>32568</p> <p>R401 and R402</p> <p>A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed an allegation that R401 hit R402.</p> <p>On 10/22/24 at 9:45 AM, an interview was conducted with R402. When queried about any altercations with other residents, R402 reported he had one altercation with another resident (R401) and said the other resident was kicked out because of it. R402 explained they were talking to a nurse at the nurse's station and was telling jokes. R401 was seated in a chair nearby. When R402 walked toward their room, R401 was upset and made a statement that the joke was not funny. R402 said something back to R401 and R401 punched me in the face. R402 pointed to their right eye to indicate where they were hit by R401. R402 reported R401 was not sent out of the facility right away, but eventually he left and did not come back. R402 stated, I'm so glad I don't have to deal with that anymore.</p> <p>A review of R402's clinical record revealed R402 was admitted into the facility on [DATE]. A review of R402's Minimum Data Set (MDS) assessment dated [DATE] revealed R402 had intact cognition.</p> <p>A review of R402's progress notes revealed a Nursing Progress Note dated 7/26/24, written by Licensed Practical Nurse (LPN) 'J' that documented, Resident (R402) was over at the Nursing Station were <sic> he told the male nurse a joke and they both laughed. (R401) was also sitting at the Nursing Station. He also heard the joke and said it was not funny. He got up and punched (R402) .(R402) complained that under his right eye is tender to the touch .MD (physician) .ordered an X-Ray of the facial [NAME] <sic> .</p> <p>A review of R401's clinical record revealed R401 was admitted into the facility on [DATE] with diagnoses that included: paranoid schizophrenia, bipolar disorder, and violent behavior. A review of R401's MDS assessment dated [DATE] revealed R401 had intact cognition and verbal and other behaviors with no physical behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of R401's progress notes revealed multiple progress notes that documented behaviors including, hitting staff with a cane (5/13/24), threw a laptop computer on the floor (5/18/24), threatening language toward staff (5/19/24), talking to himself (5/25/24), swinging a cane and shouting (5/25/24), broke toilet seat (5/25/24), expressed agitation about being in facility (6/5/24, 6/8/24, 6/12/24, 7/5/24), hit staff with a coffee mug (6/14/24), combative with staff (6/18/24), threw a chair that hit a staff member and broke a telephone (7/5/24), and threw and chair and chased staff (7/18/24).</p> <p>A review of a Nursing Progress Note dated 7/25/24 at 5:56 PM revealed R401 wanted to go to the store and did not want staff to accompany him. R401 was loud and wanted to go to the hospital.</p> <p>A review of a Nursing Progress Note dated 7/25/24 at 10:28 PM revealed Resident was agitated and having behavior issues. He punched a fellow resident because he said what he said was not funny .</p> <p>A review of the facility's investigation into the resident to resident incident that occurred on 7/25/24 between R401 and R402 revealed an Investigation Summary that documented, .In conclusion, the alleged allegation of physical abuse was substantiated . There were no additional statements/interviews with other staff or residents who were witnesses to the incident to determine the root cause of why R401 hit R402. There was no mention of R401's previous behaviors from 7/25/24 that were documented in the clinical record.</p> <p>On 10/23/24 at 1:08 PM, an interview was conducted with LPN 'J'. LPN 'J' explained they were bringing the medication cart back down the hall when they noticed an altercation between R401 and R402 and saw R401 hit R402. LPN 'J' reported the nurse who was at the nurse's station said R401 did not like a joke that R402 told the nurse.</p> <p>On 10/23/24 at 2:09 PM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. The Administrator confirmed that R401 hit R402 in the face confirmed by a witness and that R401 was known to have aggressive behaviors. The Administrator reported R402 was talking with a nurse at the nurse's station before R401 hit R402. When queried about who the male nurse was that was talking to R402 prior to R401 hitting him, the Administrator reported they did not know. The Administrator reported they did not interview anyone else, including the male nurse, as part of the investigation and said R401 was sent to the hospital on petition as a result of hitting R402 and they substantiated the abuse. When queried about whether the content of the joke R402 told was known, the Administrator reported they did not know.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568</p> <p>This citation pertains to Intake Number(s): MI00147310</p> <p>Based on observation, interview, and record review, the facility failed to implement effective interventions to prevent elopement for one (R406) of four residents reviewed for supervision, who was assessed to be at risk for elopement and had severely impaired cognition, resulting in the resident exiting the facility without staff knowledge and walking approximately one and half miles to the local police station. Findings include:</p> <p>A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed R406 eloped from the facility on 9/19/24 without notifying staff and returned approximately two and a half hours later.</p> <p>On 10/22/24 at 9:35 AM, R406 was observed ambulating in the hallway. R406 was steady on their feet and engaged in a conversation with another resident, easily blending in as staff or a visitor. R406 participated in an interview, but would not engage in conversation about whether they were permitted to leave the building unsupervised or if they ever had. R406 explained they went outside with staff a few times each day to get fresh air.</p> <p>A review of R406's clinical record revealed R406 was admitted into the facility on [DATE] with diagnoses that included: acute necrotizing hemorrhagic encephalopathy, auditory and visual hallucinations, early onset Alzheimer's Disease, and paranoid schizophrenia. A review of R406's Minimum Data Set (MDS) assessment dated [DATE] revealed R406 had severely impaired cognition, delusions, and was independent with walking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of an investigation conducted by the facility revealed a summary that documented R406 was alert and oriented times one to four, which fluctuated with impaired short-term memory and delusions. It was noted that on 9/17/24, R406 presented with distressing delusional and paranoid thinking with physically aggressive behavior and was sent to the hospital for evaluation of his mental status. R406 returned to the facility from the hospital on the morning of 9/19/24 around 3:00 AM with no new orders. It was documented that on 9/19/24, R406 exited the facility without authorization or the necessary supervision to do so which was observed by another resident in the facility when R406 exited behind a family member who was leaving the facility. It was documented that a family member left the building at 5:17 PM. That family member was contacted and denied seeing a resident exit behind them. According to the facility's investigation, R406 reported putting his foot in the door so it would not close after the visitor exited. The investigation further documented, Staff interviews report (R406) showed no exit-seeking behavior from the time of his return that morning until this event. The resident had a phone call and a staff member went to give him the phone and was unable to locate him in his room .initiated a Code Search .initiated the facility elopement procedure. The Administrator was notified .at 5:36 PM .(R406) returned to the facility by a (city) Police Office <sic> at approx (approximately) 8:30 PM (approximately three hours after the suspected time R406 exited the building) .The Police Officer stated (R406) was located sitting inside the police station and wished to return to the facility . The administrator interviewed (R406) regarding leaving the facility; he stated .he purposely snuck out because he did not want anyone to catch him or cause any commotion. The Administrator questioned why he left the facility, resident replied I don't feel safe here and I wanted to go where I felt safe. When asked why he does not feel safe here, (R406) replied because he got into a disagreement with (name redacted). The administrator asked who (name redacted) is as there is no (name redacted) working at the facility, and the resident smiled and walked to his room .(R406) was identified at risk for elopement prior to the event and care planned interventions were in place .</p> <p>A review of R406's Elopement Risk Assessments revealed R406 was assessed to be at risk for elopement since 5/16/24.</p> <p>A review of R406's progress notes revealed the following:</p> <p>A Nursing Progress Note dated 9/17/24, written by Registered Nurse (RN) 'O', documented, Witness reported resident standing outside the (facility name) building (Back) resident stated 'someone was trying to take his car out the parking lot'. Resident don't have a car, directed back into building .Next resident started to have aggressive and violent behavior, for example resident was trying to fight staff and other residents, doctor stated transfer resident to hospital to prevent injuries and that resident can be re-evaluate mental status change.</p> <p>A review of an IDT (Interdisciplinary Team) Review Note dated 9/17/24 revealed R406 was petitioned (a request for involuntary psychiatric hospitalization) to the hospital.</p> <p>A review of an Emergency Department Note from the hospital dated 9/17/24 at 6:06 PM revealed the following documentation: .presenting to the ER (emergency room) via the EMS (Emergency Medical Services) from (facility) on petition. Per petition, patient was repeatedly trying to elope, delusional thoughts were worsening, and patient was being somewhat aggressive with staff and difficult to control .</p> <p>Further review of R406's clinical record revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Nursing Progress Note dated 9/19/24 at 3:04 AM that documented R406 was returned from the hospital.</p> <p>An Admission/Readmission assessment dated [DATE] documented R406 made 1 or more attempts to elope in the past 90 days in the Elopement Risk Assessment section and indicated R406 was at risk for elopement.</p> <p>A Nursing Progress Note dated 9/19/24 at 4:32 PM, written by Unit Manager, Licensed Practical Nurse (LPN) 'B', documented, Resident re-assessed for elopement attempts .Immediate intervention implemented: 1:1 supervision .</p> <p>A Nursing Progress Note dated 9/19/24 at 9:51 PM, written by the Director of Nursing (DON), documented, Patient exited facility without following proper protocol at approximately 5:30pm, Patient safely returned to the facility at approximately 8:00pm by police .</p> <p>A History Physical note dated 9/20/24, written by Nurse Practitioner (NP) 'R', documented, .Seen today for post ED evaluation. He as sent to ED for further evaluation 9/17 after eloping from the facility stating someone was trying to steal his car from the back parking lot .returned 9/19. Later that day resident again eloped from the facility and reportedly walked to the police department where he was returned via police escort later that day .</p> <p>On 10/22/24 at 11:45 PM, the resident who witnessed R406 leave the facility on 9/19/24 (per the facility's investigation) was interviewed. The resident reported he saw R406 put his foot in the door when a visitor left, and then went out the door behind him. The resident said he told a Certified Nursing Assistant (CNA) that R406 exited the building, but could not recall the CNA's name.</p> <p>On 10/22/24 at 1:55 PM, an interview was conducted with LPN 'N' who was R406's assigned nurse at the time of the elopement on 9/19/24. LPN 'N' explained they worked the afternoon shift on 9/19/24, arrived at 3:00 PM, and attended a Skills Fair until 4:00 PM at which time they began working on the floor. LPN 'N' arrived to the unit around 4:00 PM and the residents were outside with staff smoking, including R406 who typically went out for fresh air. At that time, LPN 'N' started rounds on their assigned residents. Around 4:30 PM, LPN 'N' observed R406 in the hallway, standing at the computer kiosk, listening to music loudly. LPN 'N' explained that R406 often spent time at the kiosk listening to music. Around 5:00 PM, R406's family member contacted the facility to check on R406 so LPN 'N' went to R406's room to tell him he had a phone call. When LPN 'N' opened R406's door, there were booby traps, which were described as bottles that fell when the door opened and a chair by the window. According to LPN 'N', the window was not able to be opened fully. At that time, LPN 'N' did not know the location of R406, a search was initiated, and the Administrator and police were contacted. Staff searched inside and outside of the building. LPN 'N' went outside around 8:00 PM and police were bringing R406 back to the facility. When queried about how R406 got out of the building, LPN 'N' reported she did not know. LPN 'N' said when she asked R406 where he went and how he got out he stated, I'll save that for next time. When queried about any information provided about R406 from the previous shift's nurse, LPN 'N' reported she was told R406 was readmitted from the hospital but did not know why he was hospitalized . LPN 'N' reported she was not aware of any additional monitoring or interventions that were in place for R406. When queried about whether R406 was an elopement risk, LPN 'N' reported she felt he was and described him as very intelligent, ambulatory, blended in like a visitor or staff, and was very convincing, but that his cognition fluctuated.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/22/24 at approximately 3:00 PM, an interview was conducted with Registered Nurse (RN) 'O', the nurse assigned to R406 on 9/17/24 when R406 was sent to the hospital. When queried about why R406 was transferred the hospital on 9/17/24, RN 'O' reported R406 went outside with activities staff and did not want to come back in because he thought his car was outside. R406 was difficult to redirect, but he was confused and not his normal self. R406 was agitated and RN 'O' was concerned for the other residents so he was sent out to the hospital for safety reasons. When queried about what R406 was doing that presented a safety concern, RN 'O' did not offer a response. RN 'O' reported R406 was typically calm, liked to go outside with staff, but something triggered him on that day.</p> <p>On 10/22/24 at 3:19 PM, an interview was conducted with Recreation Aide (RA) 'L' who was present when R406 was sent to the hospital on 9/17/24. RA 'L' reported they took R406 out for fresh air and while standing outside talking, R406 abruptly said someone was trying to steal his car, referring to a car in the parking lot. RA 'L' reported they attempted to redirect R406 and explain that he did not have a car there, but he attempted to walk off toward the vehicle. R406 was difficult to redirect and refused to go back in the building. RA 'L' further reported other staff came outside to attempt to redirect R406 inside, but he refused. A nurse eventually redirected R406 inside the building and the police were called per R406's request. According to RA 'L', R406 calmed down and walked back to the unit and became aggressive when talking to someone and then calmed him down.</p> <p>On 10/22/24 at approximately 4:00 PM, an interview was conducted with the Administrator. When queried about the protocol for entering and exiting the facility, the Administrator reported the receptionist let visitors in and out or the nurse's could enter the code. When queried if there was a receptionist present when R406 eloped from the facility on 9/19/24, the Administrator reported there was not and therefore staff at the 1 [NAME] nurse's station would have to use the code to let people in and out. When queried about how R406 got out on 9/19/24, the Administrator reported he reportedly left behind a visitor after sticking his foot in the door. The Administrator was unable to say who let the visitor out and reported staff did not see R406 leave the building. When queried about what was put in place after R406 returned from the hospital, the Administrator reported nothing was put in place because what happened on 9/17/24 with R406 being fixated on the car in the parking lot did not raise any red flags. He was cussing people out and we called the police and they said we had to send him out.</p> <p>On 10/22/24 at 4:30 PM, a request was made to provide a copy of R406's petition filed on 9/17/24. The Administrator reported the petition was sent to the hospital and the facility did not keep a copy on file for the medical record.</p> <p>On 10/23/24 at 11:00 AM, an interview was conducted with Unit Manager, LPN 'B' regarding the progress note written on 9/19/24 at 4:32 PM (prior to R406's elopement from the facility) that indicated R406 was re-assessed for elopement attempted and the immediate intervention of 1:1 supervision. LPN 'B' reported R406 was re-assessed after the car incident since that was unusual for him. LPN 'B' reported that even though R406 was an elopement risk, it was not expected that he would leave the facility, but after he was fixated on the car and went to the hospital, he was re-assessed. LPN 'B' could not recall what was done to ensure 1:1 supervision was implemented per the assessment documented on 9/19/24 at 4:32 PM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facility policy titled, Elopements and Wandering Residents, revised 5/2024, revealed, in part, the following: .The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement .including identification and assessment of risk, evaluation and analysis of . risks, implementing intervention to reduce .risks, and monitoring for effectiveness and modifying interventions when necessary .Residents will be assessed for risk of elopement .upon admission and throughout their stay .Adequate supervision will be provided to help prevent .elopement .</p>		