STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235214	A. Building B. Wing	03/07/2024

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

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 0600 Level of Harm - 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** 41415 This citation pertains to intake: MI00143015 & MI00143012 Based on observation, interviews, and record reviews the facility failed to prevent an incident of resident-to-resident sexual abuse with two (R's 702 and 703) of seven residents reviewed for abuse, resulting in the reasonable person to have experienced inappropriate, unwanted sexual contact and would have experienced humiliation, embarrassment, feelings of being violated, anxiety and helplessness after being the victim of resident-to-resident sexual abuse. Findings include: Review of a complaint submitted to the State Agency (SA) documented in part . This morning, another patient, (R703 name and age) was found in (R702's name) bed with an erection. (R702 and R703 name) were both naked. It is unknown how long (R703 name) was in bed with (R702 name). There are concerns that (Facility name) did not respond appropriately to the incident . (R703 name) has been arrested for sexual assault . Review of the medical record revealed R702 was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's, dementia and hospice care. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 00, which indicated severely impaired cognition and lacked the capacity to consent to sexual activity. R702 required staff assistance for all Activities of Daily Living (ADLs). Review of a legal guardianship document revealed R702 had a full guardian appointed by the court. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/5/24 at 3:38 PM, CNA A (the aide assigned to R702 on the day/shift of the incident) was interviewed and when asked stated they were at the nursing station the morning of 2/27/24 when they saw (R702's) call light on. CNA A stated they went down to the room and opened the door which is unusual that the door was shut because R702's room door is always open, and they had just left the room not too long prior, and the door was open. CNA A stated when they opened the door, they observed R703 in R702's bed naked. CNA A stated R702 had a gown on but their pull up brief was observed on top of the bedside table. CNA A stated R702 was laying on their side with the back and buttocks exposed and R703 was observed lying behind R702 on their back with their skin touching R702 skin as if you were cuddling with your significant other and R703 was observed to have an erection. CNA A stated R703's sweatpants and pull up brief was observed on the floor next to the bed. CNA A stated they left the room to get Registered Nurse (RN) B and when they returned to the room R703 was pulling up their pull up brief. CNA A was asked why they left R702 in the room with R703 and CNA A stated they were shocked and just left to get the nurse. CNA A stated despite R703 to utilize a wheelchair, R703 is still able to stand and walk short distances with an unsteady gait. CNA A stated they stayed in the room with RN B, watched R703 get dressed and go back into their own room. CNA A stated RN B then goes to call the Administrator and they remained with R702 to clean the resident up and change their bedding because R702 had an episode of diarrhea. CNA A stated after they cleaned R702, R702 was escorted to the first floor and R703 remained on the second floor. On 3/5/24 at 4:22 PM, RN B was interviewed via telephone. When asked, RN B stated on 2/27/24 CNA A came running to the nurse's desk and told them that R703 was in the bed with R702. RN B stated they went to R702's room and they saw R703 sweatpants and pull up brief on the floor next to R702's bed. RN B stated R703 got dressed and they took R703 back to their room. RN B stated they then assessed R702 who was holding their stomach and saying they were in pain. RN B stated despite being a float nurse they were familiar with R702 and the resident holding their stomach and complaining of pain was something new. RN B was asked what R703's response was when they first saw R703 in R702's room and RN B stated R703 kept stating R702 brought them in their room and wanted R703 to be in their room. RN B stated they notified the Physician who directed RN B to send R702 out to the hospital for further evaluation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a police report dated 2/27/24, documented in part . On 02/27/2024 at approximately 0537 hours . dispatched to (facility name) . on a report of a possible criminal sexual conduct . male resident was found fully nude in bed with a female resident, who is on hospice and suffers from severe dementia . I arrived on scene, and spoke with . (CNA A name) . observed a male resident (R703) . fully nude in bed next to victim . had an erect penis and was attempting to put his underwear back on . Due to (R702 name) severe dementia, she could not recall anything. Nursing staff stated that (R702 name) was walking around holding her lower abdominal area as if in pain . I went to (R703's room number) to speak with (R703 name), who was sitting in a wheelchair, watching television . (R703 name) stated that they were just lying in bed together. I asked him if he was nude at any point in time and he stated that he was not. I asked nursing staff where the bedding was that was on the bed in (R702's room), however they stated that they had washed it due to there being diarrhea on it . Due to the allegations made by the nursing staff and the witness who saw (R703's name) nude and with an erect penis, the decision was made to have (R702 name) transported to (hospital name) for an evaluation . (hospital name) staff attempted to take vitals from (R702's name), but she became increasingly agitated. The physician's assistant attempted to lift up (R702's name) gown to conduct an assessment on the abdominal area and (R702's name) quickly grabbed her gown and yanked it down. She yelled at staff and attempted to get up several times. The attending physician made the decision that (R702) may be more comfortable with (third party entity name) conducting the examination. (Third party entity name) was contacted by hospital staff. (Third party entity name) stated they would contact (facility name) to schedule a time to examine (R702 name) . warrant for attempted CSC (criminal sexual conduct) 3rd and aggravated indecent exposure . Review of the hospital After Visit Summary dated 2/27/24, documented in part . Reason for Visit Sexual Assault . Review of R703's medical record revealed R703 was admitted to the facility on [DATE] with diagnoses that included convulsions. A MDS assessment dated [DATE], documented a BIMS score of 14, which indicated intact cognition and required minimal assistance for all ADLs. R703 did not reside in the facility at the time of the survey. This indicated R703 could consent to sexual activity, however R702 could not. On 3/6/24 at 4:07 PM, R702 was observed eating off of a food tray found on the counter top in the second-floor community room. Another resident grabbed the tray from R702 and told R702 that they couldn't do that. A staff member arrived shortly after to intervene and take the cold food tray away. An interview was attempted with R702, however R702 was unable to answer any of the questions appropriately. R702 walked away and was observed wandering the unit hallways. Review of a facility policy titled Abuse, Neglect and Exploitation revised 6/23 documented in part, . It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect exploitation . Sexual Abuse is non-consensual sexual contact of any type with a resident . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/6/24 at 8:44 AM, the facility's Abuse Coordinator (who also serves as the facility's Administrator) was interviewed and asked when they were first notified of the incident that occurred on 2/27/24 with R's 702 and 703, and the Administrator stated the nurse that was on duty (RN B) had notified them the day of the incident. The Administrator was asked the findings of their investigation, and the Administrator stated the investigation is still ongoing. The Administrator was asked the immediate decision made to protect R702 after the incident with R703 and the Administrator stated the facility staff separated the residents and ultimately R702 went to the hospital and R703 was placed in police custody. No further explanation or documentation was provided by the end of the survey.

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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 0609 Level of Harm - 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** 41415 This citation pertains to intake: MI00143015 & MI00143012 Based on observations, interviews, and record reviews the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the facility failed to ensure an allegation of sexual abuse was reported within the required time frame to the State Agency (SA) and reported the suspected crime to law enforcement, resulting in a delay in notification to the SA (when R703 was found naked with R702), the delay in notification to law enforcement and the inability for law enforcement and health officials to obtain and process evidence and resulting in the reasonable person to have felt fear, guilt, shame, anger, hurt, and anxiety as a victim of an unconsented sexual act. Findings include: Review of a complaint submitted to the State Agency (SA) documented in part . This morning, another patient, (R703 name and age) was found in (R702's name) bed with an erection. (R702 and R703 name) were both naked. It is unknown how long (R703 name) was in bed with (R702 name). There are concerns that (Facility name) did not respond appropriately to the incident as they did not call LE (law enforcement). (Facility name) sent (R702 name) to the ER (emergency room) by way of EMS (emergency medical services). EMS called LE. (R703 name) is of sound mind. (R703 name) has been arrested for sexual assault . Review of the Incident report submitted to the SA documented the date and time of the sexual assault allegation to have occurred on 2/27/24 at 4:29 AM. The incident report documented the facility's Administrator, who also served as the facility abuse coordinator to have submitted the report to the SA on 2/27/24 at 5:03 PM. Further review of the incident report documented the following information submitted to the SA (R703's name) was found in (R702's name) bed. Investigation ongoing. The Administrator reported the allegation of sexual abuse to the SA, after the two-hour required time frame and omitted the detail of R703 and 702 to have been observed naked in R702's bed with R703 to have an erection. On 3/5/24 at approximately 1:30 PM, Sergeant (SGT) C (from the local law enforcement department) was interviewed and stated in part, . The facility did not notify us of the incident, EMS did at 5:37 AM, by the time we got there they threw away the bedding and clothes of the patient and had her (R702) cleaned up. (continued on next page)

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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 0609 Level of Harm - Actual harm Residents Affected - Few	On 3/5/24 at 3:38 PM, Certified Nursing Assistant (CNA) A (the aide assigned to R702 on the shift/date of the incident) was interviewed and when asked stated they were at the nursing station the morning of 2/27/24 when they saw (R702's) call light on. CNA A stated they went down to the room and opened the door which is unusual that the door was shut because R702's room door is always opened, and CNA A stated the last time they had left R702's room the door was open. CNA A stated when they opened the door, they observed R703 in R702's bed naked. CNA A stated R702 had a gown on but their pull up brief was observed on top of the bedside table. CNA A stated R702 was laying on their side with the back and buttocks exposed and R703 was observed lying behind R702 on their back with their skin touching R702 skin as if you were cuddling with your significant other and R703 was observed to have an erection. CNA A stated R703's sweatpants and pull up brief was observed on the floor next to the bed. CNA A stated they left the room to get Registered Nurse (RN) B and when they returned to the room R703 was pulling up their pull up brief. CNA A stated RN B then goes to call the Administrator and they (CNA A) remained with R702 to clean the resident up and change their bedding because R702 had an episode of diarrhea. CNA A was asked why they disposed of R702's bed sheets, gown, brief and washed the resident before being assessed by law enforcement and health professionals and CNA A stated the police asked them the same question that night and CNA A then stated they did not know they had to preserve those items, and their main concern was cleaning the resident. CNA A was then asked if they notified law enforcement of the incident and CNA A replied No. CNA A was asked if they were given the directive from the facility's Abuse Coordinator (Administrator) to call law enforcement and to keep the resident and bedding as is until law enforcement arrived and CNA A replied No and stated they did not speak with the Administrator, RN B spoke to the Administrator. On 3/5/24 at 4:22 PM, Registered Nurse (RN) B (the nurse assigned to R702 on the shift/date of the incident) was interviewed via telephone. When asked, RN B stated on 2/27/24 CNA A came running to the nurse's desk and told them that R703 was in the bed with R702. RN B stated they went to R702's room and they saw R703 sweatpants and pull up brief on the floor next to R702's bed. RN B stated R703 got dressed and they took R703 back to their room. RN B stated they then assessed R702 who was holding their stomach and saying they were in pain. RN B stated despite being a float nurse they were familiar with R702 and the resident holding their stomach and complaining of pain was something new. RN B was asked if they notified law enforcement regarding the incident and RN B stated No, when asked why they did not notify law enforcement, RN B replied they were trained to notify the Administrator for abuse allegations. RN B explained they were considered Float Pool staff and was not a regular scheduled employee for the facility. RN B stated they informed the Administrator who directed the staff to do an assessment and document it, with no further directive given. RN B was asked if the Administrator had given them directive to call law enforcement and preserve the resident and resident bedding as is until processed by law enforcement and RN B replied no. RN B stated minimal directive was given. RN B stated they notified the Physician who directed RN B to send R702 out to the hospital for further evaluation. The phone call to EMS to transfer R702 to the hospital for the evaluation of a sexual abuse allegation, prompted EMS to notify the local law enforcement of the sexual abuse allegation. Review of a facility policy titled Abuse, Neglect and Exploitation revised 6/23 documented in part .Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence) . The facility will implement the following . Reporting of all alleged violations to the Administrator, state agency . and to all other required agencies (e.g., law enforcement) within specified timeframes . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . (continued on next page)

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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 0609 Level of Harm - Actual harm Residents Affected - Few	On 3/6/23 at 8:44 AM, the Administrator was interviewed and asked when and whom they were notified by regarding the incident on 2/27/24 with R's 702 and 703 and the Administrator stated they were informed by (RN B name) and it was reported to them that day and shift of the incident. The Administrator was asked when they reported the incident to the SA and the Administrator stated they were unsure as they did not come into the facility on [DATE]. The Administrator was asked when an allegation of abuse is supposed to be reported to the SA and the Administrator replied uhhh two hours. The Administrator was asked if they gave the directive to the staff to call the police when the staff informed of the incident and the Administrator could not recall. The Administrator was asked if they had notified the local law enforcement of the incident and the Administrator stated they did not. The Administrator was asked why they omitted the details submitted to the SA of both residents to have been observed naked in R702's bed and R703 to have an erection and the Administrator stated the investigation is ongoing and they did not want to jump to conclusions. On 3/6/24 at 4:07 PM, R702 was observed eating off of a food tray found on the counter top in the second-floor community room. Another resident grabbed the tray from R702 and told R702 that they couldn't do that. A staff member arrived shortly after to intervene and took the cold food tray away. An interview was attempted with R702, however R702 was unable to answer any of the questions appropriately. R702 walked away and was observed wandering the unit hallways. No further explanation or documentation was provided by the end of the survey.

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00143015 & MI00143012. Based on observations, interviews, and record reviews, the facility failed to protect a vulnerable resident (R702) who lacks cognitive ability to consent to sexual activity, from a sexual incident initiated by R703 a cognitively intact resident for two of six residents reviewed for abuse, resulting in the failure of the facility to protect R702 and other vulnerable residents who resided in the facility on the day of the incident, the failure to conduct a thorough investigation, the failure to preserve potential criminal evidence and the failure to notify law enforcement of the incident, which resulted in an Immediate Jeopardy (IJ). The IJ was identified on 3/6/24 at 9:15 AM. The IJ began on 2/27/24. The Administrator was notified of the IJ on 3/6/24 at 11:59 AM and a plan of removal was requested to remove the immediacy. The IJ was removed on 3/6/24 based on the provider's implementation of removal and verified onsite on 3/7/24. Although the immediacy was removed the facility's deficient practice was not corrected and remained isolated with the potential for harm that is not immediate jeopardy. Findings include: Review of a complaint submitted to the State Agency (SA) documented in part . This morning, another patient, (R703 name and age) was found in (R702's name) bed with an erection. (R702 and R703 name) were both naked. It is unknown how long (R703 name) was in bed with (R702 name). There are concerns that (Facility name) did not respond appropriately to the incident as they did not call LE (law enforcement). (Facility name) sent (R702 name) to the ER (emergency room) by way of EMS (emergency medical services). EMS called LE. (R703 name) is of sound mind. (R703 name) has been arrested for sexual assault . Review of a witness statement obtained from the local law enforcement department, written by Certified Nursing Assistant (CNA) A, documented the following . I was at the nursing station and notice (R702's room number) call light was on when I entered the room I witnessed (R703 name) in bed naked with (R702 name) with a fully erect penis. (R703 name) was on his back and (R702 name) being cuddled when I asked him what he was doing he began to dress himself. I was able to separate the two of them before getting the nurse he then went to his room and (R702 name) was taken downstairs to (room number). (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a witness statement obtained from the local law enforcement department, written by Registered Nurse (RN) B, documented the following . Called to room (room number) by CNA (CNA A name). Upon entering room male resident was pulling up his white pull up with his blue jogging pants on floor. I immediated <sic> removed male resident to his room (room number and bed number). I transferred female resident to (room number and bed number). I questioned female resident who is confused and could only tell me hurt while pointing and grabbing at her lower abdomen. When questioning male resident as to why he was lying naked in bed (R702's room number) bed ,he stated she came down to my room and I walked her back to her room. Her brief fell down. I asked male resident why was he naked and he stated, I don't have to answer that. Review of a police report dated 2/27/24, documented in part . On 02/27/2024 at approximately 0537 hours . dispatched to (facility name) . on a report of a possible criminal sexual conduct . male resident was found fully nude in bed with a female resident, who is on hospice and suffers from severe dementia . I arrived on scene, and spoke with . (CNA A name) . observed a male resident (R703) . fully nude in bed next to victim . had an erect penis and was attempting to put his underwear back on . Due to (R702 name) severe dementia, she could not recall anything. Nursing staff stated that (R702 name) was walking around holding her lower abdominal area as if in pain . I went to (R703's room number) to speak with (R703 name), who was sitting in a wheelchair, watching television . (R703 name) stated that they were just lying in bed together. I asked him if he was nude at any point in time and he stated that he was not. I asked nursing staff where the bedding was that was on the bed in (R702's room), however they stated that they had washed it due to there being diarrhea on it . Due to the allegations made by the nursing staff and the witness who saw (R703's name) nude and with an erect penis, the decision was made to have (R702 name) transported to (hospital name) for an evaluation . (hospital name) staff attempted to take vitals from (R702's name), but she became increasingly agitated. The physician's assistant attempted to lift up (R702's name) gown to conduct an assessment on the abdominal area and (R702's name) quickly grabbed her gown and yanked it down. She yelled at staff and attempted to get up several times. The attending physician made the decision that (R702) may be more comfortable with (third party entity name) conducting the examination. (Third party entity name) was contacted by hospital staff. (Third party entity name) stated they would contact (facility name) to schedule a time to examine (R702 name) . warrant for attempted CSC (criminal sexual conduct) 3rd and aggravated indecent exposure . Review of the medical record revealed R702 was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's, dementia and hospice care. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 00, which indicated severely impaired cognition and lacked the capacity to consent to sexual activity. R702 required staff assistance for all Activities of Daily Living (ADLs). Review of a legal guardianship document revealed R702 had a full guardian appointed by the court. Review of a Incident Note dated 2/27/24 at 6:59 AM, documented . Resident observed in bed naked with male resident. Resident c/o (complaints of) pain to lower abdomen. New order to transfer to ER. Resident transferred to (hospital name) for further evaluation. Notification: Resident/Family/Guardian/DPOA State who and when they were notified: Guardian notified . Administrator notified . MD (medical doctor) notified . Hospice nurse notified. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the hospital After Visit Summary dated 2/27/24, documented in part . Reason for Visit Sexual Assault . Review of R703's medical record revealed R703 was admitted to the facility on [DATE] with diagnoses that included convulsions. A MDS assessment dated [DATE], documented a BIMS score of 14, which indicated intact cognition and required minimal assistance for all ADLs. R703 was discharged from the facility at the time of the survey. Review of an Incident Note dated 2/27/24 at 7:52 AM, documented in part . Resident observed lying naked in a female resident bed . Resident removed . Administrator notified. MD notified. Family notified . Review of a Nursing Progress Note dated 2/27/24 at 8:01 AM, documented in part . Resident transferred to (city name) lockup via (city name) PD (police dept) . Administrator notified. On 3/5/24 at 3:38 PM, CNA A was interviewed and when asked stated they were at the nursing station the morning of 2/27/24 when they saw (R702's) call light on. CNA A stated they went down to the room and opened the door which is unusual that the door was shut because R702's room door is always open, and the door was open the last time CNA A had left R702's room. CNA A was uncertain of the time when they last visited R702's room, when asked. CNA A stated when they opened the door, they observed R703 in R702's bed naked. CNA A stated R702 had a gown on but their pull up brief was observed on top of the bedside table. CNA A stated R702 was laying on their side with the back and buttocks exposed and R703 was observed lying behind R702 on their back with their skin touching R702 skin as if you were cuddling with your significant other and R703 was observed to have an erection. CNA A stated R703's sweatpants and pull up brief was observed on the floor next to the bed. CNA A stated they left the room to get Registered Nurse (RN) B and when they returned to the room R703 was pulling up their pull up brief. CNA A was asked why they left R702 in the room with R703 and CNA A stated they were shocked and just left to get the nurse. CNA A stated despite R703 to utilize a wheelchair, R703 is still able to stand and walk short distances with an unsteady gait. CNA A stated they stayed in the room with RN B, watched R703 get dressed and go back into their own room. CNA A stated RN B then went to call the Administrator and they remained with R702 to clean the resident up and change their bedding because R702 had an episode of diarrhea. CNA A was asked why they disposed of R702's bed sheets, gown, brief and washed the resident before being assessed/examined by law enforcement and health professionals and CNA A stated the police asked them the same question that night and CNA A then stated they did not know they had to preserve those items, and their main concern was cleaning the resident. CNA A stated after they cleaned R702, R702 was escorted to the first floor and R703 remained on the second floor. CNA A was asked why R702 was placed on the first floor while R703 remained on the second floor with multiple other vulnerable residents, unsupervised and CNA A could not provide and answer. CNA A was then asked if they notified law enforcement of the incident and CNA A replied No. CNA A was asked if any of the Administration staff followed up with them to obtain their statement or asked them questions regarding the incident with R's 702 and 703 and CNA A stated the Administrator questioned them minutes before meeting the surveyor for this interview. CNA A was asked before today 3/6/24, had any administration staff followed up with them regarding this incident and CNA A replied No. On 3/6/24 at 4:04 PM, the Administrator was asked to provide the facility full investigation, including staff statements obtained for the incident involving R's 702 and 703, on 2/27/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235214	A. Building B. Wing	03/07/2024

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

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/6/24 at 4:07 PM, R702 was observed eating off of a food tray found on the counter top in the second-floor community room. Another resident grabbed the tray from R702 and told R702 that they couldn't do that. A staff member arrived shortly after to intervene and took the cold food tray away. An interview was attempted with R702, however R702 was unable to answer any of the questions appropriately. R702 walked away and was observed wandering the unit hallways. On 3/5/24 at 4:22 PM, RN B was interviewed via telephone. When asked, RN B stated on 2/27/24 CNA A came running to the nurse's desk and told them that R703 was in the bed with R702. RN B stated they went to R702's room and they saw R703 sweatpants and pull up brief on the floor next to R702's bed. RN B stated R703 got dressed and they took R703 back to their room. RN B stated they then assessed R702 who was holding their stomach and saying they were in pain. RN B stated despite being a float nurse they were familiar with R702 and the resident holding their stomach and complaining of pain was something new. RN B was asked what R703's response was when they first saw R703 in R702's room and RN B stated R703 kept stating R702 brought them in their room and wanted R703 to be in their room. RN B was asked if they notified law enforcement regarding the incident and RN B stated No. RN B stated they informed the Administrator who directed the staff to do an assessment and document it, with no further directive given. RN B asked why R702 was placed on the first floor, leaving R703 on the second floor with multiple vulnerable residents and no implementation of increased monitoring/supervision and RN B replied they wanted to ensure the residents were separated, as they did not receive further directive from the Administrator on how to handle the situation. RN B stated they notified the Physician who directed RN B to send R702 out to the hospital for further evaluation. RN B was asked if any of the Administration staff followed up with them regarding this incident or obtained a statement from them and RN B stated No. RN B stated when they returned to the facility on [DATE] the Regional Clinical Director of Operations (RCDO) D asked RN B for a copy of their statement that RN B provided to law enforcement and RN B stated there was no additional follow up from the Administrator or Administration staff. Review of the facility census for 2/27/24 and medical records revealed multiple residents who wandered, had the diagnoses of dementia and/or Alzheimer's residing on the second floor of the facility, while R703 continued to reside on the second floor after the incident without adequate monitoring/supervision implemented. The facility staff failed to protect R702 and other vulnerable residents who resided on the second floor when R703 was allowed to remain on the second floor, after the incident with R702. Review of R703's medical record revealed no additional monitoring/supervision in place for R703 after the incident with 702, until law enforcement returned to the facility to arrest and escort R703 from the facility premises. The facility staff also failed to preserve the evidence needed for the investigation. Review of a facility policy titled Abuse, Neglect and Exploitation revised 6/23 documented in part .Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence) . Protection . The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after investigation. Examples include but are not limited to . Responding immediately to protect the alleged victim and integrity of the investigation . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the hospital After Visit Summary dated 2/27/24, documented in part . Care after sexual assault . What should I do if I am sexually assaulted? - The first thing you should do is find a safe place away from the person who assaulted you . Do NOT try to clean up before you get medical care. Doing this can wash away proof of what happened. In particular: Do not change clothes, Do not take a shower or bath, Do not brush your teeth, Do not wash the inside of your vagina or rectum, If you can wait, try not to go to the bathroom or eat anything until after you have seen a doctor or nurse . Review of the investigation provided by the Administrator contained the incident report submitted to the State Agency (SA), which documented the Incident Summary as (R703 name) was found in a (R702 name) bed. Investigation ongoing. Further review of the investigation provided contained the facility's incident report, face sheets of both residents, progress notes, skin, and pain assessment for R702 and documentation of R702's transfer to the hospital. There were no other documents provided. On 3/6/24 at 8:44 AM, the Administrator (who also serves as the facility's Abuse Coordinator) was interviewed and asked when and by whom they were notified of the incident that occurred between R's 702 & 703, the Administrator replied they were notified by RN B on the day of the incident. The Administrator was asked what was reported to them and the Administrator replied that R703 was in R702 bed. The Administrator was asked what directive they gave the staff and the Administrator stated they instructed RN B to notify the doctor and let them know what occurred and to make sure the residents were separated and to monitor. The Administrator was asked what directive was implemented for monitoring and for which resident and the Administrator could not provide a reply. The Administrator was asked if it was their directive to move R702 the vulnerable resident to the first floor, and leave the perpetrator to remain on the second floor without additional monitoring or supervision implemented and the Administrator did not offer a response. The Administrator was asked about the safety of the other vulnerable residents that resided on the second floor with R703 to have remained on that floor without additional supervision/monitoring implemented and the Administrator did not provide a response. The Administrator was asked who completed the investigation for the incident and stated they were, and that the investigation was still ongoing. The Administrator was asked what they discovered during their investigation on 2/27/24 and the Administrator stated they did not come into the facility on [DATE] and started their investigation on 2/28/24 the next day. The Administrator was asked why at the very least did they not obtain statements from the witnesses that was on duty on the day that the incident occurred, the Administrator stated they had statements and would provide them. The Administrator was asked why the statements were not provided with the investigation documents initially as requested and the Administrator did not have a response. Shortly after the Administrator emailed copies of the two statements obtained by law enforcement as statements for the facility's investigation. At 11:34 AM, a second interview was conducted with the Administrator and the RCDO D in attendance. The Administrator was asked about their investigation into the incident and informed of the concern of a thorough investigation to not have been completed, including statements obtained by them from the witnessing staff. The Administrator was asked if their investigation into the incident identified any opportunity for improvement on how the facility staff handled the situation with R's 702 & 703, as directed by the facility's protocols and policy and the Administrator responded No, he (R703) was taken by the police, and she (R702) was taken to the hospital. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the facility policy titled Abuse, Neglect and exploitation revised 6/23, documented in part . Investigation . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or report of abuse, neglect or exploitation occur . 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 . The facility submitted a removal plan on 3/6/24, which documented the following: - Current residents with BIMS scores of 8 and above will be interviewed/assessed for potential sexual abuse. Current residents with BIMS scores of 7 and below will be assessed by a licensed nurse for an acute change in condition. Any concerns that arise will be addressed by the IDT immediately. - Resident 703 no longer resides in the facility. - Resident 702 received wellbeing checks by the facility Social Worker and her Hospice RN on the event date. Resident has shown no deviation from baseline. - The Abuse, Neglect & Exploitation Policy was reviewed by the Corporate Compliance Officer and deemed appropriate. - The abuse investigation procedure was reviewed by the Corporate Compliance Officer and deemed appropriate. - The Corporate Compliance Officer re-educated the facility Administrator on our Abuse, Neglect & Exploitation Policy, and the investigation procedure. - Beginning 3/6/24, all staff will be reeducated on the facility abuse policies, including abuse prevention and expected interventions. Education also includes preservation of potential crime scenes in the event of a sexual allegation. Any staff not educated on 3/6/24 will be educated prior to their next shift. As of 3/6/24 4:30p 62% of staff have received the education. - In the event of any future resident sexual abuse allegations, the perpetrating resident will immediately be placed on 1:1 supervision until additional safety interventions can be implemented. - The Medical Director was notified of this event on 03/06/2024.