

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Clawson		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 38271</p> <p>This citation pertains to intake #MI00143854</p> <p>Based on interview and record review the facility failed to ensure an environment free from sexual abuse for two cognitively impaired residents (R49 and R75) lacking the ability to consent for physical intimacy of six residents reviewed for abuse/neglect/mistreatment. Findings include:</p> <p>On 4/15/24 a facility reported incident (FRI) submitted to the State Agency was reviewed which indicated that on 3/26/24 R75 had wandered into R49's room and was found by staff without any clothes on with R49 in the bed and without any clothes on. Both residents were alleged to be incapacitated with court appointed-legal guardians.</p> <p>R49</p> <p>On 4/15/24 at approximately 9:23 a.m., R49 was observed in their room, laying in their bed. R49 was queried if they remembered the incident with R75 and they reported they did and that R75 had walked into their room and took their clothes off and got into bed with them. R49 indicated that R75 was trying to touch them everywhere and that R49 had been yelling out for help from staff.</p> <p>On 4/15/24 the medical record for R49 was reviewed and revealed the following: R49 was initially admitted to the facility on [DATE] and had diagnoses including Heart failure, and Major Depression. R49 was noted to have a legal guardian.</p> <p>A review of R49's progress notes pertaining to the incident revealed the following: 3/26/2024- writer was called by CENA (Certified Nursing Assistant) to resident room when writer arrived to room writer observed Cena's separating the male and female resident, both resident was bare with no clothes on at the time they were observed. Both resident was separated and skin assessment was done on resident their were no new skin issue found at the time of assessment. female resident was placed on 1 on 1 and male resident on frequent checks</p> <p>3/27/2024-Resident continues post incident day 1 monitoring r/t (related to) incident of sexual nature with frequent checks provided to maintain safety. He remains alert and oriented x 1-2, verbal and able to make needs known .</p> <p>R75</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/15/24 the medical record for R75 was reviewed and revealed the following: R75 was initially admitted to the facility on [DATE] and had diagnoses including Dementia with Psychotic Disturbance, Wandering and Violent behavior. A review of R75's MDS (minimum data set) with an ARD (assessment reference date) of 3/28/24 revealed R75 had a BIMS score (brief interview for mental status) of zero indicating severely impaired cognition. R75 was also noted to have a court appointed legal guardian.</p> <p>A review of R75's progress notes revealed the following: 3/26/2024-1915 writer summoned to resident's room [R75's room] by assigned CNA stating while making rounds she observed resident [R75] in bed with the male resident in room [R49's room]. Administrator/ police notified immediately. writer/assigned CNA stayed with resident until a one on one was assigned. writer completed skin assessment and observed red scratches to the abdomen .</p> <p>3/26/2024-Practitioner Progress Notes .Patient was seen for the incident .case was already reported. resident was assessed. will add cimetidine to help inappropriate sexual behavior .</p> <p>A review of the facility investigation pertaining to the incident between R49 and R75 on 3/26/24 was reviewed and revealed the following: Investigative Summary/Actions Taken: Reportable Event-</p> <p>On March 26th, 2024, Abuse Coordinator was informed by facility staff that resident [R75] had been found with [R49], a male resident, in his room. Both residents were undressed and laying together in his bed, holding one another. [R75]was dressed and removed from the male resident's room and immediately placed on 1 on 1 supervision. Investigation initiated The facility investigator immediately began obtaining witness statements and other documents. The C.N.A. who found [R75] in [R49's] room immediately separated the two residents and notified the Nurse supervisor. The nurse supervisor immediately placed [R75] on 1 on 1 supervision and began notifications per facility protocol. The nurse notified the Administrator, the .PD (police department), physicians and the guardians of both residents as both residents are cognitively impaired. The Nurse completed a skin assessment of [R75] with scratches noted to her abdomen. The police arrived and spoke with staff and the Administrator, who had already began gathering staff statements The facility investigator spoke with both residents involved in the incident. [R75] has a BIMS of 0 and is unable to recall any of the events. [R49] has a BIMS of 11 and stated [R75] hopped in his bed while he was asleep and he yelled out and staff entered the room at that point The facility investigator spoke with [CNA M]. She reports she was walking down the hallway looking for [R75] and found her in [R49 's room] She states the door was closed and blocked with a wheelchair so she had to push the door open. She reports [R75] was laying next to [R49] in the bed and neither resident had clothes on. She saw the residents with their arms wrapped around each other Conclusion-Based on the facility investigation, the facility substantiates the incident occurred .</p> <p>On 4/16/24 at approximately 11:37 a.m., CNA M was queried regarding the incident that they witnessed between R49 and R75 on 3/26/24 and they indicated they were looking for R75 and found them in R49's room in R49's bed and both had no clothes on and R75 had their arm around R49. CNA M indicated they put a night gown on R75 and helped them back to their room.</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 - Few</p>	<p>On 4/16/24 at approximately 3:21 p.m., during an interview with RDO A (Regional Director of Operations A), RDO A indicated they were the Administrator at the facility at the time of the incident and conducted the investigation. RDO A indicated that they substantiated that the event occurred because it was witnessed and it was reported in the correct time frame due to the sexual incident of the allegation. RDO A reported that they believed R75 and R49 did not have sex but that they were found without clothes holding each other. RDO A indicated they had placed R75 on on 1:1 supervision for 24 hours, then the majority of the males who resided on the second floor were moved to the first floor for further protection from R75.</p> <p>On 4/16/24 a facility document titled Abuse, Neglect and Exploitation was reviewed and revealed the following: Policy: 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 and misappropriation of resident property .Definitions-Sexual Abuse is non-consensual sexual contact of any type with a resident</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>38271</p> <p>This citation pertains to intake #MI00143854</p> <p>Based on interview and record review the facility failed to submit their abuse investigation within the mandatory five business day time-frame for two residents (R49 and R75) of six residents reviewed for abuse. Findings include:</p> <p>On 4/15/24 a facility reported incident (FRI) submitted to the State Agency on 3/26/24 was reviewed which indicated that on 3/26/24, R75 had gone into R49's room and was found by staff without any clothes on R49 in the bed and without any clothes on. Both residents were alleged to be incapacitated with court appointed-legal guardians.</p> <p>A review of the facility investigation pertaining to the incident between R49 and R75 on 3/26/24 was reviewed and revealed the following: Investigative Summary/Actions Taken: Reportable Event-</p> <p>On March 26th, 2024, Abuse Coordinator was informed by facility staff that resident [R75] had been found with [R49], a male resident, in his room. Both residents were undressed and laying together in his bed, holding one another. [R75] was dressed and removed from the male resident's room and immediately placed on 1 on 1 supervision. Investigation initiated The facility investigator immediately began obtaining witness statements and other documents. The C.N.A. who found [R75] in [R49's] room immediately separated the two residents and notified the Nurse supervisor. The nurse supervisor immediately placed [R75] on 1 on 1 supervision and began notifications per facility protocol. The nurse notified the Administrator, the .PD (police department), physicians and the guardians of both residents as both residents are cognitively impaired. The Nurse completed a skin assessment of [R75] with scratches noted to her abdomen. The police arrived and spoke with staff and the Administrator, who had already began gathering staff statements The facility investigator spoke with both residents involved in the incident. [R75] has a BIMS (brief interview for mental status) of 0 and is unable to recall any of the events. [R49] has a BIMS of 11 and stated [R75] hopped in his bed while he was asleep and he yelled out and staff entered the room at that point The facility investigator spoke with [CNA M]. She reports she was walking down the hallway looking for [R75] and found her in [R49 's room] She states the door was closed and blocked with a wheelchair so she had to push the door open. She reports [R75] was laying next to [R49] in the bed and neither resident had clothes on. She saw the residents with their arms wrapped around each other Conclusion-Based on the facility investigation, the facility substantiates the incident occurred .</p> <p>Further review of the facility reported investigation revealed the investigation was submitted to the Stage Agency on 4/9/24 at 2:52 p.m.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/16/24 at approximately 3:21 p.m., during an interview with RDO A (Regional Director of Operations A), RDO A indicated they were the Administrator at the facility at the time of the incident and conducted the investigation. RDO A indicated that they substantiated that the event occurred because it was witnessed and it was reported in the correct time frame due to the sexual nature of the allegation. RDO A reported that they believed R75 and R49 did not have sex but that they were found without clothes holding each other. RDO A indicated they had placed R75 on on 1:1 supervision for 24 hours, then the majority of the males who resided on the second floor were moved to the first floor for further protection from R75. RDO A was queried why the five day investigation was not submitted to the State Agency for review until 4/9/24 and they indicated that they did not have access to submit it and that the new Administrator was not available to submit it. RDO A was queried if they had contacted the State to gain access to submit the investigation in the required time frame and they indicated they did not.</p> <p>On 4/16/24 a facility document titled Abuse, Neglect and Exploitation was reviewed and revealed the following: Policy: 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 and misappropriation of resident property .VII. Reporting/Response-I . The facility will implement the following: 2, Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement) within specified timeframe's: .</p>		