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	06/25/2024

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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00145225. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident resulting in R605, who had a history of aggressive and agitated behavior, pushing one (R606) of six residents reviewed for abuse to the ground and hitting their head, sustaining a laceration, and being transferred to the hospital. Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed there was a resident to resident physical abuse incident between R605 and R606 on 6/12/24. On 6/25/24 at 10:10 AM, R606 was observed seated on the side of their bed. They were pleasant, but were unable to participate in an interview. On 6/25/24 at approximately 10:15 AM, R605 was observed walking up and down the hallway on the unit. A review of R606's clinical record revealed the following: A progress note dated 6/12/24 at 6:04 PM, written by Licensed Practical Nurse (LPN) 'D', noted a Certified Nursing Assistant (CNA) reported R606 was on the floor and reported being pushed down. The physician was contacted and R606 was sent to the hospital. A progress note dated 6/13/24 at 9:30 AM, written by the Director of Nursing (DON), noted R606 returned from the hospital and had a laceration to left side of head bruising to left leg lateral. R606 was admitted into the facility on [DATE] with diagnoses that included: dementia and osteoporosis (a disease that weakens the bones). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R606 had severely impaired cognition. A review of R605's clinical record revealed the following: (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 6/12/24 at 7:19 PM, written by LPN 'D', noted R605 was observed by a CNA standing in the hallway. R605 told the CNA they pushed her down, referring to another resident (R606) because she pushed me!. A review of R605's progress notes prior to the incident on 6/12/24 revealed the following documentation: On 6/10/24, R605 was verbally abusive to staff and other resident over the weekend, she was observed yelling at residents and using foul language towards staff and residents. Writer observed resident in another resident's room today, writer unable to redirect resident back to her own room, she became very aggressive and begin <sic> to yell .Writer informed staff to continue to monitor resident's behavior and report any changes to the nurse . Further review of R605's clinical record revealed R605 was admitted into the facility on [DATE] with diagnoses that included: dementia, paranoid personality disorder, and post traumatic stress disorder. A review of R605's MDS assessment dated [DATE] revealed R605 had severely impaired cognition and no behaviors. A review of R605's care plans revealed a care plan initiated on 3/14/23 and revised on 6/3/24 that noted, .I have a hx (history) of verbal and physical behaviors, such as .biting, slapping, and pushing, and grabbing . On 6/25/24 at 12:55 PM, an interview was conducted with LPN 'D'. When queried about what happened between R605 and R606 on 6/12/24, LPN 'D' reported a CNA notified her that R606 was on the floor and said R605 pushed her. R605 admitted to pushing R606 and said R606 pushed her first. LPN 'D' explained she was not familiar with either residents' behaviors because she worked contingently in the facility. LPN 'D' reported R606 was sent to the hospital because she hit her head. A review of the facility's investigation revealed a document titled, 5 day Investigation Summary that noted, On Wednesday, June 12, 2024, at approximately 7pm, (CNA 'E') observed resident (R606) on the floor and (R605) was standing next to her. (LPN 'D') was notified by (CNA 'E') of the observation. Upon interview of (R605) she states that (R606) was getting too close to her and was in her space. (R605) has a history of behavioral episodes and is followed by (behavioral health agency). A care conference was held with daughter to discuss behaviors . (R605's daughter) was agreeable with implementing medication to assist with behavior management. Medication has been implemented. (R605) was put on 1:1 for 24 hours. (R606) was given a skin and pain assessment which indicated a small laceration in the back of her head, and she did verbalize some pain (R606) was sent to the hospital as a precaution due to having another recent fall in which she also hit her head .Conclusion: The facility was unable to substantiate that abuse occurred. However, the facility did validate that (R605) pushed (R606) resulting in a fall . On 6/25/24 at approximately 2:15 PM, an interview was conducted with the Administrator who was the Abuse Coordinator for the facility. When queried about the conclusion of the facility's investigation for R605 and R606 that noted abuse was not substantiated but it was confirmed that R605 pushed R606 causing her to fall to the ground and hit her head after R605 verbalized she did push R606 because she got in her space, the Administrator said it was her understanding that if both residents had dementia, then it was not considered abuse because they were unable to make the decision to abuse the other resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Abuse, Neglect and Exploitation, revised 6/2023, revealed, in part, the following: Abuse means the willful infliction of injury .resulting in 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 .The facility will identify, correct, and intervene in situations in which abuse .is more likely to occur .and assure that the staff assigned have knowledge of the individual residents' care needs .

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00145225. Based on observation, interview, and record review, the facility failed to report an injury of unknown origin to the Administrator in a timely manner and to the State Agency for one (R608) of six residents reviewed for abuse. Findings include: On 6/25/24 at 10:10 AM, R608 was observed walking quickly up and down the hallway. R608 stopped in the doorway of another resident's room and that resident yelled, Hey! You can't come in here!. R608 had two black eyes and a bruise on their forehead. When addressed, R608 did not respond to questions and continued to walk quickly down the hallway. On 6/25/24 at 10:37 AM, any incident reports with associated investigations for R608 for the month of June 2024 were requested from the Administrator. A review of R608's clinical record revealed R608 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia and violent behavior. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R608 had severely impaired cognition and exhibited physical and wandering behaviors. A review of a progress note dated 6/13/24 at 7:06 AM, written by Licensed Practical Nurse (LPN) 'G' noted, Unwitnessed fall with injury 0650 (6:50 AM) resident observed laying in bed in her old room .hematoma noted to the forehead/laceration noted to the bridge of the nose, bleeding controlled .on call doctor notified, call placed to guardian . A review of a progress note dated 6/13/24 at 10:52 AM, written by the Director of Nursing, noted, Event occurred on 06/13/2024 10:45 AM. Resident was found in (room number) with bleeding from forehead. Physician and responsible party notified. A review of an Admission Note dated 6/18/24 noted, .Resident has dark purple bruising around both eyes and small laceration to center of nose . A review of a file explained to be the facility's investigation for R608 revealed the following: An incident report for Fall dated 6/13/24 at 7:00 AM that noted, Resident observed laying in bed in her old room .hematoma noted to the forehead/laceration noted to the bridge of the nose .Resident unable to give description .Mental Status - Oriented to person .Predisposing Situation Factors - Increased behaviors . increased agitation .Resident had (brand name slip on shoes) at the time of fall, may have been contributing factor .No witnesses found . It was documented R608's legal guardian and the on-call physician were contacted at 7:05 AM on 6/13/24. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at approximately 2:15 PM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. When queried about what was considered an injury of unknown origin, the Administrator reported it was anything that the facility could not explain or pin point what happened. The Administrator explained if a resident had an injury of unknown origin, it was immediately reported to the State Agency and an investigation was started to determine the cause of the injury. The Administrator further explained that once staff identified an injury of unknown origin they were to contact the Administrator immediately. When queried about R608 and the bruising to both eyes, hematoma to forehead, and laceration to the bridge of the nose, the Administrator reported the DON reported it to her but she was told R608 had a fall. The documentation on the incident report and in the clinical record that noted R608 was found lying in bed that was not hers with a hematoma to the forehead and laceration to the nose was reviewed with the Administrator. When queried about how it was determined that R608 had a fall if it was not witnessed and she was found in a bed, not on the ground, the Administrator reported she went off the information that was presented to her which was that R608 fell . The Administrator reported based on the information reviewed, R608 had an injury of unknown origin that should have been reported to her immediately, to the State Agency, and investigated. On 6/25/24 at 2:43 PM, an interview was conducted with the DON. When queried about what was reported to her regarding R608 on 6/13/24, the DON reported R608 was found in another bed bleeding from her head and prior to that a pool of blood was found at the 2 north nurse's station. The DON further explained she was told that R608 was found in the bed with the injuries to her face. When queried about whether R608 was able to say what happened, the DON reported she could not. When queried about how it was determined a fall was the cause of R608's injuries when she was found in a bed and there was no witnessed fall, the DON reported she went off of what the nurse told her. When queried about R608's wandering behaviors, the DON reported she was not aware that was an issue. On 6/25/24 at 3:33 PM, the DON was further interviewed. The DON reported the Nurse Practitioner and Unit Manager, LPN 'F' notified her of R608's injuries. The midnight nurse, LPN 'G' reported to the day shift nurse, LPN 'D', that R608 had a fall and the on-call physician said R608's provider would be in to see her. The DON explained that per facility protocol, LPN 'G' should have contacted her and she received a write-up. On 6/25/24 at 4:01 PM, an interview was conducted with Unit Manager, LPN 'F. When queried about who reported R608's injuries to her, LPN 'F' said the day shift nurse, LPN 'D' asked me to look at R608 because she was told she had a fall and had injuries to her face and head. LPN 'F' explained after seeing R608 she felt that she needed to go to the hospital and the NP who was in the building evaluated R608 and agreed to send her out. A review of a facility policy titled, Abuse, Neglect and Exploitation, revised on 6/2023, revealed, in part, the following: .Possible indicators of abuse include, but are not limited to .Physical injury of a resident, of unknown source .Reporting of all alleged violations to the Administrator, state agency .within specified timeframes: .Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the vents that cause the allegation do not involve abuse and do not result in serious bodily injury .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00145225. Based on observation, interview, and record review, the facility failed to thoroughly investigate an injury of unknown origin to rule out abuse for one (R608) of six residents reviewed for abuse. Findings include: On 6/25/24 at 10:10 AM, R608 was observed walking quickly up and down the hallway. R608 stopped in the doorway of another resident's room and that resident yelled, Hey! You can't come in here!. R608 had two black eyes and a bruise on their forehead. When addressed, R608 did not respond to questions and continued to walk quickly down the hallway. On 6/25/24 at 10:37 AM, any incident reports with associated investigations for R608 for the month of June 2024 were requested from the Administrator. A review of R608's clinical record revealed R608 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia and violent behavior. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R608 had severely impaired cognition and exhibited physical and wandering behaviors. A review of a progress note dated 6/13/24 at 7:06 AM, written by Licensed Practical Nurse (LPN) 'G' noted, Unwitnessed fall with injury 0650 (6:50 AM) resident observed laying in bed in her old room .hematoma noted to the forehead/laceration noted to the bridge of the nose, bleeding controlled .on call doctor notified, call placed to guardian . A review of a progress note dated 6/13/24 at 10:52 AM, written by the Director of Nursing, noted, Event occurred on 06/13/2024 10:45 AM. Resident was found in (room number) with bleeding from forehead. Physician and responsible party notified. A review of an Admission Note dated 6/18/24 noted, .Resident has dark purple bruising around both eyes and small laceration to center of nose . A review of a file explained to be the facility's investigation for R608 revealed the following: An incident report for Fall dated 6/13/24 at 7:00 AM that noted, Resident observed laying in bed in her old room .hematoma noted to the forehead/laceration noted to the bridge of the nose .Resident unable to give description .Mental Status - Oriented to person .Predisposing Situation Factors - Increased behaviors . increased agitation .Resident had (brand name slip on shoes) at the time of fall, may have been contributing factor .No witnesses found . It was documented R608's legal guardian and the on-call physician were contacted at 7:05 AM on 6/13/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation file, included a copy of the progress notes documented above and a post-fall assessment dated [DATE]. There were no interviews of staff or residents to determine how R608 got into another bed or how she sustained a hematoma to the forehead and a laceration to the bridge of the nose. The incident report was for a Fall and the progress note documented unwitnessed fall. However, R608 was not observed on the floor, she was in a bed, and nobody saw her fall. On 6/25/24 at approximately 2:15 PM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. When queried about what was considered an injury of unknown origin, the Administrator reported it was anything that the facility could not explain or pin point what happened. The Administrator explained if a resident had an injury of unknown origin, it was immediately reported to the State Agency and an investigation was started to determine the cause of the injury. When queried about R608 and the bruising to both eyes, hematoma to forehead, and laceration to the bridge of the nose, the Administrator reported the DON reported it to her but she was told R608 had a fall so there was no further investigation. The Administrator reviewed the incident report and progress notes and explained based on that information, the injuries should have been investigated. On 6/25/24 at 2:43 PM, an interview was conducted with the DON. When queried about what was reported to her regarding R608 on 6/13/24, the DON reported R608 was found in another bed bleeding from her head and prior to that a pool of blood was found at the 2 north nurse's station. The DON further explained she was told that R608 was found in the bed with the injuries to her face. When queried about whether R608 was able to say what happened, the DON reported she could not. When queried about how it was determined a fall was the cause of R608's injuries when she was found in a bed and there was no witnessed fall, the DON reported she went off of what the nurse told her. When queried about R608's wandering behaviors, the DON reported she was not aware that was an issue. When queried about how the DON knew the pool of blood was from R608, the DON did not have a response. The DON reported R608 did not have the black eyes prior to going to the hospital, but they were present upon readmission. When queried about how it was determined R608 was not abused when no fall was witnessed and she was not able to say what happened, the DON again reported she went off of what was told to her. The DON further explained that a Certified Nursing Assistant got R608 out of bed and placed her in the dining room with another resident. The other resident pointed to indicate R608 left the dining room and that was when she was found in the bed that was not hers. A review of a facility policy titled, Abuse, Neglect and Exploitation, revised on 6/2023, revealed, in part, the following: .Possible indicators of abuse include, but are not limited to .Physical injury of a resident, of unknown source .An immediate investigation is warranted when suspicion of abuse .or reports of abuse . occur .Investigation 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 . Focusing the investigation on determining if abuse .has occurred, the extent, and cause .Providing complete and thorough documentation of the investigation .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 49083 This citation pertains to Intake # MI00144190 Based on observation, interview, and record review, the facility failed to provide ongoing facility sponsored individual activities for one (R604) of one resident reviewed for activities, resulting in the potential for feelings of isolation, depressingly impacting physical, mental, and psychosocial well-being. Findings Include: A complaint was filed with the State Agency that alleged the resident does not have any activities to keep them occupied. Clinical record review revealed that R604 was admitted to this facility on 6/22/23 with a diagnosis of nontraumatic subdural hemorrhage (bleeding in the brain), dementia, receptive-expressive language disorder, and bilateral upper and lower contractures (permanent shortening and tightening of the muscles) which requires full assistance with all activities of daily living. A Brief Interview for Mental Status (BIMS) score assessed on 6/7/24 totaled 0/15 indicating R604 had severe impaired cognition. Further record review from the care plan revealed R604 is nonverbal, enjoys listening to music, television, and sports. On 6/25/24 at 8:20 AM, R604 was observed in a Geri chair (a chair combination of a recliner and transport wheelchair) with both upper and lower extremities contracted, lying on their right side facing the wall. When spoken to, R604 was nonverbal, but maintained eye contact when spoken to. On 6/25/24 at 9:15, R604 was observed alone in a Geri chair in the hallway outside of their room lying on their right side. R604 was spoken to again and responded with eye contact. On 6/25/24 at 9:45, R604 was observed alone in a Geri chair in the hallway outside of their room lying on their right side, asleep. On 6/25/24 at 10:30, R604 was observed alone in a Geri chair in the hallway outside of their room lying on their right side, awake. On 6/25/24 at 10:35 AM, An interview with Recreation Director A was conducted and indicated residents at the facility who are nonverbal, and physically compromised are provided one-to-one activities which include talking with the resident, listening to music, and provide hand massages. It was inquired if R604 had any documentation of such activities and Recreation Director A confirmed there is no documentation of one-to-one stimulation, but stated R604 was outside with the other male residents on Father's Day weekend but could not confirm any other activities with R604 since that weekend. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	With further inquiry, Recreation Director A was asked how often one-to-one activities are performed, and stated, Ideally, daily, but with the loss of staff, it is very challenging to provide one-to-one stimulation for such residents. Currently, only two staff members (Certified Nurse Assistant (CNA) B and former activities aid, now employed as the facilities housekeeper C) assist with activities for the entire facility. After the interview with Recreation Director A the following observation was noted: On 6/25/24 at 11:45, R604 was observed in a Geri chair, at the end of the hall, alone, placed next to a wall underneath a television monitor with music playing. On 6/25/24 at 3:55 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) acknowledged the lack of activities with all their residents. Per the NHA, currently working with new management, and planned on developing a new activities program. Review of the facilities policy title; Activities dated 1/2024 documented: .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community.