

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Greenville		STREET ADDRESS, CITY, STATE, ZIP CODE 828 E Washington St Greenville, MI 48838	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 45410</p> <p>This citation pertains to intake #MI00145456.</p> <p>Based on observation, interview, and record review, the facility failed to prevent an elopement resulting in an immediate jeopardy when 1 resident (Resident #106) of 5 residents reviewed for elopement risk, exited the facility unbeknownst to staff. This deficient practice resulted in the elopement and risk for serious harm, injury, impairment, and/or death of Resident #106 and all other residents assessed as an elopement risk.</p> <p>Findings include:</p> <p>The Immediate Jeopardy (a situation in which entity noncompliance has placed the health and safety of residents in its care at risk for serious injury, serious harm, serious impairment or death) began on 6/21/2024 at approximately 5:15 AM when Resident #106 (R106) eloped from the facility. The Nursing Home Administrator was notified of the Immediate Jeopardy on 8/20/2024 at 12:37 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 6/21/2024 and the deficient practice corrected on 6/28/2024, prior to the start of the survey and was therefore past noncompliance.</p> <p>Review of an Admission Record revealed R106 admitted to the facility on [DATE] with pertinent diagnoses which included dementia, bipolar disorder, and suicidal ideations. Further review revealed R106 had an activated Durable Power of Attorney.</p> <p>Review of a Minimum Data Set (MDS) assessment for R106, with a reference date of 7/17/2024 revealed a Staff Assessment for Mental Status score of 2, which indicated R106 was moderately cognitively impaired. Further review of same MDS assessment revealed R106 received antipsychotic, antianxiety, and antidepressant medications.</p> <p>Review of R106's Social Service Progress Note, dated 6/20/2024 at 10:00 AM, revealed resident returned from a short stay at a community psychiatric hospital after being treated for suicidal ideation.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of R106's Behavior Notes documented by Licensed Practical Nurse (LPN) K, dated 6/21/2024 at 2:31 AM, revealed .Resident exit seeking states want to go home explained that she has lived here and she has a bed here now. Resident is agitated and wants to go home . Tried to explain that she could not go tonight . She would wait until later in morning and discuss with her doctor and her responsible party .</p> <p>Review of R106's Incident Note, dated 6/21/2024 at 6:24 AM, revealed .Resident was reported to be outside of facility. Walking down 57 (a state highway) when arriving staff noted her outside of the facility . Resident stated was trying to go home .</p> <p>In an observation and interview on 8/19/2024 at 2:01 PM, Certified Nursing Assistant (CNA) O reported she saw an elderly woman with white hair and a walker walking on the road near the facility next to the mailbox of the adjacent property at approximately 5:30 AM on 6/21/2024. CNA O reported she did not recognize this person to be a resident and so she did not stop at the time CNA O reported the front door was alarming when she entered the building, but no staff were addressing the door alarm. CNA O reported she found LPN K near the nursing station and asked if there was a missing resident. After describing the woman she saw in the road, LPN K reported that must be R106. CNA O reported she told LPN K to call a code search (internal alert code) and returned to apprehend the resident. CNA O reported R106 had walked further away from the facility and was standing in the state highway when she caught up to her. CNA O reported she was able to turn R106 back toward the facility and additional staff arrived to assist. CNA O showed me exactly where she found R106 both when driving to the facility and when she returned to her.</p> <p>In a telephone interview on 8/21/2024 at 7:26 AM, LPN K reported at approximately 1:30 AM on 6/21/2024 R106 began talking about wanting to go home. LPN K reported R106 had never made a statement like this in the past, was not considered at risk for elopement prior to this incident and did not wear a wanderguard (resident alarm device) at the time. LPN K reported R106 continued talking about wanting to go home the entire night. LPN K reported staff kept an eye on R106 as much as possible and kept her near the nursing station. LPN K reported she came out of a resident room at approximately 5:30 AM, the front door was alarming, and CNA O met her at the nursing station and described a lady that fit the description of R106 that was out in the road. LPN K reported she did not call a code search. LPN K stated, Why should I involve the whole facility when I know who left? LPN K reported CNA O went out the front door on foot to apprehend R106 and she got her car keys. LPN K reported CNA O was walking R106 back toward the facility when she caught up to them a couple minutes later. LPN K was not sure how long the door was alarming and stated, It could not have been more than 5 minutes. LPN K reported she should have put a wanderguard on R106 as soon as she made comments about wanting to leave the facility. LPN K reported the wanderguard alarm is much louder than the door alarm and she would have been able to hear the alarm from the resident's room.</p> <p>In an interview on 8/19/2024 at 2:20 PM, Interim NHA A reported staff were all busy providing cares when R106 exited the building and the front door alarm went off. Interim NHA A reported the facility treated this like an Immediate Jeopardy by educating staff, conducting elopement drills, performing audits, and had been auditing and performing drills since the event.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an observation on 8/19/2024 at 3:35 PM, the distance from the front door to the mailbox where CNA O first observed R106 was approximately 120 yards. The distance from the front door to the state highway where R106 was apprehended by R106 was approximately 230 yards. The speed limit on the state highway where R106 was apprehended was 40 mph, and 55 mph just before the intersection she was found standing in.</p> <p>Review of facility policy/procedure Elopements and Wandering Residents, revised in May of 2024, revealed . This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . The facility may be equipped with door locks and/or alarms to help avoid elopements . Alarms are not a replacement for necessary supervision . Staff are to be vigilant in responding to alarms in a timely manner . The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary . Procedure for locating missing resident . Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g. internal alert code) .</p> <p>The Immediate Jeopardy that began on 6/21/2024 was removed on 6/21/2024 when the facility began education that included the facility's elopement policy, tips to prevent elopement, what to do when a resident who should not be outside is found outside independently, what to do when a door is alarming, when and how to perform a code search, and use of elopement books. Checks of external doors were completed, the Elopement and Wandering Policy was reviewed and deemed appropriate, an elopement drill was conducted, and all residents were re-assessed for elopement risk.</p> <p>The deficient practice was corrected on 6/28/2024 after the facility showed sustained compliance by conducting continued elopement code search drills involving all shifts, weekly audits, and continued education of all staff prior to working the next scheduled shift.</p>		