STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235298	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Father Murray, A Villa Center	8444 Engleman Center Line, MI 48015

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 This citation pertains to MI00145143, MI00145149, and MI00145155. Based on interview, and record review the facility failed to ensure timely follow up by social work and psychiatric services and physician notification for suicidal ideations for one (903) of one residents reviewed for mental health disorders. Findings include: R903 A review of the medical record revealed that R903 admitted into the facility on [DATE] with the following diagnoses: schizoaffective disorder and bipolar type. A review of the Minimum Data Set assessment (MDS) revealed, a Brief Interview for Mental Status score of 15/15, which indicated R903 with an intact cognition. R903's medical record also noted R903 with a history of multiple suicide attempts. The MDS also revealed a resident mood interview (PHQ depression screen) which revealed, R903 answered they had thoughts of feeling down depressed or hopeless and that they would be better off dead, or of hurting themselves, nearly every day. A consult to psychiatry was ordered on 3/5/24 for schizoaffective disorder and another consult to psychiatry was ordered on 3/12/24 for depression. Psychiatry visits were made on 3/14/24, 3/19/24 and 5/30/24. The visit note dated 3/14/24 documented R903 had a history of multiple suicide attempts and a recent suicide attempt. Further record review revealed a progress note by Licensed Practical Nurse (LPN) M on 6/2/24 as follows: Writer entered resident room for daily rounds and medication pass. Upon entering resident begin crying yelling out stating 'family gave up on (R903) and that (they) want to kill (themselves)'. Resident refused medication and told writer to 'get out of (their) room and leave me alone'. Writer left room and returned a few hours later. Resident calmed down and took medication. SW (Social Worker) is aware of behaviors. Psych consult in place. Will continue plan of care. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R903's care plan revealed a behavioral care plan focus as follows: Behavior: (R903) is/has potential to be verbally aggressive and physical aggression towards staff r/t (related to) poor impulse control. Dx (diagnosis) of schizoaffective disorder, bipolar 1 disorder, depression and anxiety. Long psychiatric history, prior to admission. Prone to catastrophic reactions. Mood: (R903) has a mood problem r/t schizoaffective disorder, bipolar type. The resident will have improved sleep pattern by reporting adequate rest or fewer documented episodes of insomnia through the review date. The care plan did not include suicidal ideations nor interventions addressing suicidal ideations. On 6/20/24 during an interview with LPN M, when asked about the progress note they wrote on 6/2/24, stated R903 had to wait for their medication, and they got verbally aggressive and verbalized suicidal ideations. LPN M stated the nurse on the previous shift reported to LPN M that R903 was also verbalizing suicidal ideations to them on the previous shift. When asked if LPN M notified the doctor, they confrimed that R903 already had psychiatry consult in place and the social work was aware of the behaviors. Record review of progress notes revealed there was no visit by or notification to the primary physician, psychiatry, or social worker. A Psychiatry visit progress note dated 6/17/24 stated: Follow up visit .reviewed the resident's conditions of Behaviors due to Psychiatric condition, which are unresolved and unstable. The current plan of care was established at over 2 months ago. Changes in psychiatric and/or other relevant medications include the following: Added Seroquel 100 mg (milligrams) po (by mouth) one time only. Writer met with resident in person today. Resident was agreeable to visit and was alert and talkative, though worried and anxious throughout visit. Discussed mood and resident reported worsening depressive sx (symptoms), increased anxiety, and says described delusions that are worsening and distressing. People are after (R903), and scaring (R903), and (R903) wants to go to the hospital. Says Seroquel is not helping. To be sent to hospital. Further record review revealed that on 6/17/24 R903 was petitioned and sent to the hospital following a suicide attempt at the facility. On 6/20/24, during an interview, Certified Nurse Assistant (CNA) K stated that R903 has good days and bad days. CNA K stated that she has heard R903 say they wish they could die. On 6/20/24, during an interview, Unit Manager L (UM L) said R903 had suicidal ideations before but not to the degree of being hospitalized . UM L stated R903 was seeing psychiatry, the psychiatry nurse practitioner comes weekly, and the psychiatry doctor writes R903 med orders. On 6/20/24, during an interview, UM B stated that if a resident verbalizes suicidal ideations they expect the nurse to notify a doctor and a social worker. On 6/20/24 at 1:09 PM, the Director of Nursing (DON) stated that R903's behaviors should be addressed on the care plan. The DON also stated the physician should be notified when a resident verbalizes suicidal ideations and someone should monitor the resident during that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 3:47 PM, during an interview, Social Worker E stated they see R903 two to three times per week and they were familiar with R903's history of suicide attempts and ideations. SW E also stated they had overheard R903 mention self-harm once during their stay at the facility. SW E also stated when a resident verbalizes suicidal ideations it is their expectation a staff member stay with the resident and not to leave the resident by themselves. SW E says they were not notified of R903's suicidal ideations on 6/2/24 and they would have monitored and checked in with R903 at least five times per week following the verbalization of suicidal ideations. The progress note by SW E dated 6/4/24 did not indicate knowledge of the suicidal ideations on 6/2/24. A review of the facility's policy titled Behavior Management noted the following: It is the policy of this facility to provide specialized interventions for those residents who consistently demonstrate significant behavior problems. These behaviors are determined as behaviors that are unsafe or impact others with a potential for a negative outcome. Interventions will be accomplished through referral to appropriate sources such as: the Attending Physician, Psychiatrist, Social Services Department and/or community mental health and consultation services. The goal of the behavior management program is to determine causes of particular behavior, address/reduce problematic behavior, increase well-being and enhance quality of life. Examples of behaviors focused on in the Behavior management Program: Unsafe Behavior: This can manifest as physical hitting, throwing self onto the floor or statements of self-harm. In these instances, focus must be made on potential for harm, or credibility of threats to self-harm. In addition to the above, care givers should be alert to: 1. Mental health histories. Procedures for behavior management techniques 1.Individualized care plans will be developed for residents identified with behavior problems, by way of the assessment process. This assessment includes the resident's history of behavior, lifestyle history and information obtained from the family and caregivers. 7. Staff who identify unsafe or behaviors that impact others will take immediate action. This includes alerting the nurse/social worker, providing TLC and observation and providing space to self-calm and self-correct. 12. Resident identified with behavioral disturbances will be referred to clinical and behavioral programs including the contracted psychiatric behavioral group as an additional resource to aide in pharmacological and psychiatric therapies as needed. Residents on psychotropic medications will be reviewed by the social worker and referred to the staff psychiatrist, as needed, to determine if the specific medication is effective.