STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235405	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clinton Twp	17001 17 Mile Rd Clinton Township, MI 48038

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 32220 This citation pertains to intake MI00145809. Based on interview and record review the facility failed to ensure the care plan was updated to reflect the wandering and related fall and bowel and bladder behaviors and document interventions for them. Findings include: A review of an incident report for R901 documented a fall on 06/21/24 and was found at 6:40 AM with a last seen time of 5:30 AM. R901 was sent out to the hospital with a head injury. A physical (rehab) medicine note dated 04/16/24 documented, .evaluated secondary to fall and decline in function . A review of a psychiatric note dated 05/23/24 documented, .Dementia with Behaviors .Last seen by writer 01/31/24, Patient was seen and evaluated and discussed with staff. (R901) is reported to have increased confusion and restlessness .will start risperdal .3/12/24 increased risperdal .noted to wander and can be quite intrusive with peers .per staff the increase in risperdal has not helped .requires constant redirection reported to continue to be impulsive and wanders and intrusive with peers .will initiate depakote (anti seizure medication used for manic episodes in bipolar disease) . A review of the practitioner note dated 06/17/24 documented, .baseline is wandering in particular at night . patient did not answer any questions for examiner . On 08/13/24 at 8:58 AM, a former roommate of R901 reported, R901 had attempted to eat rolled up toilet paper, would go into roommate's closet and take out stuff, walked while in the room, wandered all the time, did have falls, staff would bring resident back to room and not ten minutes later R901 was back out again, did wake up one time with R901's butt hovering over them, R901 often walked around with their pants down and often had pulled up R901's pants. The roommate was asked about incidents with other residents and reported an incident where R901 had a bowel movement all over the bed and laid in it. The roommate further noted R901 had done the same across the hall in another resident's room just before they went out to the hospital on 06/21/24. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/24 at 8:44 AM, Licensed Practical Nurse (LPN) A was asked about R901 and reported, R901 was demented, confused and wandered a lot. LPN A reported R901 was sometimes easy to redirect, often went into other resident rooms taking items and was unsteady when walking. It was also reported R901 would use a wheelchair but sometimes would just get up and walk around and most of residents were familiar, so would they would just tell the staff. On 08/13/24 at 10:03 AM, a visitor reported via the phone that R901 was not monitored well enough and was told different stories by staff and residents about the fall on 06/21/24.The visitor commented they did not feel staff were attentive to R901. On 08/13/24 at 10:58 AM, Certified Nursing Assistant (CNA) B reported R901 had been declining and wandering for months. CNA B reported R901 was a wanderer and would go into other resident's rooms and was sitting on their beds and went into their bathrooms. CNA B reported they had not witnessed this but had heard of incidents of R901 having had bowel incontinence in their own bed. CNA B reported R901 would grab people's stuff and roommates things. CNA B also noted R901 wandered the length of the hall and staff would have to run to catch R901 so they did not fall. On 08/13/24 at 11:00 AM, CNA C reported R901 was a wanderer but easily redirected. On 0/13/24 at 11:05 AM, CNA D reported they had not witnessed any falls and was not aware of any resident to resident incidents that involved R901. CNA D did report R901 was confused and they saw R901 wander into other rooms but was easily redirected. On 08/13/24 at 12:04 PM, Therapy staff F was asked about R901 and reported R901 was often in the hall without a brief on or naked during the evenings and would walk independently and had been on the rehab caseload. Staff F noted R901 would use the furnititure to walk. On 08/13/24 at 1:40 PM, CNA G reported they had worked with R901 off and on and recalled that R901 was confused and wandered but easy to redirect. On 08/13/24 at 3:25 PM, CNA H reported that around 6 AM on 06/21/24, R901 was found next to their bed, seated on the floor with their pants down. CNA reported R901 did not use their call light and that R901's reason for walking around was generally due to the need to use the bathroom. CNA H further reported R901 does roam into other rooms, and gets confused may go out the wrong door of the bathroom and may sit on another resident in their bed. CNA H commented they do try to monitor R901 but that it was kind of hard to be with R901 all the time. On 08/13/24 at 3:45 PM, Social Worker I was asked about R901 and reported they wound see R901 every day. SW I reported R901 was very confused and did have behaviors of getting into their own feces and putting it everywhere. SW I reported R901 just needed eyeballs on them. SW I reported that planning had started for transfer of R901 to a facility with a locked dementia unit but R901 had the fall and was discharged to the hospital. On 08/13/24 at 3:58 PM, the resident involved with R901's defecation on their bed reported R901 had wandered into their room before and they had to direct them back out, but on that day they were out on an appointment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/24 at 4:13 PM, the Director of Nursing (DON) was asked about R901 and reported the dementia and roaming had become worse before the incidents and reported they had started to put signs in bathroom to help redirect R901 and put their name in big letters on the door to help R901 find their room. The DON was asked about the fall and reported they think it was related to R901's underlying disease process. The DON was asked about the use of a one to one and reported it had not been considered and that planning had started to have R901 transferred to a locked dementia unit at another facility. A review of the record for R901 revealed R901 was admitted into the facility 01/27/22. Diagnoses on admission included Alzheimer's Disease, Dementia, Muscle Weakness, Difficulty Walking and Hearing Loss. Delirium (per Mayoclinic.org - a serious change in mental abilities resulting in confused thinking and a lack of awareness of ones surroundings) was added 02/09/24. A review of the Minimum Data Set (MDS) assessments revealed, the wandering was not captured on prior assessments. The 05/06/24 nor the 07/04/24 MDS assessments had wandering documented as being present. Cognition was documented as severely impaired. The 05/06/24 MDS documented partial/moderate assitance for toileting hygiene and supervison for transfers and bed mobility. The 07/04/24 MDS documented toileting hygiene, transfer and bed mobility as dependent A review of the active and resolved care plans revealed the care plan Alzheimer's, am at risk for elopement initiated 01/27/22, revised 06/19/24 had Elopement risk assessment on admission, then quarterly and PRN (as needed) as the only intervention and dated 01/27/22. The I am at risk for falls related to unsteady gait . care plan initiated 01/27/22 and revised last 03/07/24 did not documented the wandering behavior. The I use Antidepressant or Mood stabilizer related to Dementia care plan initiated 11/12/23 and last revised 03/07/24 was noted with no new interventions. The care plan did not represent the changes in mobility, wandering and intrusive behaviors identified. On 08/13/24 at 5:37 PM, a care plan and interventions for the indentified wandering and bowel/bladder concerns was requested. The bladder incontinence care plan provided did not identify the inappropriate use of other resident rooms for bowel and bladder needs. The Administrator and DON reported there was not a care plan for the identified concerns. A review of the policy titled, Care Planning implemented 11/2016, revealed, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person centered care .The comprehensive care plan is developed from the (resident assessment instrument) RAI (MDS) scheduled and is reviewed and revised by the (interdisciplinary team) IDT as necessary.