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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Clarkston		STREET ADDRESS, CITY, STATE, ZIP CODE 4800 Clintonville Rd Clarkston, MI 48346	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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** 34275 This citation pertains to Intake# MI00144079 Based on observation, interview and record review the facility failed to complete a full investigation following an allegation of resident-to-resident sexual abuse pertaining to two residents (R701 and R706) out of four residents reviewed for abuse. Findings include: A complaint was filed with the State Agency (SA) that alleged R701 was sexually abused by R706 who entered into their room on or about 4/14/24 and stuck their hand under the resident's covers and started to rub their thigh near their private/vaginal area. On 4/24/24 at approximately 8:50 AM, R701 was observed lying in bed. The resident was alert and able to answer questions asked. R701 was queried as to life in the facility, including safety and abuse, R701 noted that they did not always feel safe and had issues with other residents and staff. They stated that a male resident that resided in the room across from them had entered into their room about a week ago. They noted that it was in the later evening and the resident (hereinafter R706) came in and was in the corner in their room and was playing with his shirt. They threw a cup of water at him and started yelling to get him out. At that time a nurse came in and removed him from their room. R701 then stated that the R706 later returned to their room and pulled down their sheet and started rubbing their thigh near their private area. R701 stated they tried to stop him and started kicking them with their leg. R706 then left their room. R701 was asked if they reported this incident to staff, including the Administrator/Abuse Coordinator. R701 stated they did but reported that the Administrator never interviewed her about the incident. R701 noted that the Surveyor would be able to see when R706 entered the room on both occasions as they believed there was a camera in the outside hallway. A review of R701's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: type II diabetes, bipolar disorder and infarction of the kidney. A review of R701's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition). Continue review of R701's clinical record showed no notes, regarding the alleged incident or any follow-up with social services. On 4/24/24 at approximately 9:30 AM, an attempt was made to interview R706. The resident was alert, but could not answer questions appropriately in English. (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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	235461	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clarkston	4800 Clintonville Rd Clarkston, MI 48346

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R706's clinical record noted that the resident was admitted to the facility on [DATE] with diagnoses that included: type II diabetes and anxiety disorder. A review of R706's MDS noted the resident was severely cognitively impaired and Spanish was their predominant language. The resident's care plan identified the resident as an elopement risk (5/5/23). On 4/24/24 at 10:23 AM, the Administrator/Abuse Coordinator was asked via e-mail to provide any Incident/Accident (IA) reports pertaining to R701 and R706. Nothing was provided that pertained to R701's allegation of inappropriate sexual touching by R706. Following the request for any IA's regarding R701, Maintenance Supervisor (MS) N was asked if the camera that was located at the end of R701's hallway would provide any video that would show when and who might be entering into residents' rooms including R701. MS N attempted to obtain footage but noted the camera usually faces the exit doors and not the hallways. No hallway footage was obtained for 4/14/24. On 4/24/24 at approximately 1:28 PM, an interview was conducted with the Administrator. The Administrator was asked a second time if there were any IAs pertaining to an incident between R701 and R706. The Director of Nursing (DON) was in the room at that time. During the interview the Administrator noted that the incident had been reported via a Facility Reported Incident (FRI) to the SA and the investigation had been completed. They noted that there were no official IAs. When asked to provide any documents, including interviews, pertaining to the investigation, the Administrator asked the DON at approximately 1:32 PM to obtain the documents requested. At approximately 1:40 PM, the DON provided the following: 1. A typed, undated and unsigned document from Nurse L that read: I was standing in hallway during shift change. I heard the resident (R701) tell R706 to get out and I observed CNA (certified nursing assistant) putting resident in wheelchair from the doorway of R701's room. 2. A handwritten document, undated, and signed by Staff M that read: R706 had went in R701's room at the door she screams telling him to get out I was already walking down the hall so I was able to grab him out quickly .he was only at the door when I pulled him out . 3. A facility Assist Form noted to be completed by the DON documented, in part: Resident reports that another resident came in her room and touched her leg under her cover .staff identified and interviewed .staff report resident did not make it into the room, and he was removed from the doorway . * It should be noted that there were no documents that indicated an interview was conducted with R701. Following review of the documents noted above, a second interview was conducted with the Administrator, when asked why there was no interviews conducted with R701, they reported that there really was no need to complete an official interview with the resident as staff reported that R706 never entered into the room and R706 only got as far as the entry door. Based on interviews with staff they determined that the allegation did not occur. The Administrator also noted that R701 has been known to make up stories and is unhappy with the majority of the staff, including themselves and is frustrated as to their living situation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Abuse, Neglect and Exploitation (revised 6/23) documented in part, Policy: It is the policy of this facility to provide protections from the health, welfare and rights of each resident . Abuse: means the willful infliction of . physical harm, pain or mental anguish .it includes sexual abuse .mental abuse .Sexual Abuse is non-consensual sexual contact of any type with a resident .Investigation .an immediate investigation is warranted . Investigations may include .Identifying and interviewing all involved persons, including the alleged victim .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49272 This citation pertains to intake #MI00144079. Based on observation, interview and record review, the facility failed to develop a comprehensive care plan to address history of drug use for one (R702) of two reviewed for comprehensive care plans. Findings include: Review of a complaint filed with the State Agency alleged R702 overdosed on drugs in the facility on 3/30/2024. On 4/24/24 at 10:25 AM, R702 was observed sitting in a wheelchair in the hallway, conversing with other residents. No signs of alcohol or drug use observed. R702 was cooperative and answered questions appropriately. When queried about recent hospitalization (on 3/30/2024) R702 stated that he had pneumonia and couldn't breathe. When queried about any drug use R702 reported that he had left the facility earlier that day and had smoked weed but denied any further drug use, adding that was only possible if there was something in the weed he had smoked. On 4/24/24 at 1:04 PM the director of nursing (DON) was queried about the events that occurred prior to R702 going out to the hospital on 3/30/24. The DON stated that R702 had went out of the facility on an LOA (leave of absence) that day, returned to the facility and ambulated from the door to his room independently. A few hours later R702 became unresponsive when he had came out of the bathroom with the aide. The aide alerted the nurse at that time and the DON who was working a cart (passing medications) at that time heard the aide calling for help. When DON got to the resident, his respirations were shallow and he was very lethargic. The DON stated that knowing his history, she suspected an overdose and administered 2 doses of Narcan, another staff member called 9-1-1 and R702 was transferred to the hospital. This Surveyor clarified what the DON meant by his history, past medical history or history of drug use in the facility. The DON stated she had heard someone say that R702 had done this before (overdose). When queried about whether or not the residents care plan had been updated following this incident, the DON reviewed the current care plan in their EHR (electronic health record) and confirmed it had not been updated to more closely monitor visitors or to monitor for signs or symptoms of drug use. When asked if those things should be care planned to attempt to keep the resident safe, DON replied yes, absolutely. When queried about who is responsible for ensuring care plans are updated appropriately, the DON stated anyone in nursing can update them and reported not being sure if it had been confirmed R702 had overdosed. When asked if R702 responded to the 2 doses of Narcan she had provided she stated marginally to the first dose and the residents respiratory rate increased after the second dose. This Surveyor reported that the EHR notes a urine drug screen completed at the hospital, following the event on 3/30/24 was positive for cocaine. A review of the resident's clinical record included in part: An MDS (minimum data set) completed on 4/10/24 indicated resident had a BIMS=15 (brief interview for mental status) indicating he was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/29/24 at 8:08 PM, a Nursing Progress note written by LPN J stated: Patient went to daughters home; left 11:30 am and returned 7:15 pm. He returned in the same attire as he left, he is clean, and appears to be happy. He walked using prosthetic leg and walker and returned to facility the same way. He reports having a good time and is very tired. 3/30/24 by LPN K: Change in Condition note documented in part Abnormal vital signs, Altered mental status, shortness of breath, unresponsiveness .What is the reason for resident transfer/discharge? Suspected overdose .Blood pressure 78/53 .Pulse 103 . 4/6/24 Physician progress note: History of present illness .was seen in the hospital from (facility) due to concerns of possible overdose and shortness of breath. Patient had recently collapsed on the floor after having a visitor at his facility. He received a total of 8mg of Narcan (a medication used to reverse the effects of drugs), he had shortness of breath .UDS (urine drug screen) positive for cocaine .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00144079 and MI00144102. Based on observation, interview and record review, the facility failed to prevent an elopement of one (R704) of residents reviewed for accidents/supervision, resulting in R704 exiting the facility's front door and gone for four and a half hours without staff being aware. Findings include: Review of a complaint filed with the State Agency alleged R704 walked out of the building without staff knowing and was not found for four and a half hours. Review of a Facility Reported Incident (FRI) reported to the State Agency documented R704 exited the facility without the staff's knowledge on 4/19/24. On 4/24/24 at 9:56 AM, R704 was observed walking throughout the hallways pushing a four wheeled walker with a seat. The resident agreed to return to their room for an interview. When asked to recall the events from last Friday (4/19/24) and being outside, R704 pointed to their right arm (the wanderguard bracelet) and stated, I got branded. R704 further reported, I just walked out. There's a new store and I went up there. The resident reported they thought they were at Squirrel Rd. since there was construction all over for re-surfacing. When asked who picked them up, or how they returned to the facility, they stated, I don't know, I just don't know. When asked if they could recall any additional details, R704 stated, All I know was when I got back, I got this (pointing to wanderguard bracelet). I wanna take it off, I still might. When asked if they had anyone assisting them with their day to day needs, such as a guardian, R704 stated they didn't have a guardian but their cousins had been helping. R704's thought process fluctuated throughout the interview, and repeatedly talked about the loss of many family members. R704 became slightly agitated and questioned why they were being asked these questions, then asked if there would be any discussion with their ex-wife. Review of the clinical record revealed R704 was admitted into the facility on [DATE] with diagnoses that included: dementia with other behavioral disturbance, violent behavior, adjustment disorder with mixed disturbance of emotions and conduct, and personal history of traumatic brain injury. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated R704 had intact cognition (scored 13/15 on the Brief Interview for Mental Status Exam), and was independent with mobility with a walker. Further review of the documentation revealed R704 had been appointed legal guardianship on 8/8/23 (prior to their admission into the facility). Review of R704's elopement risk assessments revealed the resident was not identified as an elopement risk until the incident from 4/19/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 9:05 AM, an interview was conducted with the Administrator. When asked to provide the documentation for R704's elopement from 4/19/24, they reported they had completed a PNC (Past Non-Compliance) for R704's elopement and guardianship concerns. The Administrator was informed they could provide whatever documentation they had for review. (Discussion with the survey team concluded, the PNC as provided did not address all the components to address the deficient practice.) At that time, the Administrator was requested to observe the video footage if available from 4/19/24. On 4/24/24 at 10:45 AM, observation of the facility's video surveillance from 4/19/24 was conducted with the Administrator and Maintenance Director. They both reported that the time stamp on the video was not accurate and they were unable to figure out how to change the time, but that it displayed an hour behind the actual time. Video surveillance revealed: At 10:10:31 AM (actual time 11:10:31 AM), R704 was seen approaching the door from the right lobby area (near Administrator's office, and to the right of the front desk, when facing out the front door). R704 was then seen pushing on the door and after a few seconds, the door opened. At 10:11:16 AM (actual time 11:11:16 AM), R704 was seen exiting the building wearing sunglasses, a hat, flannel jacket and pants, while pushing a four wheeled walker with a seat and a cup of water that was stored on top of the seat. At 2:22:24 PM (actual time 3:22:24 PM), R704 was observed entering the facility with their walker, accompanied by three employees. On 4/24/24 at 11:08 AM, the Administrator was asked to explain the details of R704's elopement from 4/19/24 and they reported R704 got around the building and pretty much walks all day long, and is not usually in his room. They further reported they think an aide or someone asked have you seen him, where is [R704]?. Their Business Office manager came to the conference room and said we haven't seen [R704] and made an announcement and started to look in rooms, check the perimeter of facility and when the resident couldn't be found, they went and off in our vehicles to search for the resident. The Administrator reported R704 was found on [NAME] Rd. (according to google maps, approximately 0.5 miles away from the facility.) The Administrator reported the facility's bus driver and two CNAs located the resident on a sidewalk on [NAME] Rd. When asked what time they were alerted R704 was missing, the Administrator reported it was probably 3:30 PM going off of the phone call they made. When asked about whether R704 required any medication and whether they were given a lunch meal, the Administrator reported the nurse (Nurse 'E') was interviewed and she actually said that's when she realized, she pulled his medications and that's when she realized she hadn't seen him. She reported she gave the resident his noon medications early, before he left the facility, so these were his afternoon medications, like 2:00 PM medications, and it was not unusual for him to not be in the room. When asked about whether R704 ate in their room or the dining room, the Administrator reported they were not sure. When asked if anyone should have identified he didn't eat his lunch meal, the Administrator reported they should have. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked how often staff should be observing the residents visually throughout their shift, the Administrator reported every two hours, but with R704 he walks around the building and is continent. When asked if that would exclude him from being checked every two hours at minimum, the Administrator offered no response. The Administrator reported they initially though he went on an LOA (Leave of Absence) since the facility knew him to be his own person, however the facility later that evening identified R704 had a legal guardianship in place since before admission to the facility. The Administrator was asked whether there was any staff at the front reception area on 4/19/24 and they reported that since January 2024, their company had terminated all reception positions and on Friday 4/19/24 there was no one stationed at the desk. The Administrator further reported that they often tried to ensure there was someone seated there, such as the Business Office or other staff, but on that day, there was no one. When asked if there was no one seated at the front desk, how did their door alarm system function to either allow entrance or exit from the facility, the Administrator reported when there isn't anyone at the front desk, the phones are transferred over to the nursing station and they take over managing the doors. They have the ability to turn off the alarms as well from the nursing station. On 4/24/24 at 12:34 PM, an interview was conducted with CNA 'H' who was one of the two nurse aides assigned to 400 hall on 4/19/24. When asked to recall the events that occurred with R704 on 4/19/24, CNA 'H' reported they were working with Nurse 'E' and CNA 'I' who was the CNA assigned to R704. They reported the resident walks all day around the whole circle corridor and when he eats, they usually put the meal tray in his room or in front of the doorway. They reported the meal trays usually come out around 12:30 / 1:00 PM and reported someone else had delivered his lunch tray that day. They then reported that when it was time to go (end of shift), which was about 3:05/3:07 PM, they were waiting for the second shift to come on, they asked Nurse 'E' if they had seen R704 since they hadn't seen him walking for a minute. CNA 'H' reported they went down to check the bathroom, checked the circle, he wasn't there and that's when they called the search. CNA 'H' further reported they (unsure which staff) called him on the phone and asked him where he was and you could hear him say he was where construction was at. Then everyone came out and looked around and called for a search, it took about 10-15 minutes to find him. When he came back, the meal tray was still there, so the tray wasn't removed out of the room until 3:50 PM. They saw the tray still sitting there, with the lid on, and no food touched. CNA 'H' was asked if they were aware of any other incidents with R704 and they denied being aware of any other incidents. When asked if they were aware of any door alarms going off earlier, they denied and reported if the door was held for 15 seconds it flies open, and anyone can get up and set the alarm off at the nursing desk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 1:04 PM, an interview was conducted with the Maintenance Director. When asked to confirm the process of the facility's door alarm, they proceeded to test the facility's front door (same door R704 exited from). The Maintenance Director was asked if they could provide any documentation of when the alarm was silenced and reported they would follow-up (follow-up revealed they were not able to retrieve data prior to 4/23/24). When asked if the alarm was silenced as it had been on 4/19/24, what should staff have done, the Maintenance Director reported whoever silences the door alarm at the desk should follow-through with a visual of the area outside the door to make sure it wasn't from a resident. On 4/24/24 at 1:13 PM, a phone interview was conducted with CNA 'I'. When asked to recall the events with R704 from 4/19/24, CNA 'I' reported at first they weren't assigned to him, but right after breakfast they were. They reported they delivered the lunch meal and had told the nurse they didn't see him in his room. They went to collect the tray and saw he didn't touch it. When asked what time that might've been, CNA 'I' reported they picked it up between 12:30 / 1:00 PM (which conflicted with CNA 'H's interview). When asked if they had notified anyone of the untouched meal tray, they said they let Nurse 'E' know. CNA 'I' then reported they ended up doing their rounds for shift change and right around three o'clock was when they called the code. When asked when they had last seen R704, they reported they were unsure. When asked how often the residents should be checked, CNA 'I' reported that should happen every two hours. CNA 'I' then reported they hadn't seen him and told the nurse (Nurse 'E') and she said she had seen him. On 4/24/24 at 1:33 PM and 2:36 PM, Nurse 'E' was attempted to be contacted by phone and message was left to return the call. As of 4/25/24 2:00 PM, there was no return call. Review of the additional documentation provided by the facility for staff witness statements included: An undated/untimed statement from CNA 'I' read, Per [CNA 'I'] I started my day feeding [name of another resident] .and then passed breakfast trays .picked up breakfast trays. [R704] was still in the building. At lunch time I did not see him and told the nurse [Nurse 'E']. Nurse brushed me off and said okay. Later in the day [Nurse 'E'] stated she found [R704] around 12 noon. Nurse stated she found resident in the hallway. I originally was not assigned to [R704] but [staff name] switched sets and he was assigned to me. Towards shift change I was performing my final resident check and change when staff realized [R704] could not found. A code yellow was called I assisted with searching for [R704] I left the building once [R704] was returned safely. An undated/untimed statement from Nurse 'E' read, I went down the hall into his room and I didn't see him. I noticed I hadn't seen him for a while at around 2:30 + 3pm. I said 'Hey has anybody seen [R704]' I have <sic> him his Rx (Medication) @ 11 am and he was sitting at my cart for quite a while waiting for me. On 4/24/24 at 1:47 PM, the Administrator was requested to provide a facility policy for staff's response to door alarms. Review of the documentation provided revealed a maintenance weekly audit to Inspect all alarmed doors for proper operation. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00144079 and MI00144102. Based on observation, interview and record review, the facility failed to ensure that medically-related social services and follow up to address guardianship, patient advocacy, and care planning reviews for one (R704) of one residents reviewed for social services. Findings include: Review of a complaint filed with the State Agency alleged R704 walked out of the building without staff knowing and was not found for four and a half hours. Review of a Facility Reported Incident (FRI) reported to the State Agency documented R704 exited the facility without the staff's knowledge on 4/19/24. According to the facility's Social Services Manager job description dated 9/2023: .Assess and Evaluate Each Resident's Psychosocial Needs and Develop Goals for Providing the Necessary Service and Take Part in Admission Process as Needed .Incorporate the Social Service Goals in the Resident's Plan of Care and Attend Care Planning Conferences .Ensure completion of any required components of DPOA (Durable Power of Attorney) or guardianship paperwork . On 4/24/24 at 9:56 AM, R704 was observed walking throughout the hallways pushing a four wheeled walker with a seat. The resident agreed to return to their room for an interview. When asked to recall the events from last Friday (4/19/24) and being outside, R704 pointed to their right arm (the wanderguard bracelet) and stated, I got branded. R704 further reported, I just walked out. There's a new store and I went up there. The resident reported they thought they were at Squirrel Rd. since there was construction all over for re-surfacing. When asked who picked them up, or how they returned to the facility, they stated, I don't know, I just don't know. When asked if they could recall any additional details, R704 stated, All I know was when I got back, I got this (pointing to wanderguard bracelet). I wanna take it off, I still might. When asked if they had anyone assisting them with their day to day needs, such as a guardian, R704 stated they didn't have a guardian but their cousins had been helping. R704 thought process fluctuated throughout the interview, and repeatedly talked about the loss of many family members. R704 became slightly agitated and questioned why they were being asked these questions, then asked if there would be any discussion with their ex-wife. Review of the clinical record revealed R704 was admitted into the facility on [DATE] with diagnoses that included: dementia with other behavioral disturbance, violent behavior, adjustment disorder with mixed disturbance of emotions and conduct, and personal history of traumatic brain injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Clarkston		STREET ADDRESS, CITY, STATE, ZIP CODE 4800 Clintonville Rd Clarkston, MI 48346	

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated R704 had intact cognition (scored 13/15 on the Brief Interview for Mental Status Exam), and was independent with mobility with a walker. Further review of the documentation revealed R704 had been appointed legal guardianship on 8/8/23 (prior to their admission into the facility). Review of the social service assessments in the electronic medical record (EMR) revealed there was only an admission discharge planning assessment completed upon admission that did not include any information about code status, or whether the resident had a power of attorney, or legal guardian. On 4/24/24 at 9:05 AM, an interview was conducted with the Administrator. When asked to provide the documentation for R704's elopement from 4/19/24, they reported they had completed a PNC (Past Non-Compliance) for R704's elopement and guardianship concerns. The Administrator was informed they could provide whatever documentation they had for review. (Discussion with the survey team concluded, the PNC as provided did not address all the components to address the deficient practice.) On 4/24/24 at 11:45 AM, the Administrator was asked to explain the details of R704's elopement from 4/19/24. During this discussion, the Administrator reported once the resident was returned to the facility on [DATE], they initially thought of it more as an LOA (Leave of Absence) since he was considered to be his own responsible person. When asked who was responsible to ensure the appropriate documentation was in place, the Administrator reported that would be social services. When asked who the social services staff was currently, the Administrator reported they did not currently have one, but made an offer to someone who should start on 5/20/24. When asked how long they had not had a full-time social services staff, the Administrator reported the previous Social Worker resigned the end of February, but they had a Regional Corporate Social Worker that typically was at the facility about once a week, and works remotely but can come in when needed. When asked if discussion of guardianship and POA documentation was reviewed during care planning reviews that were held quarterly, should that have been discussed then, and the Administrator reported that should of happened. They then contacted the MDS Coordinator to confirm whether R704 had a care planning review. The MDS Coordinator was placed on speaker phone from the Administrator's cell phone and reported there was no documentation R704 had any care planning review since admission. The Administrator further reported following the elopement incident, once they identified the resident had a legal guardian, they would not have been considered able to go on an LOA when they wanted, and was why the resident was placed on their elopement risk. The Administrator reported they had spoken to the resident's daughter (actually a cousin) on Friday who reported they had given the guardianship paperwork to hospice, and not the facility, couldn't say who they gave it to, but the family had emailed the paperwork that evening (4/19/24). The Administrator was unable to offer any additional information as to how that was not completed or reviewed upon R704's admission into the facility on [DATE].