

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nursing and Rehab Center of Holly		STREET ADDRESS, CITY, STATE, ZIP CODE  313 Sherwood St Holly, MI 48442	

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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49083</p> <p>This citation pertains to Intake MI00142895.</p> <p>Based on interview and record review, the facility failed to permit one (R902) of one residents reviewed for discharge, to return to the facility following a transfer to the hospital.</p> <p>Findings include:</p> <p>On 6/4/24 a complaint received by the State Agency (SA) was reviewed alleging the facility refused to readmit one resident (R902) once medically cleared from the hospital.</p> <p>A clinical record review revealed R902 was admitted to the facility on [DATE] from the hospital with altered mental status, psychotic disorder with delusions, delirium, restlessness, dementia with severe agitation. A review of two Brief Interview for Mental Status (BIMS) exams calculated a score of 8/15 in January (2024) and a second BIMS of 5/15 in February (2024) indicating severe cognitive impairment for both scores.</p> <p>A review of an initial progress note from 1/18/24 documented R902 was living at home with their spouse and one night wandered out from the home and entered a neighbor's residence. Hospital records stated R902 beat up a neighbor but family denied and indicated no altercation. Family acknowledged that R902 had an episode of punching a family member in the chest and on most recent admission to the hospital, required four-point restraints. Progress notes on 1/18/24 documented .Family is no longer able to manage his care and he &lt;sic&gt; admitted here for long term care . (Facility was aware prior to admission of R902's behaviors as this was the same documentation available for review, and accepted R902 as a resident.)</p> <p>A review of R902's second admission assessment dated [DATE] documented R902 is easily distracted, has a history of wandering at previous residence, intrudes into other rooms, has excessive motor activity, has wandering behaviors and is at risk for elopement. Current medication regimen include antipsychotics, antidepressants, and hypnotics.</p> <p>An entry on 2/16/24 documented the facility's attending provider was notified that R902 was wandering into residents' rooms, was aggressive with the staff and was trying to elope from the building. Orders were received to transfer R902 to the hospital for further evaluation.</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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the documentation reported to the State Agency, on 2/16/24 at 5:30 PM, the hospital called the Nursing Home Administrator (NHA) indicating R902 was medically cleared to be discharged and showed no aggression of behaviors in the emergency department. The NHA indicated a Corporate decision was made to not readmit R902.</p> <p>On 6/4/24 at 4:00 PM, an interview was conducted with the NHA and the Director of Nursing (DON). When inquired why R902 was not permitted to return to the facility, the NHA and DON indicated on many occasions, R902 was physical with the staff causing injury, intruded into other residence rooms, and attempts to elope. When inquired why the facility admitted R902 knowing such behaviors were transparent prior to admission and the NHA stated there were changes in the admissions process at the time R902 was admitted and further acknowledged R902 was not an appropriate admission for the facility. The NHA further revealed a notice of an involuntary transfer or discharge form was initiated, however, the family never came to sign the documents. The documents provided by the NHA did not have a date, intention to transfer or discharge, nor any documentation that family was aware R902 would not be readmitted back to the facility.</p> <p>Review of the facility policy titled; 30 Day Discharge Notice dated 1/4/21 documented:</p> <p>The facility must give the resident at least a 30-day written notice before a resident is involuntarily transferred or discharged . The notice must state the intention to transfer or discharge a resident and notify the resident the right to appeal .</p> <p>On 6/4/24 at 4:19 PM, an interview was conducted the Admissions Director (Staff C). When asked what changes took place regarding the facility admission process, Staff C replied that after the holidays, in January and February 2024, the census took a dip and Corporate instructed the facility to take on anybody or anything to bump up the admissions. Staff C stated R902 was not an appropriate admission and was just abiding by what Corporate instructed.</p> <p>Review of the facility policy titled; Admissions dated 9/23 documented:</p> <p>.The Facility will maintain an admissions policy governing admission to the facility to ensure fair and impartial admission practices .A nursing facility must disclose and provide to a resident, prior to admission, notice of special characteristics (dementia) or service limitations of the facility .</p>		