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	235722	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	313 Sherwood Street 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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2583159. Based on interview and record reviews, the facility failed to protect the resident's right to be free from mistreatment by a staff member for one resident (R303) of two residents reviewed for neglect/abuse. Findings include:A review of a Incident Summary submitted by the facility to the State Agency (SA) documented in part . A Nursing Manager reported to this Administrator that an allegation of staff abuse against (R303's name). was brought to his attention at 11:30am on 7/30/2025. The allegation was made by a Certified Nurse's Aide (CNA- CNA J) who informed the nurse manager that another CNA (CNA I) held her hand over the resident's mouth because the resident was yelling. The alleged Perpetrator was suspended immediately pending a facility investigation. (Police department name) was contacted and an officer arrived at the facility to investigate the report.A review of the medical record revealed R303 was admitted to the facility on [DATE] with diagnoses that included: parkinsonism, bipolar disorder with severe psychotic features, and schizoaffective disorder.On 8/13/25 at 2:14 PM, CNA J was interviewed and asked about the incident that occurred with CNA I and R303. CNA J explained that CNA I was helping them change the brief of R303. CNA J stated they rolled (R303) towards CNA I and heard (R303) voice to be muffled. CNA J stated they looked over and observed CNA I 's hand over R303's mouth. CNA J stated they told CNA I not to do that and CNA I responded . she (R303) shouldn't be here she should be in a fu**ing psych ward. CNA J stated that CNA I said they were tired of hearing (R303) screaming. CNA J stated after the incident they went outside to take a few minutes to rethink the situation and returned and reported it to Nurse Manager (NM K). CNA J stated that CNA I was asked to leave the facility and the Administrator followed up with them regarding the incident. (Nurse Manager) NM K was on leave at the time of the survey and was not interviewed. Review of a written statement documented by NM K confirmed CNA J reported to them the incident with CNA I and R303. NM K documented they notified the Administrator after it was reported to them. A review of a written statement conducted with CNA I documented in part . (R303 name) was yelling right in our faces even when we were helping her. (CNA I) reported that she placed one finger over the resident's mouth and shussed <sic> her. R303 denied stating that R303 belonged in a psych ward. A review of the time sheet for CNA I verified their last day on site at the facility was 7/30/25 at 12:17 PM, when they were instructed to leave the facility. A review of a termination letter dated 8/6/25, revealed the alleged perpetrator (CNA I) was terminated due to the incident on 8/6/25. A review of a facility policy titled Abuse, Neglect and Exploitation dated 3/28/22, documented in part . It is the policy of. to follow facility protocol to provide protections for the health, welfare and right of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. Mistreatment means inappropriate treatment or exploitation of a resident. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of. efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Reporting of all alleged violations to the Administrator, state agency. law enforcement when applicable.

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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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2582047. Based on interviews and record reviews the facility failed to complete a thorough investigation for an elopement and failed to submit accurate details to the State Agency (SA) regarding the elopement incident for one (R302) of one resident reviewed for an elopement. Findings include: Review of an Incident Summary submitted to the SA documented in part . At approximately 9:45pm on Friday 7/25/2025, the Administrator was notified by a facility nurse that a nearby neighbor of the facility contacted her via phone and told her that a resident had approached their house and was asking for a ride. This nurse reported that she and a Certified Nurses Aide went outside the building, found the resident and returned him safely to his room. The resident was in no physical distress.Review of an Investigation Summary documented in part . Time of Occurrence: Approximately 7:35 pm. At 9:15pm, on the day of the incident (Registered Nurse - RN C) was notified by a Certified Nurses Aide (aide) (CNA), that a distressed neighbor was on the phone. (RN C) answered the phone and was informed by the neighbor that one of the facility residents was causing a disturbance outside of the facility. Accompanied by (Aide name), CNA (CNA E), (RN C) immediately went outside to evaluate the situation. Resident (initials) was found standing outside the facility door. It was reported by the neighbors that (R302's initials) had knocked on their door and asked for something to drink. Gatorade was offered but decline by. did trigger for elopement risk as a result of his leaving the premises unsupervised for a period of 2.5 hours. Conclusion: Based on interviews and record reviews. Once elopement was identified as a risk on 7/26/2025, Care Plan was updated. The resident demanded to the leave the facility the following day against medical advice and did so.A review of the medical record revealed R302 was admitted to the facility on [DATE] with a primary admitting diagnosis of alcohol dependence with withdrawal. A review of the admission Elopement Risk Assessment dated 7/17/25 at 1:50 PM, noted . Resident Is Not At Risk for Elopement. The assessment failed to identify the residents substance use disorder (alcohol). Review of a Nursing note created on 7/26/25 and back dated to 7/25/25 at 9:15 PM, documented in part . Notified by CNA to accept phone call from a distressed neighbor of the facility. This nurse informed by neighbor that a resident was causing a disturbance outside of the facility. Accompanied by a CNA, this nurse immediately went outside to evaluate the situation. found standing outside facility door. He explained that he needed to leave to attend to personal matters. Resident escorted into building by CNA. This nurse spoke with neighbors concerning the residents behaviors and disturbance created. This note was documented by RN C. RN C was not the assigned nurse for R302 at the time of the elopement incident. Review of an assignment sheet provided by the facility's Administrator revealed RN D was the assigned nurse for R302 at the time of the elopement incident. On 8/14/25 at 11:55 AM, a telephone interview was conducted with RN D. RN D was asked about being the assigned nurse to R302 when the elopement incident occurred and RN D replied . No, I was not. He (R302) got out sometime between 3:30 to 4 PM. RN D explained that was the time of the dayshift nurse shift and upon receiving report at 6 PM when they came on duty nothing was said about R302 to have been missing. RN D confirmed they had not seen R302 their shift until they were brought back to the facility. RN D read the investigation summary details regarding the resident to have been missing for a little over two hours and RN D replied .What was reported was not correct. RN D explained how the neighbors who informed the staff that R302 was at their house stated that the resident was out there for more than six hours. RN D explained they had no CNA to help with their assignment until 7 PM, when CNA E came on duty. RN D stated it was RN C and CNA E who went to get the resident on the night of 7/25/25 from the neighbor's house. On 8/14/25 at 12:47 PM, a telephone interview was conducted with RN C. When asked, RN C stated R302 was not outside the facility door, the male neighbor was outside the facility's door as they (RN C and CNA E) were leaving the facility to go to the neighbor's house to get R302. RN C explained how they (along with CNA E) went to the neighbor's house where R302 and a female neighbor were observed yelling at each other. RN C stated initially R302 refused to go back to the facility, however after talking to the resident R302 agreed to go back. RN C stated several neighbors had informed them that R302 was observed outside of the facility since 4 PM. RN C stated the resident also confirmed they had been out of the facility since 4 PM. RN C stated R302 was starving so CNA E went to McDonalds to get them some food, which helped to calm the resident down. RN C stated R302 verbalized that he wanted to get cocktails and still be able to work while admitted to the facility. RN C was asked about the discrepancies regarding their documented note and what was submitted to the SA and RN

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure all admission orders were reported and reconciled with the Physician for one (R302) of one resident reviewed for an elopement. Findings include: A review of the medical record revealed R302 was admitted to the facility on [DATE] with a primary admitting diagnosis of alcohol dependence with withdrawal and was documented to have intact cognition. A review of R302's hospital discharge medications revealed the following:Lorazepam tablet sliding scale. If CIWA-Ar (Clinical Institute Withdrawal Assessment for Alcohol) is 0-7: No Benzodiazepine dose indicated. 1 mg (milligram) if CIWA-AR Mild - MOD 8 -15. 2 mg if CIWA - AR Mild - MOD 16-67. Greater than 35, Notify Provider. PO (by mouth), every 2 hours PRN (as needed) for Per CIWA Scale. If CIWA-Ar is 0-7: No Benzodiazepine dose indicated. If CIWA-Ar is 8-15, give 1mg then reassess 2hrs after dose given. If CIWA-Ar >15, give 2mg then reassess 1 hr after dose given (Maximum dose 12mg/day). If score > 35 give dose indicated and notify provider; IV (intravenous) if unable to take PO. A review of the medical record and Physician orders revealed the as needed CIWA protocol was not reconciled or implemented like the rest of the medications documented on the hospital discharge medication report. On 8/14/25 at approximately 9:10 AM, the Director of Nursing (DON) was interviewed and asked why the CIWA alcohol withdrawal protocol was not implemented like the rest of the medications on the hospital discharge document. The DON stated they would look into it and follow back up. At 10:44 AM, the DON returned with Physician F (the assigned Physician to R302). Physician F was asked if they were informed of the as needed CIWA protocol that was on the discharge medication list from the hospital and Physician F stated they were not informed. The DON stated they were also unaware of the hospital discharge medication list that noted the CIWA protocol. The DON and Physician F stated they would start education with their staff. No further explanation or documentation was provided by the end of the survey.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2570372.Based on interview and record reviews the facility failed to accurately identify a pressure wound, accurately documented the worsening and correct staging of a coccyx wound for one (R301) of one resident reviewed for pressure wounds. Findings include:Based on interview and record reviews the facility failed to accurately identify a pressure wound, accurately documented the worsening and correct staging of a coccyx wound for one (R301) of one resident reviewed for pressure wounds. Findings include:A review of a complaint submitted to the State Agency (SA) documented concerns regarding the accurate assessment and description of the resident's pressure wound. A review of the medical record revealed R301 was admitted to the facility on [DATE] with a primary diagnosis of dementia and required staff assistance with all Activities of Daily Living (ADLs). A Nursing note dated 6/25/25 at 3:55 PM, documented in part . This writer was informed by resident's aide that resident had an opening located on the coccyx (L). This writer went to assess resident and see in fact there an <sic> opening on her coccyx. This writer. wound care nurse. Wound care nurse came to assess. DX (diagnosis):MASD (moisture associated skin damage). This writer was cleanse <sic> Coccyx w (with)/N.S. (normal saline) Pat dry. Apply Medihoney to wound bed. Cover with ABD (abdominal) and tape closed. This will be the treatment in place for the MASD. This note was documented by Licensed Practical Nurse (LPN) A.A review of the wound consultation reports completed by the facility's third party wound clinic revealed the following: A wound consult dated 7/2/25, documented in part . Wound #1 Coccyx is an acute Partial Thickness MASD and has received a status of Not Heal. Initial wound encounter measurements are 2.5cm (centimeters) length x 1.3 cm width x 0. 1 cm depth, with an area of 3.25 sq (square) cm and a volume of 0.325 cubic cm. Wound bed has 100%, pink, granulation. Irritant contact dermatitis due to friction or contact with body fluids.A wound consult dated 7/9/25, documented in part . This patient seen today for a follow-up visit for the management of the patient's wound. Wound #1 coccyx is an acute Partial thickness MASD and has received a status of Not Healed. Subsequent wound encounter measurements are 2.3cm length x 1.5cm width with no measurable depth, with an area of 3.45 sq. cm. There is scant amount of sero-sanguineous drainage noted. The wound margin is well defined Wound bed has no granulation, 100% slough (non-viable yellow, tan, gray, green or brown tissue. Maybe adherent to the base of the wound or present in clumps throughout the wound bed).A wound consult dated 7/16/25, documented in part . Coccyx is an acute Partial Thickness MASD and has received a status of Not Healed. Subsequent wound encounter measurements are 2.5cm length x 2.3 cm width with no measurable depth, with an area of 5.75 sq cm. There is scant amount of sero-sanguineous drainage noted which has no odor. The wound margin is well defined Wound bed has no, granulation. 100% slough.A stage 2 pressure ulcer is identified as a partial-thickness loss of skin with exposed dermis. A progress note dated 7/17/25 at 9:04 AM, documented . Pt (patient) was taken to hospital by granddaughter on 7/16/25.A review of the hospital documentation (7/16/25) to revealed the following in part . presenting from her living facility. per request of granddaughter who is patient's guardian for change in patient's mentation as well as a suppose it new bedsore that was 'extremely dirty and contaminated.' . Stage 3 pressure ulcer of coccyx (Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough maybe visible but does not obscure the depth of tissue loss). Tissue trauma consult. Present on admission.On 8/13/25 at 1:17 PM, LPN A was interviewed and asked to review their note documented on 6/25/25. LPN A stated they remembered the observation. LPN A was asked to describe the wound. LPN A confirmed the wound to be circular and stated the . hole was not bigger than a nickel. LPN A confirmed the loss of the top layer of the skin for the wound. The facility wound nurse was not present for the duration of the survey and was not interviewed. On 8/13/25 at 1:41 PM, the Director of Nursing (DON) was interviewed and questioned about the accuracy of the wound assessments for R301 on 7/2/25, 7/9/25 and 7/16/25. The review of the hospital diagnosis of the wound on the same day the resident was last assessed in the facility on 7/16/25, was reviewed. The DON stated they would look into it and follow back up. On 8/13/25 at 3:34 PM, the DON returned with the Wound Physician (WP) B on the phone for an interview. The connection of the call was bad and the interview was not conducted at that time. On 8/14/25 at 3:14 PM, a telephone interview was conducted with WP B the concern of the accuracy of the staging of the wound compared to the documented assessment of the wound was discussed. WP B acknowledged the wound initially started as MASD. WP B stated they could have changed

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2582047. Based on interviews and record reviews the facility failed to identify a substance use disorder (sud) -alcohol, and failed to implement a care plan/interventions for the sud, for one (R302) of one resident reviewed for elopements, resulting in R302 having left the facility without the knowledge of staff. Findings include: A review of the medical record revealed R302 was admitted to the facility on [DATE] with a primary admitting diagnosis of alcohol dependence with withdrawal and was documented to have intact cognition. Further review of the medical record revealed no plan of care or implemented care plan for R302's primary diagnosis of alcohol dependence or withdrawal. A review of the medical record revealed no interventions implemented to ensure the safety of the resident. On 7/25/25 R302 was reported to the State Agency (SA) to have eloped from the facility. On 8/14/25 at 11:55 AM, a telephone interview was conducted with RN D. RN D was asked about being the assigned nurse to R302 when the elopement incident occurred (on 7/25/25) and RN D replied . No, I was not. He (R302) got out sometime between 3:30 to 4 PM. RN D explained that was the time of the dayshift nurse shift and upon receiving report at 6 PM when they came on duty nothing was said about R302 to have been missing. RN D confirmed they had not seen R302 on their shift until they were brought back to the facility by RN C and CNA E.A telephone interview was conducted with Registered Nurse (RN) C on 8/14/25 at 12:47 PM. RN C was asked to recall the elopement incident with R302. RN C stated they received a phone call from a female neighbor of the facility stating a man had been outside of their house since 4 PM. RN C explained how they (along with Certified Nursing Assistant- CNA E) went to the neighbor's house where R302 and a female neighbor were observed yelling at each other. RN C stated initially R302 refused to go back to the facility, however after talking to the resident R302 agreed to go back. RN C stated several neighbors had informed them that R302 was observed outside of the facility since 4 PM. RN C stated the resident also confirmed they had been out of the facility since 4 PM. RN C stated R302 was starving so CNA E went to McDonalds to get them some food, which helped to calm the resident down. RN C stated R302 verbalized that he wanted to get cocktails and still be able to work while admitted to the facility. On 8/14/25 at 1:20 PM, a telephone interview was conducted with CNA E. When asked, CNA E confirmed they arrived to start their shift at 7 PM on 7/25/25. CNA E stated there was no CNA to give them report and the nurse was administering the resident's medications. CNA E explained several incidents that had occurred which caused it to be a busy shift with multiple residents to have required their attention. CNA E stated they did check in R302's room and saw that their dinner tray was untouched. CNA E stated they figured R302 was out on a LOA (leave of absence). CNA E explained it was after 9 PM and they were on their way to the kitchen to make waters and saw a man at the door. CNA E stated the man outside of the facility door informed them that a resident was sitting out in front of their house and had been since 4 PM. CNA E explained at that time RN C had approached the front door of the facility and explained how they received a call from a female neighbor who informed them that R302 was outside of their house. CNA E explained that they along with RN C went to the neighbor's house. CNA E stated R302 was agitated because . him and the neighbor was going back and forth. CNA E stated the neighbors reported that (R302) had asked for beer, an alcoholic drink or a ride. CNA E confirmed that they along with RN C was able to calm the resident down and get R302 back into the facility. On 8/14/25 at 2:42 PM, a telephone interview was conducted with R302. When asked, R302 confirmed they had left the facility by following another person out. R302 also confirmed the dinner tray had not been delivered to them before they left the facility. R302 admitted to having a . rough couple of weeks. and stated . I was not in a good space when I was there.R302 also confirmed that staff came to the neighbor's house and talked them into going back to the facility. On 8/14/25 at 2:05 PM, the Administrator was asked to provide the name of the CNA that was assigned to R302 from 3PM (when the dayshift CNA went off duty) to 7 PM (when CNA E came on duty). The Administrator did not provide a response. It was identified that the staff were unaware of the resident's departure and/or whereabouts from approximately 4 PM until approximately 9:15 PM (the approximate time RN C received the phone call from the reporting neighbor), more than five hours. The facility failed to develop and implement a substance use disorder plan of care and/or care plan for R302's alcohol dependence, resulting in the R302 to have eloped from the facility undetected for several hours in attempts to satisfy their addiction to alcohol. A review of the facility policy titled Behavioral Health Services dated 6/1/23, documented in part . Substance use disorder (SUD) is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2570372.Based on interview and record reviews the facility staff failed to follow the recommendation of the psych nurse practitioner (NP) and failed to identify a change of condition (urinary tract infection - uti) as the cause of a mental status/behavioral changes for one (R301) of two residents' reviewed for neglect/abuse. Findings include:A review of the medical record revealed R301 was admitted to the facility on [DATE] with a primary diagnosis of dementia and required staff assistance with all Activities of Daily Living (ADLs). A Social Service Progress Note dated 6/26/25 at 8:03 AM, recapped the recommendations from a psych consultation which documented the following . Seen 6/25/25 by (psych clinician name), NP (nurse practitioner) with psych services. Consult states the following. Patient presents with increased anxiety, agitation, and aggression. Emphasis should be placed on ruling out underlying medical or environmental contributors. Patient has a known and established history of significant agitation in the presence of acute etiologies, particularly UTIs. If behavioral changes continue to persist, would advise consideration to repeat urine analysis.A Nursing progress note dated 7/16/25 at 4:31 PM, documented in part . This writer contacted the guardian because the patient was having a behavior with another resident. The resident was heard and seen calling the resident a whore hopper and a Bitch, The granddaughter asked to speak with her. The resident did speak with her. The writer was asked to take the phone and speak with (guardian name). she told me she was having a NP (nurse practitioner) look over the resident medications. And she will be here later to see (R301's name).A Nursing progress note dated 7/16/25 at 5:28 PM, documented in part . the resident has been sitting at the nurse station for the past hour. She has been singing and to <sic> talking with this writer and other staff. The resident mood back at baseline with no memory of the previous behavior.A review of the medical record revealed a repeat urinalysis was not considered, ordered or obtained, as the recommended documentation by the psych NP on 6/26/25. A discharge emergent note dated 7/16/25 at 11:08 PM, documented the family of R301 called emergency medical services to transport R301 to the hospital regarding medical concerns with the resident. A review of the hospital documents revealed the following: . presenting from her living facility. per request of granddaughter who is patient's guardian for change in patient's mentation. Family is concerned that patient has a urinary tract infection due to her change from [NAME] <sic> (alert and oriented) to self and place to [NAME] to self. Patient was combative on July 16, 2025. Mentation was worsening from her baseline. Further review of the hospital documents revealed the identification of . Sepsis due to Enterobacter species (type of bacteria). Enterobacter cloacae complex bacteremia (presence of bacteria in the bloodstream) secondary to a urinary tract infection. On IV (intravenous) cefepime (antibiotic) and plan a 14-day course of therapy. Urinary tract infection. ID (infectious disease) on case. present on admission.The facility staff failed in following the recommendation of the psych nurse practitioner and failed to identify R301's urinary tract infection. On 8/13/25 at 1:41 PM, the Director of Nursing (DON) was asked about the mental and behavioral changes documented for R301 and why follow-up testing to rule out a UTI was not completed as recommended by the psych NP. The DON stated they were unaware of the psych NP recommendation and would look into it and follow back up. On 8/14/25 at 9:05 AM, the DON returned and stated they had missed the repeat urinalysis recommendation. No further explanation or documentation was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	313 Sherwood Street 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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2570372.Based on interview and record reviews the facility failed to identify, follow up and follow the facility policy on weight loss for one (R301) of one resident reviewed for weight loss. Findings include: A review of the medical record revealed R301 was admitted to the facility on [DATE] with a primary diagnosis of dementia and required staff assistance with all Activities of Daily Living (ADLs). A review of the resident Weight Summary documented the following: 7/3/25 at 1:25 PM- 134.4 lbs (pounds)6/5/25 at 3:04 PM- 150.8 lbs This indicates a -10.88 loss in less than a month. There was no recorded re-weight to confirm the weight loss documented. A record review of the Electronic Medical Record (EMR) and Nutrition assessments/notes were all reviewed, and none identified the clarification of the 7/3/25 recorded weight, notification to the dietician/physician, monitoring, interventions or modifications to the resident's nutrition plan of care. A review of the facility policy titled Weight Monitoring revised 01/21 documented in part .Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight to determine if a re-weight is necessary.On 8/13/25 at 1:41 PM, the Director of Nursing (DON) was interviewed and asked about the recorded weight loss on 7/3/25 and the lack of follow up. The DON replied the staff should have notified them, and a re-weight should have been obtained. The DON confirmed they were not notified of the recorded weight loss. The DON stated they would look into it further and follow back up. On 8/14/25 at 9:05 AM, the DON returned and stated the therapy staff obtained both weights in June and July 2025, however failed to inform them of the recorded weight loss. The DON stated education will be conducted with the therapy staff. No further explanation or documentation was provided by the end of the survey.