| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 414360 | A. BUILDING _____ B. WING _____ | 3/5/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MISSION POINT NSG & PHY REHAB CTR OF CEDAR SPRINGS | 400 JEFFREY CEDAR SPRINGS, MI 49319 |

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| F0000 SS= | INITIAL COMMENTS<br><br>Mission Point Nursing & Physical Rehabilitation Center of Cedar Springs was surveyed for an Abbreviated survey on 3/5/25.<br><br>Intakes: MI00150276, MI00150233<br><br>Census= 70 | F0000 | | |
| F0580 SS= D | Notify of Changes (Injury/Decline/Room, etc.)<br>§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or | F0580 | Element 1: Resident #102 resides in the facility and has a FM / DPOA who was notified of resident's condition on 3/17/2025<br><br>Element 2: All residents reviewed in Clinical stand-up meeting on 3/19/25 to identify any change of condition in real time. DPOA notified of any changes identified.<br><br>Element 3: All Nursing staff will be re-educated by the Staff Development Coordinator on the Change in Condition policy by 3/24/2025. Any staff member that has not been re-educated by 3/24/2025 will be removed from the schedule until re-education is completed.<br><br>Element 4: DON / designee will review the clinical dashboard daily, Monday-Friday to identify changes of condition and ensure notifications are completed appropriately. The Director of Nursing is responsible for achieving and maintaining compliance. | 3/24/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/19/2025 |

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.

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| | regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to intake number MI00150233.<br><br>Based on interview and record review, the facility failed to notify a responsible party of a change in care/condition for 1 of 3 residents (Resident #102) reviewed for notification of change, resulting in the responsible party not participating in medical decisions regarding care and treatment.<br><br>Findings include:<br><br>Review of a "Change of Condition" policy with a reference date of 7/24 revealed: "Policy: It is the policy of this facility to inform residents/legal representative, attending physician or designee of a change in a resident's condition. 2. The facility will inform the ...resident representative (s) when there is- ...b. a deterioration in health ...".<br><br>Review of an "Admission Record" revealed Resident #102 was originally admitted to the facility on 1/17/23 with pertinent diagnoses which included: huntington's disease (an inherited disorder that causes nerve cells in parts of the | | | |

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| | brain to gradually break down and die), dementia (disease that causes a progress decline in cognitive skills) and adult failure to thrive (syndrome in older adults characterized by a decline in physical or mental functioning).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #102 with a reference date of 2/4/25, revealed a "Brief Interview for Mental Status" (BIMS) could not be conducted. Section "C" revealed the resident had short- and long-term memory problems.<br><br>Review of a "Weekly Skin Sweep" with a reference date of 3/2/25 revealed Resident #102 was found to have an open area on right ankle.<br><br>Review of diagnoses list for Resident #102 revealed the resident was diagnosed with "localized edema" on 1/10/25.<br><br>In an interview on 3/4/25, at 9:05am, Family Member/Durable Power of Attorney (FM/DPOA) "P" reported the facility had not called to inform her of any change in the resident's condition since her admission. FM/DPOA "P" denied having any knowledge of recent diagnoses including localized edema or an open area on Resident #102's right ankle. FM/DPOA "P" reported she only was made aware of Resident #102's new health issues (other than quarterly care conferences) when she asked the resident's nurse while at the facility. FM/DPOA "P" reported she frustrated by the lack of communication.<br><br>In an interview on 3/5/25 at 2:37pm, Director of Nursing (DON) "B" reported a resident's DPOA should be informed by the floor nurse or by the provider when there is an acute change in their health. | | | |
| | Free from Abuse and Neglect §483.12 | F0600 | Element 1: Resident 106 remains in the | 3/24/2025 |

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| F0600<br>SS= G | Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to intake MI00150276<br><br>Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from resident-to-resident mental and psychosocial abuse for 1 (Resident #106) of 4 residents reviewed for abuse, resulting in Resident #106 experiencing mental anguish, intimidation, and fear.<br><br>Findings include:<br><br>Review of "Signs and Symptoms of Mental Abuse", Sanjana Gupta, 5/8/23, www.verywellmind.com revealed "Mental abuse, also known as psychological or emotional abuse, involves deliberately ... causing ...emotional pain, or trying to control or manipulate them through verbal or non-verbal communication. These are some of the different types of mental abuse ...Intimidation ...Harassment ...Controlling behaviors ...Verbal displays of anger, such as yelling ...Mental abuse ...can cause deep emotional wounds that take time to heal". | | facility. Resident's care plan was reviewed and updated as needed, well-being visits completed with resident and reflected no lasting negative outcomes from the incident. Resident 105 no longer resides in the facility. Resident 107 no longer resides in the facility.<br><br>Element 2: All residents have the potential to be affected by this practice. Alert and Oriented residents with BIMS eight (8) and above were interviewed by Guardian Angels to ensure no unreported allegations of abuse exist. Residents with a BIMS score of less than eight (8) had a skin assessment completed, no other concerns identified.<br><br>Element 3: The RDO re-educated the NHA on the abuse policy on 3/17/25. The NHA reviewed the abuse policy on 3/17/25 and deemed it appropriate. All staff will be re-educated by the SDC/Designee on the abuse policy by 3/24/2025. Any staff member not re-educated by 3/24/2025 will be removed from the schedule until re-education is complete.<br><br>Element 4: The NHA / designee will audit/interview five (5) staff members regarding abuse/neglect knowledge and reporting guidelines per week for four (4) weeks and then monthly for three (3) months. All findings will be reported to the QAPI committee monthly. The NHA is responsible for achieving and sustaining compliance. | |

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| | Resident #106<br><br>Review of an "Admission Record" revealed Resident #106 was originally admitted to the facility on 10/5/24 with pertinent diagnoses which included: weakness and nontraumatic intracerebral hemorrhage (rupture of blood vessels causing bleeding in the brain).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #106 with a reference date of 1/7/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #106 was cognitively intact.<br><br>In an interview on 3/3/25 at 11:53am, Registered Nurse (RN) "F" reported she saw Resident #105 watching Resident #106 when Resident #106 was seated in the doorway of her room. RN "F" reported Resident #105 regularly sat in the doorway of the "café" in recent months and watched Resident #106 through the windows of the double doors that separated the 2 hallways. RN "F" described Resident #105's behavior as "stalking" other residents, including Resident #106.<br><br>In an interview on 3/3/25 at 3:09pm, Resident #106 reported she noticed Resident #105 staring at her many times in recent months and as a result, she no longer sat in her doorway or in the hallway. Resident #106 stated "most of the time I just stay in my room because I feel like I can't go in the hallway because he'll watch me." Resident #106 reported she felt uncomfortable because of Resident #105 behavior of watching her but has become more fearful of him. Resident #106 reported she was walking down the hall with a therapist approximately 1 week earlier when Resident #105 moved toward her abruptly and began repeatedly saying in an aggressive, loud tone of voice, "Can I be with you?! Do I need to | | | |

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| | give you space?! Can I talk to you?!". Resident #106 reported Resident #105 was "in her face" and would not stop asking her those questions despite staff directing him to stop. Resident #106 reported the confrontational and aggressive behavior of Resident #105 made her think he was going to hit her, and she instinctively drew her forearms up by her face. Resident #106 reported staff attempted to redirect Resident #105 but he would not stop. Resident #106 reported when verbal redirection did not stop Resident #105, Licensed Practical Nurse (LPN) "H" placed herself between her and Resident #105 which seemed to get his attention, and he began wheeling his wheelchair toward his room. However, a few minutes later while Resident #106 continued therapy, now in the therapy gym, Resident #105 approached her aggressively for a second time, and asked the same questions in a "growly voice while glaring at her". Resident #106 reported after the incident, she feels more fearful and worried Resident #105 might come into her room at night. Resident #106 reported she continues to feel harassed by Resident #105.<br><br>During an observation from the south hall, on 3/3/25 at 3:17pm, it was noted that Resident #106's doorway could be seen through the windows of the double doors that separated the east hall (where Resident #106 resided) and the south hall (where Resident #105 resided). During the same observation, it was noted that Resident#106's doorway could be seen from the doorway of the café on the south hall.<br><br>In an interview on 3/4/25 at 10:25am, Certified Nursing Assistant (CNA) "G" reported Resident #105 frequently appeared to "stare hard" at Resident #106 and tried to go through the double doors toward her room at times. CNA "G" described Resident #105's behaviors as "targeting" toward Resident #106. CNA "G" reported seeing Resident #105 waiting in the café | | | |

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| | and watching Resident #106 when she came down the hall for therapy. When further queried, CNA "G" reported he worried about the safety of certain residents, including Resident #106, because the facility did not provide enough supervision for Resident #105, who had demonstrated sexually abusive behavior toward a resident in the past.<br><br>In an interview on 3/4/25 at 10:43am, LPN "H" reported she intervened during both incidents in which Resident #105 approached Resident #106 in an aggressive manner. LPN "H" reported she immediately directed Resident #105 to leave the area because he was "in her face" (Resident #106) and Resident #106 appeared scared. LPN "H" reported Resident #105 continued to direct aggressive comments to Resident #106 until LPN "H" physically intervened and moved his wheelchair. LPN "H" reported Resident #105 had been "preoccupied" with Resident #106 and directing his attention to her for several weeks. LPN "H" reported she did not feel the facility had provided enough supervision to Resident #105 given his behaviors. LPN "H" reported although she did not report the incident immediately, she felt it constituted abuse and when she told Nursing Home Administrator (NHA) "A" about the incident the following morning, and offered to write a late entry behavioral note summarizing the incident, NHA "A" told her not to do so because the note might have a negative impact on admission referrals the facility had made to other facilities for Resident #105.<br><br>In an interview on 3/4/25 at 2:53pm, Unit Manager (UM) "E" reported the facility's policy regarding accusations of abuse was that the NHA would be immediately notified, and an investigation would begin to determine if the accusation should be reported to the state agency. UM "E" reported she was told to "err on the side of caution" if there was any concern of potential | | | |

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| | abuse and report it immediately. When further queried about types of abuse, UM "E" stated "a lot of things can fall under abuse, any violation of the resident's right to be respected, to be care for, to have their property, to be treated like a human". UM "E" confirmed that if one resident's actions directed toward another caused the resident to be fearful, it could be considered abuse.<br><br>In an interview on 3/4/25 at 3:14pm, NHA "A" reported he did not conduct an abuse investigation after the incident between Resident #105 and Resident #106 on 2/26/25. NHA "A" reported he felt some staff were overly "reactive" to Resident #105's behaviors and were more upset about the incident than Resident #106 was. When further queried about what action he would have taken if he had completed an investigation and Resident #106 had told him she was fearful, NHA "A" stated "I would have talked to Resident #105". NHA "A" stated regarding Resident #106's behaviors, "I don't think he's going to do anything". NHA "A" confirmed Resident #105 had sexually abused another resident of the facility within the last six months.<br><br>In an interview on 3/5/25 at 12:14pm, Physical Therapy Assistant "PTA" "L" reported on 2/26/25, during a therapy session with Resident #106, Resident #105 approached them in the hallway and began speaking to Resident #106 in a verbally aggressive manner and began repeating "Do I need to give you your space?!" PTA "L" reported staff intervened and after several attempts were able to redirect Resident #105 to his room. PTA "L" confirmed that approximately 10 minutes later, while Resident #106's therapy continued, now in the therapy gym, Resident #105 again approached Resident #106 aggressively and this time had to be physically removed from the area. PTA "L" reported she felt she had to act when Resident #105 was "in her | | | |

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| | face" (Resident #106). PTA "L" reported Resident #106 was physically shaking after the incident and reported she felt scared. Resident #106 voiced to PTA "L" that she was worried Resident#105 was going to attempt to touch her inappropriately in the future. PTA "L" reported she told her immediate supervisor about the incident.<br><br>In an interview on 3/5/25 at 1:32pm, Resident #106 she was concerned she might be viewed as a "troublemaker", so she was hesitant to talk about the incident involving Resident #105. Resident #106 became tearful and stated, "sometimes I'm losing sleep over worrying about him getting into my room at night". Resident #106 reported she was worried Resident #105 might try to touch her inappropriately and she might not have the physical strength to fight him off. Resident #106 reported she had been harassed by men several times throughout her life and this situation felt the same way. Resident #106 balled up her fist and stated, "I'm trying to get stronger in therapy, but I'm still weak".<br><br>In an interview on 3/5/25 at 11:47am, CNA "I" reported Resident #105 was supposed to be supervised if he left the south hall, but she has found him in the east hall unattended. CNA "I" reported Resident #105's attention was "fixated" on females and often could not be redirected. CNA "I" reported Resident #105 became confrontational when his thoughts were fixated.<br><br>In an interview on 3/5/25 at 12:14pm, Rehab Director (RD) "M" reported she was informed of the incident that happened between Resident #106 and Resident #105 on 2/26/25 and saw Resident #106 while she was still in the therapy gym that day. RD "M" reported Resident #106 voiced that she did not trust Resident #105 and concerned he that he had ill intent toward her. RD "M" reported | | | |

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| | the Interdisciplinary Team (IDT) was aware of the incident and discussed additional interventions to supervise Resident #105, but none had been implemented.<br><br>In an interview on 3/5/25 at 2:37pm, Director of Nursing (DON) "B" reported the IDT discussed the incident that occurred on 2/26/25 between Resident #106 and Resident #105 as well as staff concerns that Resident #105 appears preoccupied with Resident #106. IDT determined it was necessary to place an alarm on the double doors of the south hallway that would sound only when Resident #105 exited. IDT planned to provide additional supervision for Resident #105 by alerting staff when he left the area. However, at the time of this interview, the door alarm had not been installed.<br><br>Resident #105<br><br>Review of an "Admission Record" revealed Resident #105 was originally admitted to the facility on 4/15/24 with pertinent diagnoses which included: depression and anxiety.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #105 with a reference date of 1/14/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #105 was cognitively intact. Further review of the MDS revealed Resident #105 exhibited verbal behaviors e.g. threatening others, screaming at others, cursing at others and received an antipsychotic medication.<br><br>Review of a "Care Plan" for Resident # 105 with a reference date of 9/27/24, revealed a focuses/goals/interventions of: "Focus: I have a history of physical touching myself and others inappropriately. Goal: I will not have behaviors that cause harm to myself or others | | | |

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| | ...Interventions: 2 staff with personal care ...motion sensor doorbell in my room ...encourage me to stay on my unit ...I may make sexual statements or ask ...other residents to join me in sexual acts ...".<br><br>Review of a "Behavioral Health Provider Note" for Resident #105 with a reference date of 10/10/24 revealed "Since the last visit the resident had episodes of sexual behaviors ...masturbating, verbal behaviors and auditory hallucinations ...nursing notes report on 9/12 was reported to this nurse that this resident exposed himself and started to masturbate in front of minor staff ...9/15 ...talking about paying people for sex ...physician note 10/8 he has auditory hallucinations and delusional thinking. He is talking to himself or an imaginary person frequently ...behavior log review for past 30 days ...episodes of sexually inappropriate behaviors x12 ...Assessment and plan ...4. Add dx (diagnosis) paraphilia (intense or recurring sexual arousal from atypical situations, objects, fantasies, behaviors, individuals or places)".<br><br>Review of a "Behavioral Health Provider Note" for Resident #105 with a reference date of 1/23/25, revealed "Nursing notes: 1/03 while using his wheelchair for ambulation he would look into (sic) all the female rooms ...1/4/25 resident roaming the hallway, stalking family members and watching younger children closely ...lurking in hallway. going in and out of the small dining room looking towards East hall (Resident #106's room) for about 2 minutes, several times for about 2 hours".<br><br>Review of a "Behavior Log" for Resident #105 with a reference date of 2/3-3/4/25 revealed Resident #105 was observed wandering 6 times during that time frame. | | | |

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| | 414360 | A. BUILDING _____ B. WING _____ | 3/5/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MISSION POINT NSG & PHY REHAB CTR OF CEDAR SPRINGS | 400 JEFFREY CEDAR SPRINGS, MI 49319 |

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| | Review of an "Abuse, Neglect and Exploitation" policy with a reference date of 10/24 revealed "Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident ...Definitions: "Abuse" means the willful infection of ...intimidation ...mental anguish ... which can include resident to resident altercations ...mental abuse includes ...harassment ... Prevention The facility will implement policies and procedures to prevent and prohibit all types of abuse ...and that achieves: ...care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict ...". | | | |
| F0607<br>SS= D | Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.<br>This REQUIREMENT is not met as evidenced by: | F0607 | Element 1: Resident 106 remains in the facility. Resident's care plan was reviewed and updated as needed, well-being visits completed with resident and reflected no lasting negative outcomes from the incident. Resident 105 no longer resides in the facility. Resident 107 no longer resides in the facility.<br><br>Element 2: All residents have the potential to be affected by this practice. Alert and Oriented residents with BIMS eight (8) and above were interviewed by Guardian Angels to ensure no unreported allegations of abuse exist. Residents with a BIMS score of less than eight (8) had a skin assessment completed, no other concerns identified.<br><br>Element 3: The RDO re-educated the NHA on the abuse policy on 3/17/25. The NHA reviewed the abuse policy on 3/17/25 and deemed it appropriate. All staff will be re-educated by the SDC/Designee on the abuse policy by 3/24/2025. Any staff member not re-educated by 3/24/2025 will be removed from the schedule until re-education is complete.<br><br>Element 4: The NHA / designee will | 3/24/2025 |

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| | This citation pertains to intake #MI00150276<br><br>Based on interview and record review, the facility failed to operationalize its abuse policy and procedure for 3 residents (Resident #105, Resident #106 and Resident#107) of 3 residents reviewed for resident-to-resident abuse, resulting in 1.staff not reporting resident to resident observations of abuse to the Nursing Home Administrator immediately, 2. the facility not initiating a thorough investigation 3. the facility not reporting allegations of abuse to the state agency,and the potential for further resident to resident observations of abuse to go unreported and uninvestigated.<br><br>Findings include:<br><br>Resident #105<br><br>Review of an "Admission Record" revealed Resident #105 was originally admitted to the facility on 4/15/24 with pertinent diagnoses which included: depression, paraphilia (intense or recurring sexual arousal from atypical situations, objects, fantasies, behaviors, individuals or places), unspecified dementia with psychotic disturbance (loss of contact with reality), and anxiety.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #105 with a reference date of 1/14/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #105 was cognitively intact. Further review of the MDS revealed Resident #105 exhibited verbal behaviors e.g. threatening others, screaming at others, cursing at others and received an antipsychotic medication.<br><br>Review of a "Care Plan" for Resident # 105 with a reference date of 9/27/24, revealed a | | audit/interview five (5) staff members regarding abuse/neglect knowledge and reporting guidelines per week for four (4) weeks and then monthly for three (3) months. All findings will be reported to the QAPI committee monthly. The NHA is responsible for achieving and sustaining compliance. | |

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| | focuses/goals/interventions of: "Focus: I have a history of physical touching myself and others inappropriately. Goal: I will not have behaviors that cause harm to myself or others ...Interventions: 2 staff with personal care ...motion sensor doorbell in my room ...encourage me to stay on my unit ...I may make sexual statements or ask ...other residents to join me in sexual acts ...".<br><br>In an interview on 3/4/25 at 10:43am, LPN "H" reported she intervened during two incidents in which Resident #105 approached Resident #106 in an aggressive manner on 2/26/25. LPN "H" reported she immediately directed Resident #105 to leave the area because he was "in her face" (Resident #106) and Resident #106 appeared scared. LPN "H" reported Resident #105 continued to direct aggressive comments to Resident #106 until LPN "H" physically intervened and moved his wheelchair. LPN "H" reported Resident #105 had been "preoccupied" with Resident #106 and directed his attention to her for several weeks. LPN "H" reported she did not report the incident immediately, but she felt it constituted abuse and she told Nursing Home Administrator (NHA) "A" about the incident the following morning. LPN "H" reported she offered to write a late entry behavioral note summarizing the incident, but NHA "A" told her not to do so because the note might have a negative impact on admission referrals the facility had made to other facilities for Resident #105. LPN "H" reported documentation of the incident in a behavioral note would have ensured the provider was aware of the incident.<br><br>In an interview on 3/4/25 at 2:53pm, Unit Manager (UM) "E" reported the facility's policy regarding accusations of abuse was that the NHA would be immediately notified, and an investigation would begin to determine if the accusation should be reported to the state agency. | | | |

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| | UM "E" reported she was told to "err on the side of caution" if there was any concern of potential abuse and report it immediately. When further queried about types of abuse, UM "E" stated "a lot of things can fall under abuse, any violation of the resident's right to be respected, to be care for, to have their property, to be treated like a human". UM "E" confirmed that if one resident's actions directed toward another caused the resident to be fearful, it could be considered abuse.<br><br>In an interview on 3/4/25 at 3:14pm, NHA "A" reported he did not conduct an abuse investigation after the incident between Resident #105 and Resident #106 on 2/26/25. NHA "A" reported he felt some staff were overly "reactive" to Resident #105's behaviors and were more upset about the incident than Resident #106 was. When further queried about what action he would have taken if he had completed an investigation and Resident #106 had told him she was fearful, NHA "A" stated "I would have talked to Resident #105". NHA "A" stated regarding Resident #106's behaviors, "I don't think he's going to do anything".<br><br>In an interview on 3/5/25 at 12:14pm, Physical Therapy Assistant "PTA" "L" reported on 2/26/25, during a therapy session with Resident #106, Resident #105 approached them in the hallway and began speaking to Resident #106 in a verbally aggressive manner and began repeating "Do I need to give you your space?!" PTA "L" reported staff intervened and after several attempts were able to redirect Resident #105 to his room. PTA "L" confirmed that approximately 10 minutes later, while Resident #106's therapy continued, now in the therapy gym, Resident #105 again approached Resident #106 aggressively and this time had to be physically removed from the area. PTA "L" reported she felt she had to act when Resident #105 was "in her | | | |

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| | face" (Resident #106). PTA "L" reported Resident #106 was physically shaking after the incident and reported she felt scared. Resident #106 voiced to PTA "L" that she was worried Resident#105 was going to attempt to touch her inappropriately in the future. PTA "L" reported she told her immediate supervisor about the incident.<br><br>In an interview on 3/5/25 at 2:37pm, Director of Nursing (DON) "B" reported it was expected that any staff member who witnessed a potential situation of resident abuse would immediately report it to NHA "A". DON "B" reported she did not know why this incident wasn't reported or documented.<br><br>Resident #106<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #106 with a reference date of 1/7/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #106 was cognitively intact.<br><br>In an interview on 3/3/25 at 3:09pm, Resident #106 reported she was walking down the hall with a therapist approximately 1 week earlier when Resident #105 moved toward her abruptly and began repeatedly saying in an aggressive, loud tone of voice, "Can I be with you?! Do I need to give you space?! Can I talk to you?!". Resident #106 reported Resident #105 was "in her face" and would not stop asking her those questions despite staff directing him to stop. Resident #106 reported the confrontational and aggressive behavior of Resident #105 made her think he was going to hit her, and she instinctively drew her forearms up by her face. Resident #106 reported staff intervened and diffused the situation but a few minutes later while Resident #106 continued therapy, now in | | | |

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| | the therapy gym, Resident #105 approached her aggressively for a second time, and asked the same questions in a "growly voice while glaring at her". Resident #106 reported the second altercation didn't end until staff physically moved Resident #105 out of the area. Resident #106 reported after the incidents, she began to feel more fearful and worried Resident #105 might come into her room at night. Resident #106 reported she felt harassed by Resident #105.<br><br>Resident #107<br><br>Review of an "Admission Record" revealed Resident #107 was originally admitted to the facility on 3/7/23 with pertinent diagnoses which included: vascular dementia (progressive disease resulting in loss of cognitive skills), anxiety disorder, and major depressive disorder(persistent sad mood impacting daily life).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #107with a reference date of 12/3/24, revealed a "Brief Interview for Mental Status" (BIMS) score of 7/15 which indicated Resident #107 was severely cognitively impaired.<br><br>Review of a "Care Plan" for Resident # 107 with a reference date of 5/4/23, revealed a focus/goal/interventions of: "Focus: I have severe (sic) impaired cognitive function. Goal: I will be able to communicate basic needs ...".<br><br>In an interview on 3/3/25, at 3:40pm, Family Member (FM) "O" reported she regularly visited Resident #107's roommate. FM "O" reported Resident #107's roommate voiced concerns during several different visits that a male staff member was sexually assaulting Resident #107. FM "O" reported this information to Unit Manager (UM) "E" so the concerns could be | | | |

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| | investigated.<br><br>In an interview on 3/4/25 at 2:53pm, UM "E" reported when FM "O" informed her about the concern of a potential sexual abuse of Resident #107, she contacted a manager for further instruction. UM "E" reported she verified that Resident #107 felt safe per instructions and because there were limited male staff in the facility at that time, it was determined there was no concern for sexual abuse and the incident was not reported to the state agency or further investigated.<br><br>In an interview on 3/4/25 at 3:19pm Director of Nursing (DON) "B" confirmed the facility abuse policy was not followed because there was no obvious sign of injury, the resident stated they felt safe, and the reporting resident was suspected of having an acute illness.<br><br>Review of an "Abuse, Neglect and Exploitation" policy with a reference date of 10/24 revealed "Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident ...Definitions: "Abuse" means the willful infection of injury (including sexual intercourse by force or incapacitation) ...intimidation ...mental anguish ... which can include resident to resident altercations ...mental abuse includes ...harassment ...(V.) Investigation A. An immediate investigation is warranted when suspicion of abuse ...or reports of abuse ...occur. (VI.) The facility will make efforts to ensure all residents are protected ...during the investigation ...A. Responding immediately to protect the alleged victim ...B. Examining the alleged victim for any sign of injury, including ...psychosocial assessment ...C. Increased supervision of the alleged victim and residents ...F. provide emotional support and counseling to the resident during the investigation ...VII. The facility will | | | |

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| | implement the following: 1. Reporting of all alleged violations to the facility Administrator immediately. 2. Reporting of all alleged violations to the state agency ...4. Promoting a culture of safety and open communication in the work environment ...". | | | |
| F0609<br>SS= D | Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to Intake # MI00150276. | F0609 | Element 1: Resident 106 remains in the facility. Resident's care plan was reviewed and updated as needed, well-being visits completed with resident and reflected no lasting negative outcomes from the incident. Resident 105 no longer resides in the facility. Resident 107 no longer resides in the facility.<br><br>Element 2: All residents have the potential to be affected by this practice. Alert and Oriented residents with BIMS eight (8) and above were interviewed by Guardian Angels to ensure no unreported allegations of abuse exist. Residents with a BIMS score of less than eight (8) had a skin assessment completed, no other concerns identified.<br><br>Element 3: The RDO re-educated the NHA on the abuse policy on 3/17/25. The NHA reviewed the abuse policy on 3/17/25 and deemed it appropriate. All staff will be re-educated by the SDC/Designee on the abuse policy by 3/24/2025. Any staff member not re-educated by 3/24/2025 will be removed from the schedule until re-education is complete.<br><br>Element 4: The NHA / designee will audit/interview five (5) staff members regarding abuse/neglect knowledge and reporting guidelines per week for four (4) weeks and then monthly for three (3) months. All findings will be reported to the QAPI committee monthly. The NHA is responsible for achieving and sustaining compliance. | 3/24/2025 |

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| | Based on interview, and record review, the facility failed to report allegations of abuse to the State Agency in a timely manner in 3 of 3 residents (Resident #105, Resident #106 and Resident #107) reviewed for abuse and reporting, resulting in the potential for additional allegations of abuse and to go unreported and delayed investigation.<br><br>Findings include:<br><br>Review of an "Abuse, Neglect and Exploitation" policy with a reference date of 10/24 revealed "Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident ...Definitions: "Abuse" means the willful infection of ...intimidation ...mental anguish ... which can include resident to resident altercations ...mental abuse includes ...harassment ...VII. Reporting/Response ...2. Reporting of all alleged violations to the state agency ...within the specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse ...".<br><br>Resident #105<br><br>Review of an "Admission Record" revealed Resident #105 was originally admitted to the facility on 4/15/24 with pertinent diagnoses which included: depression, paraphilia (intense or recurring sexual arousal from atypical situations, objects, fantasies, behaviors, individuals or places), unspecified dementia with psychotic disturbance (loss of contact with reality), and anxiety.<br><br>Review of a "Care Plan" for Resident # 105 with a reference date of 9/27/24, revealed a focuses/goals/interventions of: "Focus: I have a history of physical touching myself and others | | | |

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| | inappropriately. Goal: I will not have behaviors that cause harm to myself or others ...Interventions: 2 staff with personal care ...motion sensor doorbell in my room ...encourage me to stay on my unit ...I may make sexual statements or ask ...other residents to join me in sexual acts ...".<br><br>In an interview on 3/4/25 at 10:43am, LPN "H" reported she observed Resident #105 approach Resident #106 in an aggressive manner twice within a few minutes on 2/26/25. LPN "H" reported she immediately directed Resident #105 to leave the area because he was "in her face" (Resident #106) and Resident #106 appeared scared. LPN "H" reported Resident #105 continued to direct aggressive comments to Resident #106 until LPN "H" physically intervened and moved his wheelchair. LPN "H" reported she did not report the incident immediately, but she felt it constituted abuse.<br><br>In an interview on 3/5/25 at 12:14pm, Physical Therapy Assistant "PTA" "L" reported on 2/26/25, during a therapy session with Resident #106, Resident #105 approached them in the hallway and began speaking to Resident #106 in a verbally aggressive/confrontational manner and began repeating "Do I need to give you your space?!" PTA "L" reported staff intervened and after several attempts were able to redirect Resident #105 to his room. PTA "L" confirmed that approximately 10 minutes later, while Resident #106's therapy continued, now in the therapy gym, Resident #105 again approached Resident #106 aggressively and this time had to be physically removed from the area. PTA "L" reported she felt she had to act when Resident #105 was "in her face" (Resident #106). PTA "L" reported Resident #106 was physically shaking after the incident and reported she felt scared. | | | |

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| MISSION POINT NSG & PHY REHAB CTR OF CEDAR SPRINGS | 400 JEFFREY CEDAR SPRINGS, MI 49319 |

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| | Resident #106<br><br>In an interview on 3/3/25 at 3:09pm, Resident #106 reported she was walking down the hall with a therapist approximately 1 week earlier when Resident #105 moved toward her abruptly and began repeatedly saying in an aggressive, loud tone of voice, "Can I be with you?! Do I need to give you space?! Can I talk to you?!". Resident #106 reported Resident #105 was "in her face" and would not stop asking her those questions despite staff directing him to stop. Resident #106 reported the confrontational and aggressive behavior of Resident #105 made her think he was going to hit her, and she instinctively drew her forearms up by her face. Resident #106 reported staff intervened and diffused the situation but a few minutes later while Resident #106 continued therapy, now in the therapy gym, Resident #105 approached her aggressively for a second time, and asked the same questions in a "growly voice while glaring at her". Resident #106 reported the second altercation didn't end until staff physically moved Resident #105 out of the area. Resident #106 reported after the incidents, she began to feel more fearful and worried Resident #105 might come into her room at night. Resident #106 reported she felt harassed by Resident #105.<br><br>In an interview on 3/4/25 at 2:53pm, Unit Manager (UM) "E" reported the facility's policy regarding accusations of abuse was that the NHA would be immediately notified, and an investigation would begin to determine if the accusation should be reported to the state agency. UM "E" reported she was told to "err on the side of caution" if there was any concern of potential abuse and report it immediately. UM "E" confirmed that if one resident's actions directed toward another caused the resident to be fearful, it could be considered abuse. | | | |

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| | In an interview on 3/4/25 at 3:14pm, NHA "A" reported he did not conduct an abuse investigation or file a report with the state agency after an incident between Resident #105 and Resident #106 on 2/26/25. NHA "A" reported he was not aware of any abuse concerns related to that incident. NHA "A" reported he felt some staff were overly "reactive" to Resident #105's behaviors and were more upset about the incident than Resident #106 was. NHA "A" reported he was aware that Resident #106 was not comfortable being around Resident #105.<br><br>Resident #107<br><br>Review of an "Admission Record" revealed Resident #107 was originally admitted to the facility on 3/7/23 with pertinent diagnoses which included: vascular dementia (progressive disease resulting in loss of cognitive skills), anxiety disorder, and major depressive disorder (persistent sad mood impacting daily life).<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #107with a reference date of 12/3/24, revealed a "Brief Interview for Mental Status" (BIMS) score of 7/15 which indicated Resident #107 was severely cognitively impaired.<br><br>Review of a "Care Plan" for Resident # 107 with a reference date of 5/4/23, revealed a focus/goal/interventions of: "Focus: I have severe (sic) impaired cognitive function. Goal: I will be able to communicate basic needs ...".<br><br>In an interview on 3/3/25, at 3:40pm, Family Member (FM) "O" reported she regularly visited Resident #107's roommate. FM "O" reported Resident #107's roommate voiced comments during several different visits that a male staff member was sexually assaulting Resident #107. | | | |

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| | FM "O" reported this information to Unit Manager (UM) "E" so the concerns could be investigated.<br><br>In an interview on 3/4/25 at 2:53pm, UM "E" reported when FM "O" informed her about the concern of a potential sexual abuse of Resident #107, she contacted a manager for further instruction. UM "E" reported she verified that Resident #107 felt safe per instructions and because there were limited male staff in the facility at that time, it was determined there was no concern for sexual abuse and the incident was not reported to the state agency or further investigated.<br><br>In an interview on 3/4/25 at 3:19pm Director of Nursing (DON) "B" confirmed that the facility did not report the allegation of abuse to the state agency.<br><br>Review of an "Abuse, Neglect and Exploitation" policy with a reference date of 10/24 revealed "Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident ...Definitions: "Abuse" means the willful infection of injury (including sexual intercourse by force or incapacitation) ...intimidation ...mental anguish ... which can include resident to resident altercations ...mental abuse includes ...harassment ...(V.) Investigation A. An immediate investigation is warranted when suspicion of abuse ...or reports of abuse ...occur. (VI.) The facility will make efforts to ensure all residents are protected ...during the investigation ...A. Responding immediately to protect the alleged victim ...B. Examining the alleged victim for any sign of injury, including physical assessment ...psychosocial assessment ...C. Increased supervision of the alleged victim and residents ...F. provide emotional support and counseling to the resident during the investigation | | | |

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| | ...VII. The facility will implement the following: 1. Reporting of all alleged violations to the facility Administrator immediately. 2. Reporting of all alleged violations to the state agency ...4. Promoting a culture of safety and open communication in the work environment ...". | | | |
| F0610 SS= D | Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to intakes MI0015276<br><br>Based on interview and record review, the facility failed to investigate an allegation of abuse for 3 residents (Resident #105, Resident #106 and Resident #107) of 3 total residents reviewed for abuse resulting in the potential for the allegation to not be thoroughly investigated and further abuse to occur.<br><br>Findings include:<br><br>Resident #105 & Resident #106 | F0610 | Element 1: Resident 106 remains in the facility. Resident's care plan was reviewed and updated as needed, well-being visits completed with resident and reflected no lasting negative outcomes from the incident. Resident 105 no longer resides in the facility. Resident 107 no longer resides in the facility.<br><br>Element 2: All residents have the potential to be affected by this practice. Alert and Oriented residents with BIMS eight (8) and above were interviewed by Guardian Angels to ensure no unreported allegations of abuse exist. Residents with a BIMS score of less than eight (8) had a skin assessment completed, no other concerns identified.<br><br>Element 3: The RDO re-educated the NHA on the abuse policy on 3/17/25. The NHA reviewed the abuse policy on 3/17/25 and deemed it appropriate. All staff will be re-educated by the SDC/Designee on the abuse policy by 3/24/2025. Any staff member not re-educated by 3/24/25 will be removed from the schedule until re-education is complete.<br><br>Element 4: The NHA / designee will audit/interview five (5) staff members regarding abuse/neglect knowledge and reporting guidelines per week for four (4) weeks and then monthly for three (3) months. All findings will be reported to the QAPI committee monthly. The NHA is responsible for achieving and sustaining compliance. | 3/24/2025 |

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| | Review of an "Admission Record" revealed Resident #105 was originally admitted to the facility on 4/15/24 with pertinent diagnoses which included: depression, paraphilia (intense or recurring sexual arousal from atypical situations, objects, fantasies, behaviors, individuals or places), unspecified dementia with psychotic disturbance (loss of contact with reality), and anxiety.<br><br>In an interview on 3/3/25 at 3:09pm, Resident #106 reported she was walking down the hall with a therapist approximately 1 week earlier when Resident #105 moved toward her abruptly and began repeatedly saying in an aggressive, loud tone of voice, "Can I be with you?! Do I need to give you space?! Can I talk to you?!". Resident #106 reported Resident #105 was "in her face" and would not stop asking her those questions despite staff directing him to stop. Resident #106 reported the confrontational and aggressive behavior of Resident #105 made her think he was going to hit her, and she instinctively drew her forearms up by her face. Resident #106 reported staff intervened and diffused the situation but a few minutes later while Resident #106 continued therapy, now in the therapy gym, Resident #105 approached her aggressively for a second time, and asked the same questions in a "growly voice while glaring at her". Resident #106 reported the second altercation didn't end until staff physically moved Resident #105 out of the area. Resident #106 reported after the incidents, she began to feel more fearful and was worried Resident #105 might come into her room at night. Resident #106 reported she felt harassed by Resident #105.<br><br>In an interview on 3/4/25 at 10:43am, LPN "H" reported she intervened during two incidents in which Resident #105 approached Resident #106 in an aggressive manner on 2/26/25. LPN "H" | | | |

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| | reported she immediately directed Resident #105 to leave the area because he was "in her face" y (Resident #106) yelling and Resident #106 appeared scared. LPN "H" reported Resident #105 continued to direct aggressive comments to Resident #106 until LPN "H" physically intervened and moved his wheelchair. LPN "H" reported Resident #105 had been "preoccupied" with Resident #106 and directing his attention to her for several weeks. LPN "H" reported she did not report the incident immediately but should have. LPN "H" reported she felt the incident constituted abuse and she told Nursing Home Administrator (NHA) "A" about the incident the following morning. LPN "H" reported she offered to write a late entry behavioral note summarizing the incident, but NHA "A" told her not to do so because the note might have a negative impact on admission referrals the facility had made to other facilities for Resident #105.<br><br>In an interview on 3/4/25 at 2:53pm, Unit Manager (UM) "E" reported the facility's policy regarding accusations of abuse was that the NHA would be immediately notified, and an investigation would begin to determine if the accusation should be reported to the state agency. UM "E" confirmed that if one resident's actions directed toward another caused the first resident to be fearful, it could be considered abuse.<br><br>In an interview on 3/4/25 at 3:14pm, NHA "A" reported he did not conduct an abuse investigation after the incident between Resident #105 and Resident #106 on 2/26/25. NHA "A" reported he felt some staff were overly "reactive" to Resident #105's behaviors and were more upset about the incident than Resident #106 was. When further queried about what action he would have taken if he had completed an investigation and Resident #106 had told him she was fearful, NHA "A" stated "I would have talked to Resident #105". NHA "A" stated regarding Resident #106's | | | |

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| | behaviors, "I don't think he's going to do anything".<br><br>Resident #107<br><br>In an interview on 3/3/25, at 3:40pm, Family Member (FM) "O" reported she regularly visited Resident #107's roommate. FM "O" reported Resident #107's roommate voiced concerns during several different visits that a male staff member was sexually assaulting Resident #107. FM "O" reported this information to Unit Manager (UM) "E" so the concerns could be investigated.<br><br>In an interview on 3/4/25 at 2:53pm, UM "E" reported when FM "O" informed her about the concern of a potential sexual abuse of Resident #107, she contacted a manager for further instruction. UM "E" reported she verified that Resident #107 felt safe per instructions and because there were limited male staff in the facility at that time, it was determined there was no concern for sexual abuse and the incident was not reported to the state agency or further investigated.<br><br>In an interview on 3/4/25 at 3:19pm Director of Nursing (DON) "B" confirmed that a full investigation of the sexual abuse concerns for Resident #107 was not completed.<br><br>Review of an "Abuse, Neglect and Exploitation" policy with a reference date of 10/24 revealed "Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident ...Definitions: "Abuse" means the willful infection of injury (including sexual intercourse by force or incapacitation) ...intimidation ...mental anguish ... which can include resident to resident altercations ...mental abuse includes ...harassment ...(V.) Investigation | | | |

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| | A. An immediate investigation is warranted when suspicion of abuse ...or reports of abuse ...occur. (VI.) The facility will make efforts to ensure all residents are protected ...during the investigation ...A. Responding immediately to protect the alleged victim ...B. Examining the alleged victim for any sign of injury, including physical assessment ...psychosocial assessment ...C. Increased supervision of the alleged victim and residents ...F. provide emotional support and counseling to the resident during the investigation ...VII. The facility will implement the following: 1. Reporting of all alleged violations to the facility Administrator immediately. 2. Reporting of all alleged violations to the state agency ...4. Promoting a culture of safety and open communication in the work environment ...". | | | |
| F0645<br>SS= D | PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition | F0645 | Element 1: Resident #105's change in condition was submitted to OBRA on 3/17/25<br><br>Element 2: A facility-wide audit was completed by the regional social worker on 3/13/25 to ensure that no significant diagnosis or medications have been changed. Any changes identified were corrected.<br><br>Element 3: The resident assessment/coordination with PASARR program policy was reviewed by the NHA and deemed appropriate on 3/17/25.<br><br>The social services director/designee was re-educated regarding the resident assessment/coordination with PASARR program policy on 3/17/25<br><br>Element 4- All residents reviewed in daily clinical meeting for any new significant mental illness diagnosis or medications weekly x4 weeks and monthly 3 months. Any diagnosis or medications requiring a Level II | 3/24/2025 |

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| | of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to intake #MI00150276 | | assessment will be submitted to OBRA by social services director/designee.<br><br>The NHA is responsible for achieving and sustaining compliance. | |

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| | Based on interview and record review, the facility failed to ensure a referral was made for a level II evaluation (a comprehensive evaluation completed by the local (state mental health authority) for one (Resident #105) of one resident reviewed for PASARR (Preadmission Screening/Annual Resident Review) screenings, resulting in a potential for unmet behavioral health needs.<br><br>Findings include:<br><br>Review of a facility policy "Resident Assessment-Coordination with PASARR Program" with a reference date of 9/24 revealed "Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental health disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs ...9. Any resident who exhibits a newly evident or possible serious mental disorder ...will be referred promptly to the state mental health authority for a level II review ...".<br><br>Resident #105<br><br>Review of an "Admission Record" revealed Resident #105 was originally admitted to the facility on 4/15/24 with pertinent diagnoses which included: depression and anxiety.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #105 with a reference date of 1/14/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #105 was cognitively intact. Further review of the MDS revealed Resident #105 exhibited verbal behaviors e.g. threatening others, screaming at others, cursing at others and | | | |

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| | received an antipsychotic medication.<br><br>Review of a "Care Plan" for Resident # 105 with a reference date of 9/27/24, revealed a focuses/goals/interventions of: 1. "Focus: I use an anti-psychotic medication r/t (related to) psychoses. Goal: I will utilize the lowest effective dosage of my psychotropic medication without significant side effects ...Interventions: Consult with pharmacy". 2. "Focus: I have a history of physical touching myself and other inappropriately. Goal: I will not have behaviors that cause harm to myself or others ...Interventions: 2 staff with personal care ...motion sensor doorbell in my room ...encourage me to stay on my unit ...I may make sexual statements or ask ...other residents to join me in sexual acts ...".<br><br>Review of an "OBRA PASARR CORRESPONDENCE" document regarding Resident #105 with a reference date of 5/29/24 revealed "Based on a review of available information, the recipient does not meet criteria for a serious mental illness ...the recipient may be admitted to or remain in the nursing facility ...Further PASARR Level II Evaluations are not required unless a significant change has been reported by the nursing facility ...This does not alter the facility's requirement for ...reporting significant changes to (mental health authority)."<br><br>Review of "Physician Orders" for Resident #105 revealed the resident was started an antipsychotic medication on 9/27/24.<br><br>Review of a "Behavioral Health Provider Note" for Resident #105 with a reference date of 10/10/24 revealed "Since the last visit the resident had episodes of sexual behaviors ...masturbating, verbal behaviors and auditory hallucinations ...nursing notes report on 9/12 was reported to | | | |

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| | this nurse that this resident exposed himself and started to masturbate in front of minor staff ...9/15 ...talking about paying people for sex ...physician note 10/8 he has auditory hallucinations and delusional thinking. He is talking to himself or an imaginary person frequently ...behavior log review for past 30 days ...episodes of sexually inappropriate behaviors x12 ...Assessment and plan ...4. Add dx (diagnosis) paraphilia".<br><br>Review of a list of medical diagnoses for Resident #105 revealed the resident was diagnosed with paraphilia (intense or recurring sexual arousal from atypical situations, objects, fantasies, behaviors, individuals or places) on 12/12/24.<br><br>In an interview on 3/5/25, at 1:31pm, Licensed Medical Social Worker (LMSW) "T" from mental health authority reported the facility should promptly refer any nursing home resident who begins taking an antipsychotic medication and/or begins to display symptoms of a significant mental health issue to the agency for a PASARR Level II assessment. LMSW "T" reported a PASARR Level II assessment provides an in-depth evaluation of resident needs, determination of appropriate setting, and a set of recommendations for services for the individual. LMSW "T" reported he had no referral for a PASARR Level II evaluation for Resident #105.<br><br>In an interview on 3/5/25 at 2:37pm, Director of Nursing (DON) "B" reported the facility had struggled to determine how to address Resident #105's psychosocial needs and behaviors and was concerned that a skilled nursing facility may not be the most appropriate placement for him. DON "B" reported to her knowledge a referral for a PASARR Level II assessment had not been completed. | | | |

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| | 414360 | A. BUILDING _____ B. WING _____ | 3/5/2025 |

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| F0689<br>SS= G | Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to intake #MI00150233<br><br>Based on observation, interview and record review, the facility failed to provide adequate supervision and implement effective interventions to prevent falls with injury for a resident with a history of multiple falls in 1 (Resident #100) of 3 residents reviewed for falls, resulting in Resident #100 falling and sustaining a humerus (bone of the upper arm) fracture and significant pain.<br><br>Findings include:<br><br>Review of an "Admission Record" revealed Resident #100 was originally admitted to the facility on 2/5/25 with pertinent diagnoses which included: unsteadiness on feet, repeated falls, cognitive communication deficit, weakness, and need for assistance with personal care.<br><br>Review of a "Minimum Data Set" (MDS) assessment for Resident #100 with a reference date of 2/11/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 1/15 which indicated Resident #100 was severely cognitively impaired. Section "A" of the MDS revealed Resident #100 was admitted to the facility from a short-term general hospital. Section "GG" revealed Resident #100 required maximal (helper does more than half the effort) assistance to come | F0689 | Element 1: Resident #100 no longer resides at the facility.<br><br>Element 2: All residents have the potential to be affected by this deficient practice. A 100% audit of current residents with falls in the last 30 days was completed on 3/24/25 to ensure care plan interventions accurately reflect resident's current needs, have appropriate notification and care plans were updated as needed.<br><br>Element 3: NHA and DON reviewed the Fall prevention policy on 3/17/25 and deemed it appropriate.<br><br>The DON/designee will re-educate all licensed nurses on fall prevention policy prior to 3/24/2025. Any licensed nurses not re-educated by 3/24/25 will not work until re-education is completed.<br><br>An Ad-Hoc QAPI meeting will be held on 3/20/25 to review fall reduction policies and the plan of correction. Medical Director reviewed.<br><br>Element 4: DON/Designee will review newly admitted residents and residents with falls weekly during clinical meetings for three (3) months to ensure interventions were implemented and appropriate, and notifications completed.<br><br>Results will be reported to QAPI, and audits will not be discontinued until substantial compliance is achieved.<br><br>DON is responsible for achieving and sustaining compliance. | 3/24/2025 |

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| | to a standing position and was dependent (helper does all the effort) to transfer from the bed to a chair.<br><br>Review of a "Care Plan" for Resident # 100 with a reference date of 2/5/25, revealed focuses/goals/interventions of: "Focus: I am at an increased risk for falls ...Goal: My risk for falls will be reduced through the next review. Interventions: Be sure my call light in within reach. I need prompt response to all requests ...ensure that I am wearing non-skid footwear ...".<br><br>Review of a an "Admission Assessment" for Resident #100 with a reference date of 2/5/25 revealed the resident had a history of falls, had fallen within the last month, and had suffered a fracture because of a fall in the last 6 months. Further review revealed Resident #100 had symptoms of orthostatic hypotension (low blood pressure which may cause dizziness or fainting upon rising), and restlessness.<br><br>During an observation, it was determined that the room in which Resident #100 resided, was at the far end of the south hall, near an emergency exit, approximately 100' from the common areas and nurses station for the unit.<br><br>Review of a "Daily Staffing" document with a reference date of 2/6/25 revealed 2 staff were scheduled to provide cares on Resident #100's hall from 11pm-7am.<br><br>Review of a "Census Report" for 2/7/25 revealed 21 residents resided on Resident #100's hall.<br><br>Review of an Incident Report with a reference date of 2/7/25 revealed: "Nursing Description: Resident was found on the ground after an unwitnessed fall. Resident was unable to lift right arm post fall. Resident stated they fell onto their | | | |

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| | right arm/shoulder. Injuries observed at time of incident: unable to determine type of injury, injury location right shoulder. Review of a section labeled "Predisposing Situation Factors" revealed Resident #100 displayed increased behaviors, increased agitation, poor safety awareness and transferring without assistance prior to his fall.<br><br>Review of an "Emergency Department Provider Note" for Resident #100 with a reference date of 2/7/25 at 6:33am revealed: "Diagnosis at time of disposition: 1. Other closed nondisplaced fracture of proximal end of right humerus (break in the upper arm bone near the shoulder joint) initial encounter (first time a patient is seen by a healthcare provider for a specific condition or injury). 2. Fall, initial encounter. 3. Other closed fracture of twelfth thoracic vertebra, initial encounter."<br><br>Review of a "History and Physical" physician assessment for Resident #100 with a reference date of 2/7/25 revealed "he (Resident #100) was hospitalized at (name of hospital omitted) from 2/3/25 to 2/5/25 for multiple falls. He has memory loss. He said his legs buckle. He was sent to (name of skilled nursing facility omitted). On 2/7/25 he fell out of bed and fractured his R (right) humerus and T10 (thoracic vertebrae)."<br><br>Review of a "Post Fall Documentation" note for Resident #100, with a reference date 2/8/25 revealed "Pain Assessment: c/o (complained of) RUE (right upper extremity) once during the night "10" (worst pain possible on pain scale) (name of opioid medication omitted) given with good relief."<br><br>In an interview on 3/3/25, at 11:53am, Registered Nurse (RN) "F" reported on 2/7/25 she was standing at the medication cart at approximately | | | |

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| | 4:00am, when she heard Resident #100's roommate calling to her from the far end of the hall. The roommate reported Resident #100 needed help. RN "F" found Resident #100 on the floor near his bed when she arrived in his room. RN "F" reported Resident #100 was unable to say what he was trying to do, but he did say he fell and hit his right arm. RN "F" reported Resident #100's roommate had activated the call light. RN "F" reported she noted a decrease in Resident #100's ability to move his right arm and a complaint of pain. RN "F" reported she was new to the hall and did not know if Resident #100 was considered at risk for falls at that time. RN "F" reported the facility staffed Resident #100's hall with 1 nurse and 1 Certified Nursing Assistant (CNA) from 11pm-7am and staff were not able to provide close supervision/frequent checks to him.<br><br>In an interview on 3/3/25 at 12:40pm, Family Member (FM) "R" reported he was present when Resident #100 was admitted to the facility and told the resident's nurse that he (Resident #100) became confused and restless at night and frequently needed close supervision to remain safe. FM "R" reported he stressed to the facility that Resident #100 was unsafe without close supervision and an immediate response to his needs during the nighttime hours. FM "R" reported Resident #100 resided in his own home prior to his recent fall and was not used to using a call light for assistance.<br><br>In an interview on 3/4/25 at 11:47am, CNA "I" reported she and 1 other staff member were responsible for providing cares to all the residents on Resident #100's hall on 2/7/25. CNA "I" reported Resident #100 was very confused during the night of 2/6-2/7/25. CNA "I" reported Resident #100 was constantly talking about trying to leave, did not understand where he was, didn't use a call light, and was unaware that he could not safely walk on his own. CNA "I" reported she | | | |

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| | found Resident #100 sitting at the edge of his bed trying to get up at which time she lowered is bed as far as it would go. CNA "I" described Resident #100 as "restless and anxious" throughout the night. CNA "I" reported it was "inevitable" that Resident #100 was going to fall that night because he needed more supervision than the staff could provide. CNA "I" reported she tried to provide frequent checks to Resident #100, who's room was at the far end of the hall, but was also had to provide cares to other residents and she had last seen Resident #100 about 30 minutes before his roommate came into the hall and notified staff he had fallen. CNA "I" reported she was in another room providing cares at the time of Resident #100's fall. CNA "I" reported several residents on the hall required the assistance of 2 staff members for cares that night. CNA "I" reported she was not aware of any actions the facility had taken to provide increased supervision to Resident #100.<br><br>In an interview on 3/5/25 at 2:37pm, Director of Nursing (DON) "B" reported Resident #100 came to the facility on 2/5/25 after having multiple falls at home. DON "B" described Resident #100 as "very restless" from the time of his admission to the facility.<br><br>Review of a "Fall Reduction Policy" with a reference date of 4/23 revealed "Policy: Our residents have the right to be free from falls, or to sustain no or minimal injury from falls. Compliance Guidelines: 1. The facility utilizes a standardized risk assessment for determining a resident's fall risk upon admission ...2. The nurse will initiate interventions on the resident's baseline care plan, in accordance with the resident's identified risks." | | | |
| F0842 | Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable | F0842 | Element 1: Resident #105 no longer resides at the facility. Resident #106 care plan was | 3/24/2025 |

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| SS= D | information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. | | reviewed and updated as needed, well-being visits completed with resident and reflected no lasting negative outcomes from the incident.<br><br>Element 2: All residents have the potential to be affected by this practice. IDT team reviewed 24-hour on 3/19/2025 to review all residents and ensure information was not missing from medical record.<br><br>Element 3: Clinical staff have been re-educated by the DON/designee on Nursing documentation of healthcare data from Perry and Potter 10th edition pg 51- 53; Legal guidelines for documenting and reporting and recording. to include timely documentation of resident condition variances. Those not receiving the education prior to date of allegation of compliance 3/24/25 will complete the education prior to their next scheduled shift.<br><br>Element 4: Facility IDT will review the electronic health record during facility daily clinical meeting Monday through Friday with a lookback review done on Monday for any weekend documentation. The DON/designee will follow up on any identified missing or incomplete documentation. Any incomplete documentation will be resolved upon identification.<br><br>Results will be reported to QAPI, and audits will not be discontinued until substantial compliance is achieved.<br><br>The Administrator is responsible for achieving and sustaining compliance. | |

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| | §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to intake #MI00150276<br><br>Based on interview, and record review, the facility failed to maintain complete and accurate medical records in 1 of 3 residents (Resident #105) reviewed for complete documentation, resulting in the lack of proper documentation of evaluation of abusive behaviors.<br><br>Findings include:<br><br>Review of "Principles for Nursing Documentation" published by the American Nurses Association, 2010, revealed "Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice."<br><br>Review of Resident #105's progress notes, incident reports and behavioral logs revealed no documentation of resident-to-resident altercations on 2/26/25.<br><br>In an interview on 3/4/25 at 10:43am, LPN "H" reported she witnessed Resident #105 aggressively confront Resident #105 in the | | | |

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| | hallway and again in the therapy gym on 2/2/6/25. LPN "H" reported Resident #106 appeared scared as Resident #105 "got in her face" and made comments about wanting to spend time with her. LPN reported she was concerned for Resident #106's wellbeing and initially tried to verbally redirect Resident #105 but when that didn't resolve Resident #105's behaviors, she had to physically remove Resident #105 from the situation. LPN "H" reported she felt Resident #105 behavior toward Resident #106 was abusive in nature and that she should have immediately reported it to Nursing Home Administrator (NHA) "A". LPN "H" confirmed she did not document the incident in Resident #105's chart at the time. LPN "H" reported she informed NHA "A" of the incident the following day and planned to enter a late entry note in Resident #105's medical chart regarding the incident that took place on 2/26/25. LPN "H" reported NHA "A" told her not to enter the incident because it could negatively impact the outstanding transfer referrals for Resident #105. LPN "H" reported if the incident had been entered in a behavioral note, it would have ensured the provider was aware of Resident #105's behavior that day.<br><br>In an interview on 3/5/25 at 12:14pm, Physical Therapy Assistant "PTA" "L" reported on 2/26/25, during a therapy session with Resident #106, Resident #105 approached them in the hallway and began speaking to Resident #106 in a verbally aggressive manner and began repeating "Do I need to give you your space?!" PTA "L" reported LPN "H" intervened and after several attempts she and LPN "H" were able to redirect Resident #105 to his room. PTA "L" confirmed that approximately 10 minutes later, while Resident #106's therapy continued, now in the therapy gym, Resident #105 again approached Resident #106 aggressively and this time had to be physically removed from the area. PTA "L" reported she felt she had to act when Resident | | | |

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| | #105 was "in her face" (Resident #106). PTA "L" reported Resident #105 was physically assisted out of the gym by LPN "H". PTA "L" reported Resident #106 was physically shaking after the incident and reported she felt scared. Resident #106 voiced to PTA "L" that she was worried Resident#105 was going to attempt to touch her inappropriately in the future. PTA "L" reported she told her immediate supervisor about the incident.<br><br>In an interview on 3/5/25 at 10:47am, Physician's Assistant (PA) "N" reported she was responsible for managing medical interventions to reduce Resident #105's inappropriate behaviors. PA "N" reported to her knowledge, the interventions in place for Resident #105 were effective. PA "N" reported she was not aware of any recent resident to resident altercations involving Resident #105. PA "N" reported it was very important that staff document Resident #105's behaviors so she could review precipitating factors and evaluate the situation that arose. When further queried, PA "N" reported she would be concerned for the safety of other residents if Resident #105's behaviors were not appropriately documented and monitored.<br><br>In an interview on 3/5/25 at 2:37pm, Director of Nursing (DON) "B" reported it was expected that any staff member who witnessed a potential situation of resident abuse would immediately report it to NHA "A". DON "B" reported she did not know why this incident wasn't reported or documented. | | | |