STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344010	A. BUILDING _____ B. WING _____	7/9/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION POINT NSG & PHYSICAL REHAB CTR OF BELDING	414 E STATE ST BELDING, MI 48809

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F0000 SS=	INITIAL COMMENTS Mission Point Belding was surveyed for an Abbreviated survey on 7/8/25. Intakes: MI00153884 and MI00154082 Census=101	F0000		
F0689 SS= D	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: This citation pertains to intakes MI00153884 and MI0015408 Based on observation, interview and record review the facility failed to prevent one Resident (R1) of 3 Residents reviewed from leaving the facility unsupervised. Finding included: Review of R1's admission record revealed she was 78 years old and admitted to the facility on 12/9/21 and had diagnoses that included: vascular dementia, aphasia (language disorder that affects the ability to communicate), and history of falling. She was not her own responsible party. Review of the facility reported incident, 5 day report revealed R1 was found outside the facility on 6/24/25 at 4:31 PM. R1 was placed on 1:1 supervision for safety at that time. The conclusion	F0689		

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

Electronically Signed | 07/10/2025

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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	revealed, "After investigation and interviews the facility was able to identify that R1 did leave the facility unauthorized. R1 was unsupervised for approximately 3 - 4 minutes and does not have any lasting harm and no injuries." Review of Registered Nurse (RN) "G's "statement in the facility 5 day report revealed, "on 6/24/25 noted R1 was observed outside the facility in the parking lot unattended by a recreation department staff member at approximately 16:32 (4:32 PM) Staff member redirected resident back into the facility after spending approximately 6 -8 minutes convincing resident to return back inside the facility. " Review of Activity Aide AA "F's" statement in the 5 day report revealed, "I clocked out at 4:31 and I left the building. When I got outside onto the sidewalk I saw R1 walking by the cars. She was trying to see if they would open. I ran over to her. I asked her what are you doing out here. We should go back inside. R1 responded with I just want to go home. I want my family. I continued to talk to her suggesting that we could try to call family back inside the building. " R1 was observed in the facility on 7/8/25 at 8:30 AM standing over her bedside table. She was looking at her menu choices. She appeared to be trying to read the menu choices, but the words did not match what was written. Certified Nurse Aide (CNA) "H" came over to assist R1 get her wheeled walker and attempted to determine what R1 wanted. CNA "H" read the menu choices to R1 several times. After several attempts CNA "H "questioned R1 if she wanted the chicken and R1 nodded her head yes. R1 lifted her shirt and indicated she needed help. CNA offered to get R1 dressed, and she agreed to having CNA "H" provide care.			

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	During an interview with the Nursing Home Administrator (NHA) on 7/8/25 at 9:15 AM, the NHA confirmed that R1 had eloped from the facility on 6/24/25. The facility was not 100 percent certain how R1 got out of the facility. He believed the most likely way was out the door near the parking lot. To increase the safety, they have disabled to the button outside that allowed anyone entry (visitor now need to call for assistance to get in). The NHA said he decreased the locking time on the door to 5 seconds. They have also placed an alarm on R1 which locks the doors when she is in proximity to any outside door. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included ... Review of the "Past Noncompliance - Elopement, June 24, 2025" revealed, "R1, was observed by an activity aide in the parking lot of the facility at approximately 16:32 (4:32 PM) on 6/24/25. This serves as the facility Plan of Correction, in response to the following action plan had been implemented." Action taken for issue involved: -Resident was returned to facility - nursing assessment and elopement risk assessment completed. -Resident was placed on 1:1 until 12:35 PM on 06/25/25 as soon as WanderGuard was put in place. -All resident charts were reviewed and verified that Elopement Risk Assessments were in place. -All mag-lock doors in the facility were checked			

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	and verified for functions by EVS Director -Review elopement book to validate it was up-to-date and included all at-risk residents. Action taken for the employees involved: -Verbal re-education provided to all staff in the facility the following day of the incident. Area identified requiring quality improvement: -Staff re-education on Elopement and Wandering policy. How facility identified resident(s) affected and residents with potential to be affected: - All residents deemed to be at risk for elopement have the potential to be affected. Quality Improvement measures or systemic changes made: - All facility staff were provided re-education regarding the following policies/procedure: Elopement and Wandering Policy. - Initiation of QAA Investigation on 06/24/25 to identify details of the incident and to identify any potential deficient practice that may have occurred in relation to the incident. - Maintenance care check of all facility doorways and checked and reviewed for completion and accuracy. - The facility substantiated that the resident did elope form the facility. The facility substantiated that the resident was able to leave without direct supervision. A Past-Non-Compliance was			

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	developed by the QAA Committee for immediate response to the identified concern: Resident's ability to exit the building without staff supervision. - The facility's Elopement and Wandering Policy has been reviewed and deemed appropriate by the Administrator and Director of Nursing. - Immediate in-serving of all facility staff on Elopement and Wandering Policy. All staff who have not received education by the end of the day 06/25/25 will be educated prior to their next scheduled shift. - Audits were developed for checking for new elopement risk residents and for exit seeking behaviors - DON/CCC's completed an audit on Elopement Risk Assessments for the current residents in the facility. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.			