STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32568 This citation pertains to Intake Number(s): MI00140912 and MI00141646. Based on observation, interview, and record review, the facility failed to ensure the facility was clean, comfortable, and homelike for 13 (R802,R804,R806,R808, R810, R811, R813, R814, R815, R816, R817, R818, and R819) of 13 residents reviewed for the environment. This had the potential to affect all 128 residents who resided in the facility. Findings include: Review of a complaint submitted to the State Agency revealed allegations that several showers were not working, and resident rooms did not have heat. Review of a second complaint submitted to the State Agency reveled allegations that the facility was dirty, the facility did not have a maintenance worker, and there was a bug problem on the 2 East Unit. On 12/19/23 at 9:45 AM, upon entrance to the facility, a strong, foul smelling urine odor was observed throughout the first floor. The odor permeated into the conference room which was away from resident rooms. The floors throughout the first floor appeared unclean and sticky with debris. On 12/20/23 at approximately 8:00 AM, urine odor was observed on the first floor of the facility. On 12/20/23 at 9:06 AM, an observation of the 2 East and 2 Center Units was conducted. A very strong, stale, urine odor was observed in the hallways of both units. On 12/20/23 at 9:08 AM, R802 was observed sleeping in bed. A foul odor was observed in the room. The floor in R802's room was sticky with multiple dried stains. On 12/20/23 at 9:10 AM, signage was observed on the door of the shower room on the 2 [NAME] Unit that indicated it was out of order and to not use the shower or toilet. On 12/21/23 at 1:00 PM, an observation of the 2 East unit was conducted. The following was observed: Multiple (approximately 10-15) transparent trash bags that included dirty briefs with visible feces were observed piled up in the hallway outside of the soiled utility room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The foot board of R813's bed was hanging off the bed. In R814's and R815's room, the floor was sticky and dirty. The floor next to R804's bed was littered with trash and debris. R815's dresser drawer was open and inside a washcloth soaked with a pink-orange colors liquid was observed. Dead bugs were observed stuck to the washcloth. The bathroom was observed with flying bugs, an overflowing trash can, no toilet paper holder, and the floor was littered with food. In R816 and R817's room, the floor was sticky and littered with debris. The heating and cooling unit was observed caked with thick dirt and debris inside of the vent. The dial to adjust the temperature and settings was broken off. Flying bugs were observed near R816's closet. The inside of the closet was observed to have trash, food particles, and food containers on the floor. R808 was observed lying in bed. R808 did not participate in conversation and made noises and then began crying. Trash, food particles, dirty gloves, and multiple plastic medication cups were observed on the floor near and under R808's bed. The wooden molding behind R808's bed was pulled out of the wall exposing multiple holes. The molding had screws pointing upward. R808's bathroom was observed with an overflowing trash can. A foul odor was present in the room. The shower room on the 2 Center Hallway was observed to be very cold. An interview was conducted with Certified Nursing Assistant (CNA) 'AA' who reported they did not utilize that shower room. CNA 'AA' reported they just weighed a resident in the shower room. A trash bag full of dirty briefs with feces visible from the outside of the bag which was not tied up was observed on the floor of the shower. The shower floor was observed with brown stains. The toilet was observed to have dried feces in the toilet bowl and the trash can was overflowing. On 12/21/23 at 1:05 PM, an observation of the 2 [NAME] Unit was conducted. The following was observed: R818's floor was littered with trash and was unwashed and sticky. There was a missing floor tile. R811's floor was observed with a missing tile and there was a yellow dried puddle next to the bed. A foul odor was observed in the room. The hallway of the 2 [NAME] Unit was observed to be cold. On 12/21/23 at 1:34 PM, an interview was conducted with R806. When queried about any issues with the physical condition of the facility, R806 reported the facility was dirty and there was a period of time when there was no hot water and there was an issue with the heat. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/21/23 at 2:06 PM, an interview was conducted with Corporate Maintenance Director 'Z'. Corporate Maintenance Director 'Z' reported he covered 14 buildings and when problems arise, he is contacted to address them. Corporate Maintenance Director 'Z' explained he was mainly contacted for big issues. When queried about where he documented jobs that he completed or if there was any documentation of jobs he was contacted about, Corporate Maintenance Director 'Z' reported he did not maintain any documentation of jobs he did in the facility. When queried about any known issues with the heat on the second floor, Corporate Maintenance Director 'Z' reported he was not aware of any issues with the heat. Corporate Maintenance Director 'Z' reported Maintenance Director 'O' began working in that role on 12/18/23 and prior to that there was no Maintenance Director since October. Maintenance Director 'O' reported there was a Maintenance Technician, but he thought they were out on leave at that time. On 12/21/23 at approximately 2:15 PM, the following observations were made with Corporate Maintenance Director 'Z' and Maintenance Director 'O': Maintenance Director 'O' took the temperature of the shower room on the 2 Center Unit where CNA 'AA' reported he brought residents in to weight them. The temperature was 55.2 degrees Fahrenheit (F). Maintenance Director 'O' reported he was not aware of any issues with the heat. On the 2 [NAME] Unit, Maintenance Director 'O' acknowledged that it felt cold in the hallway. At that time, R819, was in the hallway and reported it was cold in her room. An observation of R819's room revealed the heating and cooling unit was turned off. The vent was caked with dirt and debris. Maintenance Director 'O' removed the filter which was covered with a thick layer of dust and dirt. Upon exiting the room, R810 reported it was cold on the unit and stated, You know why it is so cold? It's because the vents are so dirty! R810 further explained that the residents were unable to use the shower room on the 2 [NAME] unit and they had to go downstairs to use the shower. R810 reported it was inconvenient and he wished he could get a shower on the unit he resided on. An observation of the 2 [NAME] shower room was conducted and revealed a temperature of 67.1 degrees F. The toilet room located inside of the shower room did not have a functioning light. A dirty glove turned inside out with thick brown substance that appeared to be feces was observed on the floor next to the toilet. Signage on the door noted the toilet and shower was out of order. Observation of the toilet revealed it appeared to be functioning according to Maintenance Director 'O'. Maintenance Director 'O' did not know why they were not using that shower room and was not made aware of any issues with the heat or light. An observation of the 2 East hallway revealed approximately 10-15 bags of trash in the hallway outside of the soiled utility room located in an area where residents were present, as seen at 1:00 PM. When Maintenance Director 'O' attempted to open the soiled utility room, the door could only be opened a crack which revealed multiple bags of trash that prevented the door from being open further and were piled more than halfway up the length of the door. According to Maintenance Director 'O', when he started on 12/18/23, they had to call for an emergency trash pick up because the dumpsters were full and there was nowhere to put the trash. Some was removed, but there was not enough space to remove all the trash from the inside of the facility. Maintenance Director 'O' was unsure how long it had been since trash had been removed from the dumpsters. The soiled utility room on the 2 [NAME] unit was observed to have trash piled all the way up the door to the point where the door could not be opened. The second floor had a strong, foul odor of feces and urine for the duration of the survey. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/21/23 at 3:06 PM, an interview was conducted with the Administrator. When queried about why there was so much trash on the second floor, the Administrator reported the problem was corrected on 12/18/23 when they had the trash picked up. The Administrator reported she was unaware it was still an issue. At that time, an observation of the second-floor soiled utility rooms and the trash bags piled on the 2 East hallway was conducted with the Administrator and Regional Clinical Director (RDC) 'E'. The Administrator began telling housekeeping staff to dispose of all the trash outside. An observation of the dumpsters located outside of the facility with RDC 'E' revealed they were completely full and there was not space to dispose of all the trash bags observed inside of the facility. The Administrator reported she was not aware of any other maintenance issues in the facility. The facility was unable to provide any documentation or maintenance logs of issues reported and/or resolved. Review of a facility policy titled, Maintenance Inspection revised 1/2023, revealed, in part, the following: .The Director of Maintenance Services will perform routine inspections of the physical plant using the Maintenance Checklist .The Administrator .will perform random inspections of the physical plant using the Maintenance Checklist .All opportunities will be addressed and corrected by maintenance personnel . Review of a facility policy titled, Safe and Homelike Environment, dated 1/11/21, revealed, in part, the following: In accordance with residents ' rights, the facility will provide a safe, clean, comfortable and homelike environment .This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk .The facility will create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment .The facility will provide and maintain adequate and comfortable lighting levels in all areas .The facility will maintain comfortable and safe temperature levels . The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit .Minimize odorReport any furniture in disrepair to Maintenance promptly .Report any unresolved environmental concerns to the Administrator.s by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to Housekeeping Department .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00141646 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for one (R801) of four residents reviewed for abuse and neglect, resulting in R801 being punched in the face by R803 and hit with a cane by R802 resulting in black eyes after both incidents. Findings include: R801 and R802 Review of a complaint submitted to the State Agency revealed an allegation that R801 was beat up by R802 which resulted in a black eye. Review of a Facility Reported Incident (FRI) submitted to the State Agency on 12/11/23 revealed there was a resident to resident altercation occurred in (R801 and R802's room) between (R801 and R802). The assigned nurse heard yelling and commotion and was able to intervene wherein (R802) reported to her that (R801) had punched him in the face as he was sleeping. (R802) was not attempting to hit (R801) with his cane when the nurse stepped in to intervene and prohibit him from doing so. The two men were immediately removed from within the vicinity of each other with (R801) moved to a room on a different unit .The facility will submit more details after the matter is investigated further . Review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and discharged to the hospital on 12/14/23 with diagnoses that included: Huntington's Disease (a rare, inherited disease that causes the progressive breakdown of nerve cells in the brain. It has impact on a person's functional abilities and usually results in movement, cognitive, and psychiatric disorders). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had moderately impaired cognition, clear speech, was able to be understood, and had some verbal behaviors. Review of R801's progress notes revealed a Nursing Progress Note dated 12/8/23 at 12:47 AM, written by Licensed Practical Nurse (LPN) 'N', that noted, This writer heard yelling and commotion in (R801 and R802's room). Upon entering the room, resident's roommate (R802) was standing over resident (R801) with a cane attempting to hit him. This writer intervened and was able to prevent the hit. Residents' roommate (R802) claimed that (R801) punched him in his face while he was asleep . Review of a Nursing Progress Note dated 12/11/23, written by Unit Manager, LPN 'A' revealed, Resident radiology results for orbital rim (bony outer edges of the eye socket) is intact. No blowout fracture seen . recommend CT (computed tomography) for more sensitive if there is persistent concern . Review of a Weekly Skin Sweep for R801 dated 12/8/23 at 12:56 AM revealed R801's skin was intact with no skin conditions. Review of a Weekly Skin Sweep for R801 dated 12/8/23 at 2:45 PM, completed by Registered Nurse (RN) 'H' revealed R801 had Left eye bruising . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/20/23, at approximately 8:00 AM, the Administrator was asked to provide the facility's investigation into the alleged resident to resident incident that occurred between R801 and R802 on 12/8/23 and any additional incident reports for R801 since his admission. On 12/20/23, at approximately 10:00 AM, the Administrator provided a file and explained it was the investigation mentioned above. Review of the investigation revealed the following: A typed 5 Day Investigation Summary dated 12/16/23 that documented the allegation of made by R802 that R801 hit him. It was not documented that R802 was standing over R801 about to hit him with a cane. There was no mention of the left eye bruising documented on R801's skin assessment dated [DATE]. On 12/20/23 at 10:05 AM, an interview was conducted with the Administrator who is the facility's Abuse Coordinator. When queried about what occurred between R801 and R802 on 12/8/23, the Administrator stated, There wasn't any contact, so we just moved his (R801) room. When queried about the left eye bruising documented on R801's skin assessment on 12/8/23, the Administrator did not offer a response. On 12/20/23 at 11:51 AM, an interview was conducted via the telephone with LPN 'N' who was R801 and R802's assigned nurse on the 12/7/23 midnight shift. When queried about what happened between the residents that night, LPN 'N' reported she heard commotion and when she entered the room, R802 was about to hit R801 with a cane, but she was able to intercept the hit. LPN 'N' reported R802 accused R801 of punching him. LPN 'N' stated, I can't say what happened before I entered the room because the door was closed. I just know what I saw. On 12/20/23 at 11:19 AM, an interview was conducted via the telephone with RN 'H', the nurse who completed R801's skin assessment that noted left eye bruising. RN 'H' explained she noticed the black eye and completed a skin assessment, wrote a progress note, and notified the physician and unit manager. When queried about whether any incidents were reported from the previous shift, RN 'H' reported nothing was reported from the previous shift. On 12/20/23 at approximately 11:40 AM, an interview was conducted with Unit Manager, LPN 'B'. When queried about what she knew about the incident between R801 and R802, LPN 'B' reported she was told there was an incident, but no contact was made, but then one of the day shift nurses notified her that R801 had a black eye. On 12/20/23 at 12:18 PM, an interview was conducted with the Director of Nursing (DON). The DON reported she was not made aware that R801 had a black eye on 12/8/23. The DON reported the nurse (LPN 'N') said there was no contact and no injury and no further monitoring was done. Review of R802's clinical record revealed R802 was admitted into the facility on [DATE] with diagnoses that included: psychotic disorder with hallucinations. Review of a MDS assessment dated [DATE] revealed R802 had intact cognition and verbal behaviors. Review of R802's progress notes revealed R802 had Documentation of a verbal type behavior on 7/26/23, 8/28/23, and 9/15/23. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a Nursing Progress Note dated 12/7/23 at 11:58 PM, written by LPN 'N' revealed, (R802) claims that (R801) punched him in his face while he was sleeping so when this writer walked into the bedroom (R802) was yelling and cursing and attempting to hit (R801) with a cane. This writer was able to intercept the hit . R801 and R803 Further review of R801's clinical record revealed the following: A Nursing Progress Note dated 11/2/23, written by LPN 'L' that documented, (R801) was hit in face by (resident medical record number) .Physician notified, Administrator notified, DON notified . A SBAR (Situation-Background-Assessment-Recommendation, a form used to communicate a change in condition to the physician) Communication Form dated 11/2/23, completed by LPN 'L', that documented, R801 had a Change in skin color or condition. No incident report was provided regarding the documented incident between R801 and another resident where R801 was hit in face. On 12/20/23 at 1:04 PM, an interview was conducted with LPN 'L'. When queried about what happened with R801 on 11/2/23, LPN 'L' reported R801 was able to talk and make his needs known and on that day he approached LPN 'L' and reported that another resident (R803) hit him in the face. LPN 'L' explained R803 was always aggressive, but R801 was not an aggressive resident. LPN 'L'. When queried about what LPN 'L' did after R801 reported the incident to her, LPN 'L' reported the Unit Manager and Administrator were notified of the alleged incident. LPN 'L' reported she completed an incident report and was able to pull it up on her computer. Review of the incident report revealed on 11/2/23 at 10:34 AM, (R801) came out to hallway to say he had been hit by resident in other room. Resident stated, 'he hit me' and pointed to (R803) .Resident was assessed for injuries .Injuries post incident .Bruise .Face . On 12/20/23 at 1:30 AM, an interview was conducted with the Administrator regarding R803 hitting R801 in the face causing a bruise. The Administrator reported she did not know about that incident and the nurse documented she was contacted but did not notify her. When queried about whether incident reports were reviewed in daily interdisciplinary team meetings, the Administrator reported they were. The Administrator did not offer a response as to how she was unaware of the incident when there was an incident report completed. Review of R803's clinical record revealed the following: R803 was admitted into the facility on [DATE] with diagnoses that included: schizoaffective disorder and bipolar disorder. Review of a MDS assessment dated [DATE] revealed R803 had moderately impaired cognition. Review of R803's progress note revealed he had a history of aggressive behaviors as evidenced by the following: On 7/25/23, a Nursing Progress Note documented, Resident became combative with writer .started to make statements that he would harm writer and started to argue with his room mate . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/22/23, a Nursing Progress Note documented, Resident was shouting at resident and trying to hit roommate . On 11/2/23, a Nursing Progress Note documented, Resident went through the common bathroom of him and (R801) and struck resident in face with fist. Then (R803) came and told writer he did it .Administrator notified; DON notified . Review of R803's care plan revealed there was no care plan to address his behaviors until 11/13/23. Review of a facility policy titled, Abuse, Neglect and Exploitation, revised on 6/2023, revealed, in part, the following: It is the policy of this facility to provide protections for the health, welfare and rights of each resident .The facility will identify, correct, and intervene in situations in which abuse .is more likely to occur .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on interview and record review, the facility failed to report an allegation of resident to resident abuse resulting in black eye to the State Agency and a second allegation of resident to resident abuse to the State Agency in the required time frame for three (R801, R802, and R803) of three residents reviewed for abuse. Findings include: R801 and R802 Review of a complaint submitted to the State Agency revealed an allegation that R801 was beat up by R802 which resulted in a black eye. Review of a Facility Reported Incident (FRI) submitted to the State Agency on 12/11/23 revealed there was a resident to resident altercation occurred in (R801 and R802's room) between (R801 and R802). The assigned nurse heard yelling and commotion and was able to intervene wherein (R802) reported to her that (R801) had punched him in the face as he was sleeping. (R802) was not attempting to hit (R801) with his cane when the nurse stepped in to intervene and prohibit him from doing so. The two men were immediately removed from within the vicinity of each other with (R801) moved to a room on a different unit .The facility will submit more details after the matter is investigated further . It was documented on the report that the incident was discovered on 12/8/23 at 12:12 AM and it occurred on 12:15 AM. Review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and discharged to the hospital on 12/14/23 with diagnoses that included: Huntington's Disease (a rare, inherited disease that causes the progressive breakdown of nerve cells in the brain. It has impact on a person's functional abilities and usually results in movement, cognitive, and psychiatric disorders). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had moderately impaired cognition, clear speech, was able to be understood, and had some verbal behaviors. Review of R802's clinical record revealed R802 was admitted into the facility on [DATE] with diagnoses that included: psychotic disorder with hallucinations. Review of a MDS assessment dated [DATE] revealed R802 had intact cognition and verbal behaviors. Review of R801's progress notes revealed a Nursing Progress Note dated 12/8/23 at 12:47 AM, written by Licensed Practical Nurse (LPN) 'N', that noted, This writer heard yelling and commotion in (R801 and R802's room). Upon entering the room, resident's roommate (R802) was standing over resident (R801) with a cane attempting to hit him. This writer intervened and was able to prevent the hit. Residents' roommate (R802) claimed that (R801) punched him in his face while he was asleep . Review of an incident report for R801 revealed the above mentioned incident occurred on 12/7/23 at 11:50 PM and there were no injuries observed post incident. Review of a Weekly Skin Sweep for R801 dated 12/8/23 at 2:45 PM, completed by Registered Nurse (RN) 'H' revealed R801 had Left eye bruising . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/23 at 10:05 AM, an interview was conducted with the Administrator who is the facility's Abuse Coordinator. When queried about why the alleged resident to resident abuse between R801 and R802 was not reported to the State Agency until 12/11/23, the Administrator reported she was unable to recall. When queried about why the bruising to R801's eye was not included in the report to the State Agency when it was identified on 12/8/23 and the report was not submitted until 12/11/23, the Administrator did not offer a response. When queried about when the facility was required to report allegations of abuse to the State Agency, the Administrator said it should be done right away. R801 and R803 Further review of R801's clinical record revealed the following: A Nursing Progress Note dated 11/2/23, written by LPN 'L' that documented, (R801) was hit in face by (resident medical record number) .Physician notified, Administrator notified, DON notified . A SBAR (Situation-Background-Assessment-Recommendation, a form used to communicate a change in condition to the physician) Communication Form dated 11/2/23, completed by LPN 'L', that documented, R801 had a Change in skin color or condition. No incident report was provided regarding the documented incident between R801 and another resident where R801 was hit in face. Review of R803's clinical record revealed the following: R803 was admitted into the facility on [DATE] with diagnoses that included: schizoaffective disorder and bipolar disorder. Review of a MDS assessment dated [DATE] revealed R803 had moderately impaired cognition. Review of a Nursing Progress Note dated 11/2/23, written by Unit Manager, LPN 'B', revealed, Resident (R803) went through the common bathroom of him and (R801) and struck resident in face with fist. Then (R803) came and told writer he did it .Administrator notified; DON notified . On 12/20/23 at 12:18 PM, an interview was conducted with the Director of Nursing (DON). When queried about the alleged resident to resident abuse between R803 and R801 resulting in a bruised eye to R801 on 11/2/23, the DON reported she was not aware of any resident to resident incident between R803 and R801. The DON reported no incident report was completed. On 12/20/23 at 1:04 PM, an interview was conducted with LPN 'L'. When queried about what happened with R801 on 11/2/23, LPN 'L' reported R801 was able to talk and make his needs known and on that day he approached LPN 'L' and reported that another resident (R803) hit him in the face. LPN 'L' explained R803 was always aggressive, but R801 was not an aggressive resident. LPN 'L'. When queried about what LPN 'L' did after R801 reported the incident to her, LPN 'L' reported the Unit Manager and Administrator were notified of the alleged incident. LPN 'L' reported she completed an incident report and was able to pull it up on her computer. Review of the incident report revealed on 11/2/23 at 10:34 AM, (R801) came out to hallway to say he had been hit by resident in other room. Resident stated, 'he hit me' and pointed to (R803) .Resident was assessed for injuries .Injuries post incident .Bruise .Face . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/23 at 1:30 AM, an interview was conducted with the Administrator regarding R803 hitting R801 in the face causing a bruise to the left eye. The Administrator reported she did not know about that incident and the nurses documented she was contacted but did not notify her. When queried about whether incident reports were reviewed in daily interdisciplinary team meetings, the Administrator reported they were. The Administrator did not offer a response as to how she was unaware of the incident when there was an incident report completed. The Administrator explained the alleged incident should have been reported to the State Agency, but it was not because she did not know it happened. Review of a facility policy titled, Abuse, Neglect and Exploitation, revised on 6/2023, revealed, in part, the following: .The facility will implement the following: .Reporting of all alleged violations to the Administrator, state agency .and to all other required agencies .within specified timeframes .Immediately, but not later than 2 hours after the allegation is made, if the vents that cause the allegation involve abuse or result in serious bodily injury .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00141513 and MI00141646. Based on interview and record review, the facility failed to initiate an investigation of an alleged incident of resident to resident abuse resulting in a black eye, thoroughly investigate and maintain documentation of the investigations of a second incident resident to resident abuse resulting in a black eye, and an elopement; and failed to report the results of the investigations to the State Survey Agency within 5 working days of the incident for four (R801, R802, R803, and R807) of four residents reviewed for abuse and neglect. Findings include: R801 and R802 Review of a Facility Reported Incident (FRI) submitted to the State Agency on 12/11/23 revealed there was a resident to resident altercation occurred in (R801 and R802's room) between (R801 and R802). The assigned nurse heard yelling and commotion and was able to intervene wherein (R802) reported to her that (R801) had punched him in the face as he was sleeping. (R802) was not attempting to hit (R801) with his cane when the nurse stepped in to intervene and prohibit him from doing so. The two men were immediately removed from within the vicinity of each other with (R801) moved to a room on a different unit .The facility will submit more details after the matter is investigated further . Review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and discharged to the hospital on 12/14/23 with diagnoses that included: Huntington's Disease (a rare, inherited disease that causes the progressive breakdown of nerve cells in the brain. It has impact on a person's functional abilities and usually results in movement, cognitive, and psychiatric disorders). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had moderately impaired cognition, clear speech, was able to be understood, and had some verbal behaviors. Review of R801's progress notes revealed a Nursing Progress Note dated 12/8/23 at 12:47 AM, written by Licensed Practical Nurse (LPN) 'N', that noted, This writer heard yelling and commotion in (R801 and R802's room). Upon entering the room, resident's roommate (R802) was standing over resident (R801) with a cane attempting to hit him. This writer intervened and was able to prevent the hit. Residents' roommate (R802) claimed that (R801) punched him in his face while he was asleep . Review of an incident report revealed the above mentioned incident occurred on 12/7/23 at 11:50 PM. Review of a Nursing Progress Note dated 12/11/23, written by Unit Manager, LPN 'A' revealed, Resident radiology results for orbital rim (bony outer edges of the eye socket) is intact. No blowout fracture seen . recommend CT (computed tomography) for more sensitive if there is persistent concern . Review of a Weekly Skin Sweep for R801 dated 12/8/23 at 12:56 AM revealed R801's skin was intact with no skin conditions. Review of a Weekly Skin Sweep for R801 dated 12/8/23 at 2:45 PM, completed by Registered Nurse (RN) 'H' revealed R801 had Left eye bruising . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/23, at approximately 8:00 AM, the Administrator was asked to provide the facility's investigation into the alleged resident to resident incident that occurred between R801 and R802 on 12/8/23 and any additional incident reports for R801 since his admission. On 12/20/23, at approximately 10:00 AM, the Administrator provided a file and explained it was the investigation mentioned above. Review of the investigation revealed the following: A typed 5 Day Investigation Summary dated 12/16/23 that documented the allegation made by R802 that R801 hit him. It was not documented that R802 was standing over R801 about to hit him with a cane. There was no mention of the left eye bruising documented on R801's skin assessment dated [DATE]. On 12/20/23 at 10:05 AM, an interview was conducted with the Administrator who is the facility's Abuse Coordinator. When queried about what was done to investigate the incident between R802 and R801 on 12/7/23, the Administrator stated, It only required kind of a simplified investigation because there wasn't any contact so we just moved his (R801) room. When queried about what was done to determine what occurred before the incident and if any assessments were done or interviews with staff, the Administrator reported they interviewed the assigned nurse and a skin assessment was done and there was no contact or injury. When queried about what additional investigation was done when it was discovered R801 had left eye bruising, the Administrator stated, I am looking for another folder with some things in it. When queried about why they moved R801 into a room with R802, the Administrator reported they felt it was a good room to put him in because (R802) wasn't aggressive. When queried about when the investigation was submitted to the State Survey Agency, the Administrator reported she was unable to recall. Review of the report submitted to the State Agency revealed the 5 day investigation summary was not submitted by the facility. No additional information regarding the investigation was provided prior to the end of the survey. On 12/20/23 at 11:51 AM, an interview was conducted via the telephone with LPN 'N' who was R801 and R802's assigned nurse on the 12/7/23 midnight shift. When queried about what happened between the residents that night, LPN 'N' reported she heard commotion and when she entered the room, R802 was about to hit R801 with a cane, but she was able to intercept the hit. LPN 'N' reported R802 accused R801 of punching him. LPN 'N' stated, I can't say what happened before I entered the room because the door was closed. I just know what I saw. On 12/20/23 at 11:19 AM, an interview was conducted via the telephone with RN 'H', the nurse who completed R801's skin assessment that noted left eye bruising. RN 'H' explained she noticed the black eye and completed a skin assessment, wrote a progress note, and notified the physician and unit manager. When queried about whether any incidents were reported from the previous shift, RN 'H' reported nothing was reported from the previous shift. On 12/20/23 at approximately 11:40 AM, an interview was conducted with Unit Manager, LPN 'B'. When queried about what she knew about the incident between R801 and R802, LPN 'B' reported she was told there was an incident, but no contact was made, but then one of the day shift nurses notified her that R801 had a black eye. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/23 at 12:18 PM, an interview was conducted with the Director of Nursing (DON). The DON reported she was not made aware that R801 had a black eye on 12/8/23. The DON reported the nurse (LPN 'N') said there was no contact and no injury and no further monitoring or interviewing was done. The DON stated, I was just trusting what the nurse told me. Review of R802's clinical record revealed R802 was admitted into the facility on [DATE] with diagnoses that included: psychotic disorder with hallucinations. Review of a MDS assessment dated [DATE] revealed R802 had intact cognition and verbal behaviors. Review of R802's progress notes revealed a Nursing Progress Note dated 12/7/23 at 11:58 PM, written by LPN 'N' revealed, (R802) claims that (R801) punched him in his face while he was sleeping so when this writer walked into the bedroom (R802) was yelling and cursing and attempting to hit (R801) with a cane. This writer was able to intercept the hit . R801 and R803 Further review of R801's clinical record revealed the following: A Nursing Progress Note dated 11/2/23, written by LPN 'L' that documented, (R801) was hit in face by (resident medical record number) .Physician notified, Administrator notified, DON notified . A SBAR (Situation-Background-Assessment-Recommendation, a form used to communicate a change in condition to the physician) Communication Form dated 11/2/23, completed by LPN 'L', that documented, R801 had a Change in skin color or condition. No incident report was provided regarding the documented incident between R801 and another resident where R801 was hit in face. On 12/20/23 at 1:04 PM, an interview was conducted with LPN 'L'. When queried about what happened with R801 on 11/2/23, LPN 'L' reported R801 was able to talk and make his needs known and on that day he approached LPN 'L' and reported that another resident (R803) hit him in the face. LPN 'L' explained R803 was always aggressive, but R801 was not an aggressive resident. LPN 'L'. When queried about what LPN 'L' did after R801 reported the incident to her, LPN 'L' reported the Unit Manager and Administrator were notified of the alleged incident. LPN 'L' reported she completed an incident report and was able to pull it up on her computer. Review of the incident report revealed on 11/2/23 at 10:34 AM, (R801) came out to hallway to say he had been hit by resident in other room. Resident stated, 'he hit me' and pointed to (R803) .Resident was assessed for injuries .Injuries post incident .Bruise .Face . On 12/20/23 at 1:30 AM, an interview was conducted with the Administrator regarding R803 hitting R801 in the face causing a bruise. The Administrator reported she did not know about that incident and the nurse documented she was contacted but did not notify her. When queried about whether incident reports were reviewed in daily interdisciplinary team meetings, the Administrator reported they were. The Administrator did not offer a response as to how she was unaware of the incident when there was an incident report completed. The Administrator reported she did not investigate the incident. Review of R803's clinical record revealed the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R803 was admitted into the facility on [DATE] with diagnoses that included: schizoaffective disorder and bipolar disorder. Review of a MDS assessment dated [DATE] revealed R803 had moderately impaired cognition. Review of a Nursing Progress Note dated 11/2/23, written by Unit Manager, LPN 'B', revealed, Resident (R803) went through the common bathroom of him and (R801) and struck resident in face with fist. Then (R803) came and told writer he did it .Administrator notified; DON notified . R807 Review of a Facility Reported Incident (FRI) submitted to the State Agency on 11/25/23 revealed R807 eloped from the facility on 11/24/23 and was located at a family member's home. Review of a complaint submitted to the State Agency revealed an allegation that R807 eloped from the facility and showed up at a family member's house. On 12/20/23 at 3:20 PM, the Administrator was asked to provide the facility's investigation regarding the elopement of R807 as reported to the State Agency on 11/25/23. Review of R807's clinical record revealed R807 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included: head injury and bipolar disorder. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R807 had severely impaired cognition. Review of a progress note dated 11/24/23 at 10:04 PM revealed, Writer observed resident wandering the hallways in a good mood talking with staff and other residents. During dinner time staff being <sic> passing trays to all resident's staff then noticed resident was not in room. Writer and assistant began to look for resident unable to locate writer then called code yellow to being full staff search of the building and outside the building grounds. Writer then notified on-call managers, DON (Director of Nursing) was notified doctor was notified and 911 was called .Resident was found and returned to facility . The progress note was written by Licensed Practical Nurse, LPN 'X'. On 12/20/23 at 3:55 AM, an interview was conducted with the Administrator. When queried about what the facility did to investigate the root cause of how R807 got out of the building, the Administrator stated, The police were here. He (R807) was fine. The Administrator did not offer any additional information regarding the investigation. When queried about whether a five day summary of the facility's investigation was submitted to the State Agency, the Administrator did not offer a response. Review of the State Agency report revealed the facility did not submit a summary of their investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/23 at approximately 4:15 PM, an interview was conducted with Regional Director of Operations (RDO) 'D' and the DON. RDO 'D' and the DON reported they were alerted that R807 was missing from the facility on the evening of 11/24/23. The DON reported she came to the facility and the police were already there, but the resident was not. The DON and RDO 'D' got into a vehicle and searched a five mile radius to see if they could see R807 walking anywhere and were unable to locate him. The facility received a phone call from R807's sister who reported R807 was at another family member's home. The DON and RDO 'D' drove the family member's home accompanied by police and brought R807 back to the facility. The DON reported they were notified by Unit Manager, LPN 'B' and that a code yellow (missing persons) was called. The DON came to the facility to help search. The DON explained that a staff member reported R807 was observed walking up and down the hallway but was redirected to his room and when she went back in there he was not in his room. When queried about how R807 was able to exit the facility, the DON reported she did not know how he got out. The DON reported that it was possible R807 left the building when the residents who smoked went out to smoke which they did so through the main entrance. The DON reported a code was required to exit through the main entrance on the 1 [NAME] Unit and also the side door or the 1 [NAME] Unit. When queried about whether there were any issues with either door not functioning as they should, the DON reported the doors were working at that time. At that time, RDO 'D' provided the address where R807 was found at his family member's home and it was approximately seven miles from the facility. The DON reported she investigated R807's elopement and interviewed staff but did not have any documentation of the investigation. On 12/20/23 at 4:55 PM, an observation of the side door on the 1 [NAME] Unit was conducted with the DON. The door was observed to be unlocked and did not alarm when opened. The door led to a corridor with another door that led to the outside of the facility into the parking lot. That door was unlocked and unalarmed as well. At that time, the Administrator was interviewed. When queried about the door, the Administrator reported Maintenance Director 'O' who began working in that position two days prior on 12/18/23, installed screechers on that date (12/28/23). The Administrator reported she was unaware the door was not functioning and then said staff are standing watch. When queried about why staff would need to stand watch if the door was functioning, the Administrator did not offer a response. At that time, an interview was conducted with Maintenance Director 'O' who reported he installed screechers on the door on 12/18/23 that were supposed to alarm when the door was opened. At that time, Maintenance Director 'O' opened the door and reported the door was somewhat engaging but it sounds like it is shorting out. On 12/21/23 at approximately 8:30 AM, the DON provided a document and explained the facility identified Past Non-Compliance in regards to R807's elopement on 11/24/23. When queried as to why it was not provided the previous day when queried about any investigation and the statement that there was no documentation of an investigation, the DON did not offer a response. When queried about what the facility identified as non-compliance, the DON reported the staff did not identify behaviors that indicated possible elopement and properly follow the elopement policy. There was no information that indicated the doors were checked for proper functioning. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/21/23 at 10:12 AM, an interview was conducted with the DON in the presence of Regional Clinical Director (RCD) 'E' and the Administrator. When queried about any knowledge of the 1 [NAME] side door not functioning, the DON reported it was not functioning on or around 12/5/23 but that it was addressed and repaired as far as she knew. The DON reported the side door worked as intended on 11/24/23, the day of the elopement. When queried as to how she knew the door was functioning, the DON did not offer a response. The Administrator reported the 1 [NAME] side door was repaired but could not give specific dates or specify what needed to be repaired. The DON reported R807 may have left the building behind the residents who smoked. It was explained by the DON that some residents were able to sign themselves out on a leave of absence and go outside to smoke without staff. It was further explained that in order for the residents to get outside, a staff member would have to let them out by entering the code into the door. The DON reported she did not interview any staff members who let residents out to smoke on 11/24/23. The DON reported the root cause of R807's elopement was not determined. At that time, the Administrator reported the facility did not have a Maintenance Director since 10/25/23 and a Corporate Maintenance Director assisted with maintenance in the facility. At that time any maintenance logs since 10/25/23 and any door audits or invoices for repairs of the 1 [NAME] side door were requested. The Administrator did not have an explanation as to why there were no evaluations of the facility doors to determine how R807 got out of the building and no interviews with staff who were responsible for letting residents out to smoke. Review of Task List Reports since 10/1/23 provided by RCD 'E' were reviewed. Each month there was an entry for Weekly Doors/Locks & Alarms .Test operation of doors and locks .logs. In the column to indicate if the task was done, the box was not checked off to indicate it had been completed. Prior to the end of the survey no documentation or invoices were provided that indicated any repairs were performed on the 1 [NAME] Unit side door prior to 12/20/23. On 12/21/23, an interview was conducted via the telephone with LPN 'X' who was present on 11/24/23 when R807 eloped from the facility. It was reported by LPN 'X' that on 11/24/23, when the DON came to the facility she was upset that staff were not watching the door and LPN 'X' explained that they were unable to be at the door and do our work. When queried about why the door needed to be watched, LPN 'X' explained that the side door on the 1 [NAME] Unit was not functioning properly and could be accessed without a code or alarm. On 12/21/23 at 11:18 AM, an interview was conducted with Certified Nursing Assistant (CNA) 'I' who worked on 11/24/23 when R807 eloped from the facility. CNA 'I' did not know how R807 got out of the building and reported the side door to the 1 [NAME] Unit was not properly functioning on that day. CNA 'I' explained the door did not lock or alarm when opened. Review of a facility policy titled, Abuse, Neglect and Exploitation, revised on 6/2023, revealed, in part, the following: .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .Investigations may include but not limited to: .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause .Providing complete and thorough documentation of the investigation .Taking necessary actions as a result of the investigation .Analyzing the occurrence(s) to determine why abuse, neglect .occurred, and what changes are needed to prevent further occurrences .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00141646, MI00141647, MI00141617, and MI00141607. Based on interview and record review, the facility failed to administer medication according to physician's orders, contact the physician regarding a change in behavior, and timely assess a resident after a change in condition for one (R801) of one residents reviewed for quality of care, resulting the resident receiving an excessive amount of antianxiety medication, sustaining a fall, and a delay in identification of a head injury which required the resident to be transferred to the hospital on an emergent basis where he was diagnosed with subarachnoid hemorrhage (bleeding between the brain and the tissue covering the brain) and bilateral subacute subdural hematomas (A brain bleed where symptoms usually appear hours to days or even weeks after the head injury) and required intubation to support breathing. Findings include: Review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and discharged to the hospital on 12/14/23 with diagnoses that included: Huntington's Disease (a rare, inherited disease that causes the progressive breakdown of nerve cells in the brain. It has impact on a person's functional abilities and usually results in movement, cognitive, and psychiatric disorders). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had moderately impaired cognition, clear speech, was able to be understood, had some verbal behaviors, no wandering behaviors, and no falls since admission. Review of R801's progress notes revealed the following: On 12/12/23 at 3:44 PM, a Nursing Progress Note documented by the Director of Nursing (DON) noted, Resident was observed pacing, restless throughout the 2-West Unit. Resident was difficult to redirect and became aggressive when writer and CNA (certified nursing assistant) made attempts. Physician was notified of resident's behavior and a 1-time order to administer Ativan 2 mg (milligrams) IM (intramuscular) was received. Resident currently in his room but remains agitated AEB (as evidenced by) pacing and sitting in bed then abruptly getting up then sitting back down again. Assigned nurse was informed of 1 time order and to continue to monitor for increased behavior. On 12/12/23 at 6:59 PM, a Nursing Progress Note documented by RN 'Q' noted, Resident have been wandering to other residents room. Resident became aggressive when redirected to his room. (Physician 'T') was notified with order for stat (right away) Ativan 2mg IM. Medication was given to the resident. Resident continued to walk around and tried to go out of his room. Writer have redirected resident to his room multiple times. Resident states he wanted to go home. When dinner tray got to the floor, writer helped distributing the dinner trays. Writer observed resident lying on the floor near his bed. Vital signs was assessed, range of motion was assessed. Skin integrity was assessed. writer noted skin tear on resident's chin and bruise under the left eye. Cold compress was applied to both areas. (Physician 'T') was notified of resident status . On 12/13/23 at 3:35 PM, RN 'Q' documented the following in a Nursing Progress Note, Writer making rounds for second shift, noted resident sleeping in (another resident's room). Resident was redirected to his room with difficulty. Resident was starting to be agitated. Writer gave resident 2 mg Ativan IM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/13/23 at 5:37 PM, RN 'Q' documented the following in a Nursing Progress Note, Resident came out of his room, started getting to other residents room. Writer heard resident in (R812's room). Resident was redirected to his room with difficulty. Resident started to get agitated. Resident was given 2 mg Ativan IM. Review of R801's Physician's Orders revealed an order with a start date of 12/12/23 for Lorazepam (Ativan) Injection Solution 2 MG/ML (milligram per milliliter) Inject 2 mg intramuscularly every 24 hours as needed for agitation. Review of R801's Medication Administration Record (MAR) revealed RN 'Q' administered 2 mg of Ativan IM on 12/13/23 at 3:10 PM and 2 mg of Ativan IM at 5:53 PM, which was approximately two and a half hours after the previous dose was given (The order was for every 24 hours). Review of a eINTERACT SBAR Summary for Providers assessment dated [DATE] at 8:07 AM completed by LPN 'R' revealed, Situation: The Change in Condition/s reported on this CIC (change in condition) Evaluation are/were: Abnormal vital signs .Falls .Seems different than usual Tired, Weak, Confused, or Drowsy . It was documented that R801's blood pressure was 80/54 (low) on 12/14/23 at 11:24 AM. It should be noted that the assessment was time stamped three hours earlier at 8:07 AM. The assessment documented, SEE NURSE NOTE 12/14/23 in the section for nursing observations, evaluation, and recommendation. The documented recommendations were Physician in building, with new orders to send resident out via 911 (It should be noted that the vitals were documented at 11:24 AM, over three hours after the SBAR form was created. Review of a Nursing Progress Note dated 12/14/23 at 8:07 AM written by LPN 'R' revealed, Writer entered room during nursing rounds, resident was observed on floor with dried blood under head, vitals as followed <sic> 80/55 .chest rising and falling resident made eye contact with writer. Resident was removing finger when writer attempted to get O2 (oxygen) by pulse ox when writer called resident name resident groaned. Writer called (Physician 'T') no new orders stated, 'I'll be there soon to see him'. Writer was unable to give morning medication to resident r/t (related to) resident change in condition. Writer called unit manager who updated DON (Director of Nursing) on situation. (Physician 'T') examined resident in person, pupils then on-reactive to light with active finger and body movement. Skin issues not new previous skin issue that were noted .New orders given to writer to send resident out via 911 emergency. Nurse updated unit manager who was present in the building that physician wanted him sent out via 911. Writer called 911 and report was given. Review of a SNF/NF (Skilled Nursing Facility/Nursing Facility) to Hospital Transfer Form completed by LPN 'R' revealed R801 was transferred to the hospital on 12/14/23 at 11:17 AM. The reason for the transfer was documented as Fall. It was documented that R801 had a Black bruised left eye, black bruise on bottom chin, back of head was palpated by writer and physician, lump with active bleeding. It should be noted that LPN 'R's progress note regarding R807's change in condition (low blood pressure, observed on the floor, dried blood under head) was documented at 8:07 AM on 12/14/23, approximately three hours prior to the hospital transfer. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a Progress Note written by Physician 'T' on 12/14/23 at 12:54 PM revealed, .Patient has been agitated and wandering around in different rooms and was given IM Lorazepam for agitation. Patient has refused meals. Patient has a fall and was found on floor earlier today. Patient was throwing stuff in his room, agitated and wants to go home .No acute distress .Blood Pressure 80/55 .On examination at noon time patient was not responsive and gaze preference to left side will send out .Repeated falls .will send out . It should be noted that Physician 'T' documented his examination was done at noon time and LPN 'R' observed R807 on the floor at 8:07 AM per the progress note. Review of a Nursing Progress Note dated 12/14/23 at 8:06 AM written by LPN 'P' (the midnight shift nurse from 12/13/23 going into 12/14/23) revealed the following, Resident alert continue to throw items around room. Attempt to re-direct and put resident in bed resident continue to state im going home .Made on-coming aware nurse of resident behavior . It should be noted that LPN 'P' documented that progress note after LPN 'R' had already observed R801 on the floor. There were no additional progress notes written by the midnight shift on 12/13/23. Review of a hospital Inpatient Facesheet revealed R801 arrived at the hospital on 12/14/23 at 12:11 PM, approximately four hours after LPN 'R' documented R801 was observed on the ground with low blood pressure with dried blood under his head. Review of ED (emergency department) Provider Notes dated 12/14/23 revealed, Pt with history of Huntington's disease .presents via EMS (Emergency Medical Services) as level 1 trauma (life threatening) . Per EMS he was found by home staff to have altered mental status this morning .Physical Exam .Head: Raccoon eyes (bruising to both eyes which can indicate a skull fracture or head injury, increased pressure in the brain, or external force to the eye) and contusion present .Eyes: .Right eye: Abnormal extraocular motion (movement of eye muscles) present .Left eye: Abnormal extraocular motion present .ED course: Patient arrived with altered mental status, minimal response to stimuli .Patient intubated for airway protection. CT (computed tomography) head revealed small amount of subarachnoid hemorrhage and bilateral subacute on <sic> chronic subdural hematomas with associated mass effect (displacement of the soft tissues of the brain) . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/19/23 at 11:33 AM, an interview was conducted with LPN 'R', the day shift nurse assigned to R801 on 12/14/23. When queried about what happened on 12/14/23 prior to R801 being sent to the hospital, LPN 'R' reported on 12/14/23 around 7:30 AM when she arrived for her shift (LPN 'R' explained she arrived late that day as the shift began at 7:00 AM) the midnight nurse, LPN 'P' reported R801 had been throwing things around his room around 2:00 AM on the midnight shift. LPN 'R' further explained it was reported to her by CNA 'S' around 8:00 AM that R801 was on the floor in his room. LPN 'R' reported she went to R801's room and he looked like he was sleeping on the floor. LPN 'R' reported R801 made eye contact, was breathing, and swatted her away when she tried to take his vital signs. At that time, LPN 'R' did not get R801 from the floor, asses for injuries, or contact a physician. LPN 'R' further reported around 9:00 AM, R801 remained on the floor and she tried to get him up for breakfast and he wasn't looking too great so further assessment was done. LPN 'R' stated, He seemed like he was in a deep sleep and not responding and explained it was different from earlier when he made eye contact. LPN 'R' reported R801's blood pressure was 80/55 (low) and she was unable to administer medications because he would not open his mouth. At that time, LPN 'R' notified Unit Manager, LPN 'A' and she came to assess R801 and got him off the floor with two other staff members. LPN 'R' explained it was at that time that dried blood was observed underneath R801's head. LPN 'R' contacted Physician 'T' who told her to get vital signs every 15 minutes and to wait until he came to the facility to assess the resident as he was on his way. LPN 'R' reported Physician 'T' got to the facility five minutes later and when he evaluated R801 his eyes were non-reactive, and he started bleeding from the head and Physician 'T' said to call 911. (It should be noted that based on LPN 'R's documentation and interview statement above, R801 was first observed on the ground by her around 8:00 AM and he was assessed with low blood pressure, in a deep sleep and not responding, and wasn't looking too great around 9:00 AM. Physician 'T' documented he evaluated R801 at noon time and the hospital records indicated R801 arrived at 12:11 PM). When queried about why R801 wasn't fully assessed at 8:00 AM when LPN 'R' was first notified R801 was on the floor, LPN 'R' reported because he made eye contact and was breathing. On 12/19/23 at 11:52 AM, an interview was conducted with CNA 'S', the CNA assigned to R801 on the day shift of 12/14/23. When queried about what occurred with R801 on 12/14/23, CNA 'S' reported her shift started at 7:00 AM and arrived on the floor at approximately 7:05 AM and began room checks. CNA 'S' reported she knocked on R801's door which was closed and observed him face down on the floor flat on his stomach. CNA 'S' reported there was a smear of blood on the floor and explained that R801 was located kind of behind the door. CNA 'S' tried to talk to R801 and he did not say anything that I could understand. CNA 'S' explained she went to notify LPN 'P', the midnight shift nurse, who was seated at the nurses station. CNA 'S' reported that LPN 'P' told her R801 was lying there like that all night. CNA 'S' explained LPN 'P' did not go to R801's room and assess him after it was reported he was on the floor. CNA 'S' further explained that she reported R801 being on the floor to LPN 'R', the day shift nurse as soon as she arrived for her shift. CNA 'S' reported LPN 'R' was late for her shift, but assessed R801 after she was notified, approximately one hour after CNA 'S' initially saw R801 face down on the floor. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/19/23 at 12:35 PM, an interview was conducted via the telephone with LPN 'P', the midnight shift nurse who worked the evening of 12/13/23 (Review of LPN 'P's time punches revealed she worked from 4:18 PM on 12/13/23 until 8:10 AM on 12/14/23). When queried about what occurred with R801 during her shift that began on 12/13/23 and ended the morning of 12/14/23, LPN 'P' reported R801 had behaviors and was tearing his room up on her shift. LPN 'P' reported the CNAs tried to redirect him but they were unsuccessful. LPN 'P' reported that a resident who resided in the room next door who shared a bathroom with R801 notified LPN 'P' that he was tearing up the bathroom. When queried about what was done to address R801's behaviors, LPN 'P' stated, We just tried to get him to stay put and not let him get out of his room and monitor him. LPN 'P' reported she did not work with R801 much and was not sure if he exhibited agitation regularly. LPN 'P' reported she did not contact the physician and that R801 eventually calmed down and was in his bed but fidgety. LPN 'P' denied any notification from CNA 'S' about R801 being found face down on the floor on 12/14/23 around 7:05 AM. LPN 'P' further explained nobody notified her that R801 had a fall on the afternoon shift, but she heard people talking about it and that he was given Ativan. LPN 'P' reported a CNA mentioned around 3:00 AM that R801 had a fall earlier that day. LPN 'P' reported that later she was called in by management asking about a fall and if she did neurochecks. LPN 'P' reported she did not know about a fall until LPN 'R' came in and found him on the floor. LPN 'P' was unsure of the last time she saw R801 and reported it was probably around 5:00 AM or 6:00 AM. LPN 'P' reported she was written up for late documentation because she documented R801's behaviors after LPN 'P' saw him on the floor. LPN 'P' stated, You can't believe anything the CNAs say. It's all hearsay. On 12/19/23 at 1:07 PM, an interview was conducted via the telephone with RN 'Q'. RN 'Q' reported he was assigned to R801 on 12/12/23 and 12/13/23 on the afternoon shift. When queried about R801 on 12/12/23 and 12/13/23, RN 'Q' reported R801 was difficult to redirect on 12/12/23, pushed RN 'Q' and kept going into other residents' rooms. RN 'Q' reported he felt they could not properly supervise R801 and contacted the physician to send him to the hospital. At that time, the physician ordered a one-time dose of IM (in muscle injection) Ativan which was administered, calmed R801 down for a little while, and then he started with his usual routine. RN 'Q' reported R801 repeatedly moved from the bed to the mattress that was on the floor on 12/12/13 and later that evening R801 had a fall and sustained a bruise under the left eye and a skin tear on his cheek. RN 'Q' further reported that on 12/13/23 on the afternoon shift, R801 continued with behaviors of going into other residents' rooms and was difficult to redirect. The physician was notified and an order for Ativan 2 mg IM was ordered. RN 'Q' explained he administered the Ativan to R801, but a few hours later he was up knocking on walls and going into other residents' rooms so he decided to give R801 a second dose of 2mg (milligrams) IM Ativan. RN 'Q' reported it was approximately two hours between the first and second dose of Ativan administered. When queried about whether the physician was contacted prior to giving the second dose of Ativan to notify him that the first dose was not effective, RN 'Q' reported he did not. RN 'Q reported R801 was quiet for the rest of the night, but he did observe him on the floor. When queried about what was done when R801 was observed on the floor, RN 'Q' reported he did not do anything because he did not consider it a fall. RN 'Q' reported R801 kept going from the bed to the floor so he did not think it was a fall. When queried about what was reported to the oncoming midnight shift, RN 'Q' reported he told the nurse R801 was up and about in the afternoon. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/19/23 at 2:25 PM, an interview via the telephone was conducted with CNA 'M' who was assigned to R801 on the afternoon shift of 12/13/23. When queried about R801, CNA 'M' reported R801 was agitated and confused throughout the shift and she reported the behaviors to RN 'Q'. CNA 'M' explained RN 'Q' gave R801 some medicine to calm and relax him, but after a few hours R801 was more agitated. CNA 'M' further reported that while she was providing care to another resident, a coworker told her they had to assist RN 'Q' to get R801 off the floor after a fall. On 12/19/23 at 3:15 PM, an interview was conducted with CNA 'U', a CNA that worked on the 2 [NAME] Unit on the afternoon shift of 12/13/23. When queried about R801, CNA 'U' reported she was not assigned to R801. On 12/13/23, CNA 'U' went into R801's room and the call light cord was pulled out of the wall. CNA 'U' asked R801 if he was okay and when she left out of the room R801 said Wait! and got up and fell . CNA 'U' reported she witnessed R801 fall and notified RN 'Q'. RN 'Q' entered the room and along with CNA 'U' and another CNA, helped R801 from the floor. CNA 'U' did not know if RN 'Q' assessed the resident or contacted the physician. On 12/19/23 at 4:17 PM, an interview was conducted via the telephone with CNA 'V', R801's assigned CNA on the midnight shift of 12/13/23 going into the morning of 12/14/23. CNA 'V' reported she worked from 11:00 PM until about 7:15 AM. When queried about when the last time she saw R801 during the shift, CNA 'V' reported it was at 6:00 AM during rounds and he was lying on the mattress. When queried about where the mattress was located, CNA 'V' began talking about how she only worked on that unit for two days. When queried about how R801 was positioned on the mattress, CNA 'V' stated, He was half way on the mattress. I think he was sideways. CNA 'V' reported R801 did not respond to her when addressed. When queried about whether the nurse was notified, CNA 'V' reported she did not call the nurse because I think she went on break. When queried about whether the nurse was on break at 6:00 AM an hour before shift change, CNA 'V' reported the nurse was on break earlier in the shift and was unclear about when she found R801 halfway on the mattress. CNA 'V' reported that she recalled the nurse attempted to put a dressing on R801's head earlier in the shift around 1:00 AM or 1:30 AM because he had a small cut on his head. CNA 'V' kept going back and forth about whether R801 was on the mattress or the floor and did not provide a response when queried about the cut on R801's head. On 12/19/23 at 4:10 PM, an interview was conducted via the telephone with Physician 'T'. When queried about whether he was contacted about any falls that R801 had between 12/12/23 and 12/14/23, Physician 'T' recalled being contacted on 12/12/23 about a fall, but could not recall if he was notified of a fall on 12/13/23. Physician 'T' reported he ordered IM Ativan for R801 after the nurse called him about his behaviors. When queried about whether he instructed the nurse to give a second dose of 2 mg IM Ativan to R801 two hours after the first dose was given on 12/13/23, Physician 'T' reported he did not. Physician 'T' explained that if the first dose was ineffective, the nurse should have contacted him for further instructions because the order was for every 24 hours. Physician 'T' reported that although that dose could be used for some conditions, it could have contributed to increased drowsiness and increased risk of falling. Physician 'T' reported the next time he was contacted was by the day shift nurse on 12/14/23 about R801 having a change in condition and said R801 was hypotensive (low blood pressure). Physician 'T' reported he was on his way to the facility and came and evaluated R801 and he was not responsive and bleeding from the back of the head. Physician 'T' reported he was close to the facility when the nurse called and asked her to wait until he evaluated R801 before sending to the hospital. Physician 'T' could not recall the time he was contacted. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of an Employee Counseling Notice for LPN 'P' dated 12/15/23 revealed LPN 'P' was suspended from employment. The following was documented in the Company Statement section: .Employee may not physically, verbally, emotionally, or psychologically abuse a resident, visitor, or another employee; neglect resident care duties related to the safety, health and/or physical comfort of the residents; or engage in a serious violation of residents rights .At 7:05 AM 12/14/23, day shift CNA reported that (R801) on lay face down on floor. (LPN 'P') responded 'he been like that all night'. (LPN 'P') failed to assess resident after being notified. Review of an Employee Counseling Notice for RN 'Q' dated 12/14/23 revealed RN 'Q' was suspended from employment. The following was documented in the Company Statement section: .Employee may not physically, verbally, emotionally, or psychologically abuse a resident, visitor, or another employee; neglect resident care duties related to the safety, health and/or physical comfort of the residents; or engage in a serious violation of residents rights .On Wednesday 12/13/23 during the 3p-11p shift (RN 'Q') failed to follow up per facility process/police related to a fall that the was made aware of during his shift by the assigned CNA. (RN 'Q') assisted resident to bed but he did not do the follow up assessments, and or documentation. Prior to the previous fall dated on 12/12/23 the resident had a fall, an incident report was created however (RN 'Q') failed to indicate the resident hit his head and he did not follow the process/policy related to a fall initiating neuro checks. On 12/19/23 at approximately 3:00 PM, an interview was conducted with the DON. The DON reported they immediately realized there was a process failure and that the ball had been dropped regarding R801. The DON reported the facility was in the process of investigating but that based on what she had discovered so far, LPN 'P' and RN 'Q' were suspended. The DON reported the facility began investigating after he was sent out to the hospital on 12/14/23 and it was discovered that R801 had a fall on the afternoon shift of 12/13/23. The DON reported there was nothing documented, no incident report, and nobody was notified (physician or DON). The DON reported RN 'Q' did not follow the process for a fall. The DON reported LPN 'P' did not assess R801 when CNA 'S' notified her R801 was on the ground and then documented information and assessment of R801 after her shift was over. The DON was not aware that R801 received two doses of IM Ativan 2 mg two hours apart on 12/13/23. The DON provided the following: Further review of R801's clinical record revealed late entry progress notes completed by RN 'Q' for 12/13/23. However, per the interview with RN 'Q', he reported he did not assess R801 because he did not not consider a fall because R801 was going up and down off the bed to the floor. RN 'Q' documented a late entry on 12/14/23 for 12/13/23 at 6:50 PM that noted R801 was observed lying on the floor near his mattress and that his vital signs, range of motion, and level of consciousness was assessed and then helped to the mattress. It should be noted that RN 'Q' denied assessing the resident during the interview on 12/19/23. A second late entry progress note documented on 12/13/23 at 6:54 PM documented the above event occurred on 12/13/23 at 6:45 PM and the physician was notified. It should be noted that during the interview with Physician 'T' on 12/19/23, he did not recall being contacted about a fall on 12/13/23. During an interview with a complainant who was contacted on 12/19/23, they responded to a 911 call at the facility on 12/14/23 and received the call at 11:29 AM, four and a half hours after CNA 'S' found R801 face down on the floor. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a facility policy titled, Change in Condition, revised 6/2023, revealed, in part, the following: .The facility will .consult with the resident's provider .when there is .an accident involving the resident which results in injury and has the potential for requiring physician intervention .A significant change in the resident's physical, mental, or psychosocial status .A need to alter treatment significantly (that is .a need to .commence a new form of treatment . The policy did not address what the nursing staff's responsibilities were when a resident had a change in condition. Review of a facility policy titled, Medication Administration - General Guidelines, dated June 2019, revealed, in part, the following: .Medications are administered in accordance with written orders of the prescriber .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00141607, MI00141617, MI00141646, and MI00141647. This citation has two Deficient Practice Statements (DPS). DPS #1 Based on interview and record review, the facility failed to provide appropriate supervision and interventions to prevent repeated falls, and timely assessment of the resident following a fall for a resident who was exhibiting unsafe behaviors and who had incidents of prior falls, resulting in serious harm and impairment to one (R801) of four residents reviewed for accidents when additional interventions were not implemented after a fall on 12/12/23 and R801 fell again on 12/13/23 and R801 was found unresponsive on the floor the following day (12/14/23) bleeding from the head, and showing signs of a head injury. R801 was transferred to the hospital where they were diagnosed with subarachnoid hemorrhage (bleeding between the brain and the tissue covering the brain) and bilateral subacute subdural hematomas (A brain bleed where symptoms usually appear hours to days or even weeks after the head injury), a left eye and diffuse scalp contusions (bruises under the skin typically caused by direct repeated blows to the area), multiple abrasions to the ear and knees, and required intubation to support breathing. Findings include: The Immediate Jeopardy began on 12/12/2023 when R801 fell the first time, with no interventions put in place. The Administrator was notified of the Immediate Jeopardy on 12/21/2023 at 12:13 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on 12/21/2024, but compliance remians at a harm level due to sustained compliance that has not been verified by the State Agency. Review of a complaint submitted to the State Agency on 12/14/23 revealed, On 12/14/2023, an acquaintance of (R801) found him unresponsive and called EMS (emergency medical services) on his behalf .(R801's) room was in disarray with random objects and trash all over the floor. (R801) was unresponsive lying on his cot wearing urine-soaked clothing. (R801) had dried blood on his face and right leg, a black left eye that was swollen shut, and multiple hematomas on the left side of his head. (R801's) pupil response was sluggish and his gaze was deviated to the left which are signs of a closed head injury. (R801) was transported to the hospital where he was discovered to have a brain bleed and placed on a ventilator .staff member was asked it (R801) had fallen. The staff member did not answer. The staff member was asked if (R801) had been assaulted. The staff member said (R801) was assaulted by another resident about a week ago .The stages of (R801's) hematomas did not appear to be a week old based on the amount of swelling and the coloring of the bruising . Review of a second complaint submitted to the State Agency on 12/15/23 revealed allegations that R801 was .found unresponsive and bleeding from the head by a family friend who was asked to check on the resident by his relatives .Per the EMS report, (facility staff) were engaging in avoidance behavior, peaking <sic> into the room and then ducking away behind the doorway any time EMS personnel attempted to request information .No staff at (facility) was able to provide information about when the patient's condition changed.' . (continued on next page)

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	235187	A. Building B. Wing	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a third complaint submitted to the State Agency on 12/15/23 revealed allegations that R801 was bleeding from the head and unresponsive with a hematoma on the left eye, which was swollen shut with two additional hematomas on the left side of the patient's head. A multitude of small scratches and abrasions were noted across the pt's (patient's) whole body in various states of healing. Dry blood noted on the sheets around the back of the pt's head and on the right side of his face as though a drop of blood had run from the back of the head to the chin .Pupils were sluggish to react, left eye swollen shut and unable to be assessed. Pt gaze noted to be fixed and deviated to the left. Urinary incontinence noted, pt not in a brief .Staff were engaging in avoidance behavior .It was at 11:47 (AM) that a staff member was located to give EMS a report on the pt and his condition .Staff stated that 'nights' passed on that patient was found in this state at some point last night and has been like this since at least 0800 (8:00 AM). When a staff member was asked if the pt fell , the staff didn't reply .Nobody was able to provide information about when the pt's condition changed . Transport initiated to (local hospital) . Review of a fourth complaint submitted to the State Agency on 12/18/23 revealed allegations that .on 12/13/2023 a male nurse gave (R801) too much Ativan (an antianxiety medication) due to his erratic behavior. The complainant states on 12/14/2023 (R801) passed out, fell to the floor where he hit his head and cracked his skull .the resident was laying on the floor bleeding and unconscious .the resident is currently on life support . On 12/19/23, an unannounced, onsite investigated was started to investigate the allegations. Review of a Case Report from the local police department (PD) dated 12/12/23 revealed the PD received a report from a local agency that provided the following information, .yesterday (12/11/23), (R801) was observed (unknown by whom). (R801) had a black eye, and his head was cut open . Review of a Case Report from the local PD dated 12/14/23 revealed the PD was dispatched to the facility on [DATE] at 11:43 AM after the local fire department (FD) requested an officer to come to the facility. The following was documented in the report: On my arrival, (FD/rescue) was loading up (R801) .(FD), advised me that he was dispatched to (facility) for a (resident) with low blood pressure and head wounds that were bleeding. (FD Staff) stated that the building staff did not cooperate or give information to (FD). The victim, (R801), was not responsive, however, (R801) would respond to painful stimuli only .(R801) had wounds and bruises all over his body. He was lying in blood-spotted sheets and had a swollen left eye with bruising and bruises on his head as well .(FD staff) states that (R801) had signs of a head injury .I then spoke with (a support person to R801's family who is a nurse and a member of a Huntington's Disease association - Visitor 'F') .(Visitor 'F') was on her way up to (R801's room) to meet (R801) for the first time .states she went into (R801's) room with rescue. While in the room, (Visitor 'F') .(R801) was altered, not speaking, and appeared to have a swollen black eye, rash, molted <sic> skin, and bruising on his foot .There were also multiple areas of dried blood on the floor .also dried blood on (R801's) face .(Visitor 'F') attempted to speak with staff regarding his condition .staff was stating 'this is how he was given to me' .I spoke with (Licensed Practical Nurse - LPN 'R') .advised me on 12/14/2023 at 0730 (7:30 AM) .she got to work and was briefed by the midnight nurse, (Registered Nurse - RN 'Q') .while doing her rounds, she (LPN 'R') observed (R801) on the floor .during her assessment she observed dried blood on the floor .observed (R801) on his back and his head was not in a normal position. At this time, (LPN 'R') called her floor manager, who contacted (Physician 'T'), due to (R801's) vitals and skin tone and color. (LPN 'R') then called 911 and (R801) was turned over to the care of (local FD) . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/19/23, R801's hospital records were reviewed and revealed as of that date R801 remained hospitalized . Review of a hospital Inpatient Facesheet revealed R801 arrived at the hospital on 12/14/23 at 12:11 PM. Review of ED (emergency department) Provider Notes dated 12/14/23 revealed, Pt with history of Huntington's disease .presents via EMS as level 1 trauma (life threatening) .Per EMS he was found by home staff to have altered mental status this morning .Physical Exam .Head: Raccoon eyes (bruising to both eyes which can indicate a skull fracture or head injury, increased pressure in the brain, or external force to the eye) and contusion present .Eyes: .Right eye: Abnormal extraocular motion (movement of eye muscles) present .Left eye: Abnormal extraocular motion present .ED course: Patient arrived with altered mental status, minimal response to stimuli .Patient intubated for airway protection. CT (computed tomography) head revealed small amount of subarachnoid hemorrhage and bilateral subacute on <sic> chronic subdural hematomas with associated mass effect (displacement of the soft tissues of the brain) . Review of a Trauma Surgery Evaluation Note dated 12/14/23 revealed, .Multiple scalp bruises noted .R (right) auricular abrasion (abrasion to the ear), OS (one sided) eye contusion, chin laceration .scattered abrasions and bruising R arm, Abrasion L (left) elbow, Abrasion BL (bilateral) knees . Review of a CT Facial radiology report revealed, .FINDINGS .Comminuted, minimally displaced left nasal bone fracture .hematoma overlying the left orbit .There is high density layering material concerning for hemorrhage within the left maxillary sinus. There is nondisplaced medial orbital rim (eye socket) fracture as well as a nondisplaced superior orbital rim fracture extending to the anterior frontal bone and including the anterior skull base . Review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and discharged to the hospital on 12/14/23 with diagnoses that included: Huntington's Disease (a rare, inherited disease that causes the progressive breakdown of nerve cells in the brain. It has impact on a person's functional abilities and usually results in movement, cognitive, and psychiatric disorders). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had moderately impaired cognition, clear speech, was able to be understood, had some verbal behaviors, no wandering behaviors, and no falls since admission. Review of a SNF/NF (Skilled Nursing Facility/Nursing Facility) to Hospital Transfer Form completed by LPN 'R' revealed R801 was transferred to the hospital on 12/14/23 at 11:17 AM. The reason for the transfer was documented as Fall. It was documented that R801 had a Black bruised left eye, black bruise on bottom chin, back of head was palpated by writer and physician, lump with active bleeding. Review of R801's progress notes revealed the following: A Nursing Progress Note written on 12/12/23 at 12:46 AM revealed R801 was moved to the second floor due to attempts to go out of the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/12/23 at 3:44 PM, a Nursing Progress Note documented by the Director of Nursing noted, Resident was observed pacing, restless throughout the 2-West Unit. Resident was difficult to redirect and became aggressive when writer and CNA (certified nursing assistant) made attempts. Physician was notified of resident's behavior and a 1-time order to administer Ativan 2 mg (milligrams) IM (intramuscular) was received. Resident currently in his room but remains agitated AEB (as evidenced by) pacing and sitting in bed then abruptly getting up then sitting back down again. Assigned nurse was informed of 1 time order and to continue to monitor for increased behavior. On 12/12/23 at 6:59 PM, a Nursing Progress Note documented by RN 'Q' noted, Resident have been wandering to other residents room. Resident became aggressive when redirected to his room. (Physician 'T') was notified with order for stat (right away) Ativan 2mg IM. Medication was given to the resident. Resident still continued to walk around and tried to go out of his room. Writer have redirected resident to his room multiple times. Resident states he wanted to go home. When dinner tray got to the floor, writer helped distributing the dinner trays. Writer observed resident lying on the floor near his bed. Vital signs was assessed, range of motion was assessed. Skin integrity was assessed. writer noted skin tear on resident's chin and bruise under the left eye. Cold compress was applied to both areas. (Physician 'T') was notified of resident status . On 12/13/23 at 9:33 AM, a Nursing: Antigravity Team Note (explained by Unit Manager, LPN 'A' as an interdisciplinary team that reviewed falls) written by LPN 'A' noted, .New interventions: Encourage me to participate in activities that promote exercise, physical activity for strengthening and improved mobility . Attendees: (only LPN 'A' was listed). There was no mention of the wandering and agitated behaviors documented by the DON or RN 'Q' that occurred prior to the fall or the administration of Ativan. On 12/13/23 at 1:27 PM, LPN 'A' wrote an Alert Note that documented, Resident has had a fall documented. Please monitor closely for changes/additional falls. Review new fall intervention with the nurse/CCC (clinical care coordinator) to prevent future falls . On 12/13/23 at 3:07 PM, a Therapy Notes progress note documented, The writer attempted to evaluate the patient s/p (status post) eval <sic> and the patient was not participating with PT (Physical Therapy) eval (evaluation). The writer noticed that he was wandering over the 2 W (west) hallway and was going to deferent <sic> rooms. The nurse said that the patient was transferring to the floor and getting back to the bed by himself yesterday secondary of his abnormal behavior and did not show any signs of pain or imbalance after the fall. On 12/13/23 at 3:35 PM, RN 'Q' documented the following in a Nursing Progress Note, Writer making rounds for second shift, noted resident sleeping in (another resident's room). Resident was redirected to his room with difficulty. Resident was starting to be agitated. Writer gave resident 2 mg Ativan IM. On 12/13/23 at 5:37 PM, RN 'Q' documented the following in a Nursing Progress Note, Resident came out of his room, started getting to other residents room. Writer heard resident in (R812's room). Resident was redirected to his room with difficulty. Resident started to get agitated. Resident was given 2 mg Ativan IM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R801's Medication Administration Record (MAR) revealed RN 'Q' administered 2 mg of Ativan IM on 12/13/23 at 3:10 PM and 2 mg of Ativan IM at 5:53 PM, which was approximately two and a half hours after the previous dose was given. Review of R801's Physician's Orders revealed an order with a start date of 12/12/23 for Lorazepam (Ativan) Injection Solution 2 MG/ML (milligram per milliliter) Inject 2 mg intramuscularly every 24 hours as needed for agitation. Review of a eINTERACT SBAR Summary for Providers assessment dated [DATE] at 8:07 AM completed by LPN 'R' revealed, Situation: The Change in Condition/s reported on this CIC (change in condition) Evaluation are/were: Abnormal vital signs .Falls .Seems different than usual Tired, Weak, Confused, or Drowsy . It was documented that R801's blood pressure was 80/54 (low) on 12/14/23 at 11:24 AM. It should be noted that the assessment was time stamped three hours earlier at 8:07 AM. The assessment documented, SEE NURSE NOTE 12/14/23 in the section for nursing observations, evaluation, and recommendation. The documented recommendations were Physician in building, with new orders to send resident out via 911. Review of a Nursing Progress Note dated 12/14/23 at 8:07 AM written by LPN 'R' revealed, Writer entered room during nursing rounds, resident was observed on floor with dried blood under head, vitals as followed <sic> 80/55 .chest rising and falling resident made eye contact with writer. Resident was removing finger when writer attempted to get O2 (oxygen) by pulse ox when writer called resident name resident groaned. Writer called (Physician 'T') no new orders stated, 'I'll be there soon to see him'. Writer was unable to give morning medication to resident r/t (related to) resident change in condition. Writer called unit manager who updated DON on situation. (Physician 'T') examined resident in person, pupils then on-reactive to light with active finger and body movement. Skin issues not new previous skin issue that were noted .New orders given to writer to send resident out via 911 emergency. Nurse updated unit manager who was present in the building that physician wanted him sent out via 911. Writer called 911 and report was given. Review of a Progress Note written by Physician 'T' on 12/14/23 at 12:54 PM revealed, .Patient has been agitated and wandering around in different rooms and was given IM Lorazepam for agitation. Patient has refused meals. Patient has a fall and was found on floor earlier today. Patient was throwing stuff in his room, agitated and wants to go home .No acute distress .Blood Pressure 80/55 .On examination at noon time patient was not responsive and gaze preference to left side will send out .Repeated falls .will send out . Review of a Progress Note written by Physician 'T' on 12/14/23 for the date of service 12/12/23 revealed, . Patient has been agitated and wondering <sic> around and I was asked to assess .restlessness and agitation .Lorazepam as needed . Review of a Nursing Progress Note dated 12/14/23 at 8:06 AM written by LPN 'P' (the midnight shift nurse from 12/13/23) revealed the following, Resident alert continue to throw items around room. Attempt to re-direct and put resident in bed resident continue to state im going home .Made on-coming nurse of resident behavior . It should be noted that LPN 'P' documented that progress note after LPN 'R' had assessed R801 on the floor. There were no additional progress notes written by the midnight shift on 12/13/23. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/19/23 at 11:33 AM, an interview was conducted with LPN 'R', the day shift nurse assigned to R801 on 12/14/23. When queried about what happened on 12/14/23 prior to R801 being sent to the hospital, LPN 'R' reported she had to go get her notes. LPN 'R' reported on 12/14/23 around 7:30 AM when she arrived for her shift (LPN 'R' explained she arrived late that day as the shift began at 7:00 AM) the midnight nurse, LPN 'P' reported R801 had been throwing things around his room around 2:00 AM on the midnight shift. LPN 'R' further explained it was reported to her by CNA 'S' around 8:00 AM that R801 was on the floor in his room. LPN 'R' reported she went to R801's room and he looked like he was sleeping on the floor. LPN 'R' reported R801 made eye contact, was breathing, and swatted her away when she tried to take his vital signs. At that time, LPN 'R' did not get R801 off of the floor, asses for injuries, or contact a physician. LPN 'R' further reported around 9:00 AM R801 remained on the floor and she tried to get him up for breakfast and he wasn't looking too great so further assessment was done. LPN 'R' stated, He seemed like he was in a deep sleep and not responding and explained it was different from earlier when he made eye contact. LPN 'R' reported R801's blood pressure was 80/55 and she was unable to administer medications because he would not open his mouth. At that time, LPN 'R' notified Unit Manager, LPN 'A' and she came to assess R801 and got him off the floor with two other staff members. LPN 'R' explained it was at that time that dried blood was observed underneath R801's head. LPN 'R' contacted Physician 'T' who told her to get vital signs every 15 minutes and to wait until he came to the facility to assess the resident as he was on his way. LPN 'R' reported Physician 'T' got to the facility five minutes later and when he evaluated R801, his eyes were non-reactive and he started bleeding from the head and Physician 'T' said to call 911. When queried about any falls or incidents that were reported by the previous shift, LPN 'R' reported R801 had a swollen black eye that she though was from a resident to resident incident that occurred a week ago. LPN 'R' reported she was no aware of any falls, but heard about an incident the day before where R801 was knocking on the wall and another resident's family member was concerned. When queried about why R801 wasn't fully assessed at 8:00 AM when LPN 'R' was first notified R801 was on the floor, LPN 'R' reported because he made eye contact and was breathing. On 12/19/23 at 11:52 AM, an interview was conducted with CNA 'S', the CNA assigned to R801 on the day shift of 12/14/23. When queried about what occurred with R801 on 12/14/23, CNA 'S' reported her shift started at 7:00 AM and arrived on the floor at approximately 7:05 AM and began room checks. CNA 'S' reported she knocked on R801's door which was closed and observed him face down on the floor flat on his stomach. CNA 'S' reported there was a smear of blood on the floor and explained that R801 was located kind of behind the door. CNA 'S' tried to talk to R801 and he did not say anything that I could understand. CNA 'S' explained she went to notify LPN 'P', the midnight shift nurse, who was seated at the nurses station. CNA 'S' reported that LPN 'P' told her R801 was lying there like that all night. CNA 'S' explained LPN 'P' did not go to R801's room and assess him after it was reported he was on the floor. CNA 'S' further explained that she reported R801 being on the floor to LPN 'R', the day shift nurse, as soon as she arrived for her shift. CNA 'S' reported LPN 'R' was late for her shift, but assessed R801 after she was notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/19/23 at 12:35 PM, an interview was conducted via the telephone with LPN 'P', the midnight shift nurse who worked the evening of 12/13/23 (Review of LPN 'P's time punches revealed she worked from 4:18 PM on 12/13/23 until 8:10 AM on 12/14/23). When queried about what occurred with R801 during her shift that began on 12/13/23 and ended the morning of 12/14/23, LPN 'P' reported R801 had behaviors and was tearing his room up on her shift. LPN 'P' reported the CNAs tried to redirect him but they were unsuccessful. LPN 'P' reported that a resident who resided in the room next door who shared a bathroom with R801 notified LPN 'P' that he was tearing up the bathroom. When queried about what was done to address R801's behaviors, LPN 'P' stated, We just tried to get him to stay put and not let him get out of his room and monitor him. LPN 'P' reported she did not work with R801 much and was not sure if he exhibited agitation regularly. LPN 'P' reported she did not contact the physician and that R801 eventually calmed down and was in his bed but fidgety. When queried about any notification from the day shift CNA regarding R801, LPN 'P' denied that the day shift CNA notified her of R801 lying on the floor. LPN 'P' reported she was at the nurses station finishing up documentation, worked a double shift and did not get up to the second floor until late. LPN 'P' further explained nobody notified her that R801 had a fall on the afternoon shift, but she heard people talking about it and that he was given Ativan. LPN 'P' reported a CNA mentioned around 3:00 AM that R801 had a fall earlier that day. LPN 'P' reported that later on she was called in by management asking about a fall and if she did neurochecks. LPN 'P' reported she did not know about a fall until LPN 'R' came in and found him on the floor. LPN 'P' was unsure of the last time she saw R801 and reported it was probably around 5:00 AM or 6:00 AM. LPN 'P' reported she was written up for late documentation because she documented R801's behaviors after LPN 'P' saw him on the floor. LPN 'P' stated, You can't believe anything the CNAs say. It's all hearsay. On 12/19/23 at 1:07 PM, an interview was conducted via the telephone with RN 'Q'. RN 'Q' reported he was assigned to R801 on 12/12/23 and 12/13/23 on the afternoon shift. When queried about any behaviors or falls that occurred on those dates during his shift, RN 'Q' explained on 12/12/23 he came to the second floor, 2 [NAME] unit and noticed right away that R801 was unable to be redirected. When redirected, R801 pushed RN 'Q' and R801 was confused with an unsteady gait. RN 'Q' reported R801 went through different resident rooms and the other residents were complaining. RN 'Q' reported that he expressed to the DON that with the number of residents that were on that unit at that time, the assigned staff were unable to provide proper supervision and redirection that he required. RN 'Q' explained he wanted to send R801 to the hospital and the DON explained R801 had to stay in the facility and called the physician for Ativan. RN 'Q' reported they tried to do their best and no additional staff were called in to assist with supervising R801. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN 'Q' explained R801 came to the 2 [NAME] Unit from the first floor on 12/11/23 after he tried to elope from the facility. RN 'Q' reported R801 was very difficult to redirect once on the second floor and he even tried to open the window in his room. RN 'Q' explained that was reported to the DON and that was when she said to contact the physician for an Ativan order. RN 'Q' reported he called the physician who ordered a one time dose of Ativan IM, he administered the Ativan which calmed R801 for a little while but then he started with his usual routine. When queried about what interventions were put into place to address R801's behaviors besides the Ativan, RN 'Q' reported they continuously put him back into his room where R801 pulled the mattress from his bed and threw it on the floor and then tried to lay on the bed without a mattress. RN 'Q' explained that R801 repeatedly moved from the bed to the mattress to the floor and later that night (on 12/12/23) R801 fell and sustained a bruise under the left eye and a skin tear on his cheek. RN 'Q' contacted the physician as asked if he could be put on one to one supervision, but the physician said to get an x-ray to the face, write an incident report, and conduct neurochecks. RN 'Q' reported no additional supervision was provided for R801. RN 'Q' reported he worked on 12/13/23 on the afternoon shift and arrived at 3:00 PM. At that time, R801 was found lying down in another resident's bed and RN 'Q' woke him up and redirected him to his room. While walking with R801, RN 'Q' kept pulling on RN 'Q' to enter other residents' rooms. RN 'Q' reported he got R801 into his room and gave him a IM dose of Ativan which kept him quiet for a few hours, but then R801 was up again, knocking on the walls which concerned another resident's family member. After talking to the family member of the other resident, RN 'Q' went back to R801's room and he was not there. RN 'Q' heard R811 yelling Help! Help! Help! from the hallway and R801 was observed in R811's room. R801 was directed to his room. At that time, RN 'Q' reported he decided to give R801 more Ativan. RN 'Q' reported it was approximately two hours after the previous dose was given. (It should be noted that the physician's order was for every 24 hours). RN 'Q' reported R801 was quiet for the rest of the night, but was observed on the floor multiple times. When queried about any assessment for injuries or additional interventions that were implemented when R801 was observed on the floor, RN 'Q' reported he did not consider them falls because he kept going from the bed to the floor. When queried about what was reported to the oncoming nurse at the end of his shift, RN 'Q' reported he told the nurse R801 was up and about in the afternoon. On 12/19/23 at 2:25 PM, an interview via the telephone was conducted with CNA 'M' who was assigned to R801 on the afternoon shift of 12/13/23. When queried about R801, CNA 'M' reported R801 was agitated and confused throughout the shift and she reported the behaviors to RN 'Q'. CNA 'M' explained RN 'Q' gave R801 some medicine to calm and relax him, but after a few hours R801 was more agitated. CNA 'M' further reported that while she was providing care to another resident, a coworker told her they had to assist RN 'Q' to get R801 off the floor after a fall. CNA 'M' reported R801 was just sitting there when she went to check on him last, but he had previously flipped the bed over and made the room a mess. CNA 'M' reported she was assigned to R801 in the past when he resided on the first floor where he had some wandering behaviors, but was not agitated. CNA 'M' reported it did not seem like R801 was adjusted to the facility. CNA 'M' reported she believed R801 required one to one supervision. On 12/19/23 at 3:15 PM, an interview was conducted with CNA 'U', a CNA that worked on the 2 [NAME] Unit on the afternoon shift of 12/13/23. When queried about R801, CNA 'U' reported she was not assigned to R801. On 12/13/23, CNA 'U' went into R801's room and the call light cord was pulled out of the wall. CNA 'U' asked R801 if he was okay and when she left out of the room R801 said Wait! and got up and fell . CNA 'U' reported she witnessed R801 fall and notified RN 'Q'. RN 'Q' entered the room and along with CNA 'U' and another CNA, helped R801 off of the floor. CNA 'U' did not know if RN 'Q' assessed the resident or contacted the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/19/23 at 4:17 PM, an interview was conducted via the telephone with CNA 'V', R801's assigned CNA on the midnight shift of 12/13/23 going into the morning of 12/14/23. CNA 'V' reported she worked from 11:00 PM until about 7:15 AM. When queried about when the last time she saw R801 during the shift, CNA 'V' reported it was at 6:00 AM during rounds and he was lying on the mattress. When queried about where the mattress was located, CNA 'V' began talking about how she only worked on that unit for two days. When queried about how R801 was positioned on the mattress, CNA 'V' stated, He was half way on the mattress. I think he was sideways. CNA 'V' reported R801 did not respond to her when addressed. When queried about whether the nurse was notified, CNA 'V' reported she did not call the nurse because I think she went on break. When queried about whether the nurse was on break at 6:00 AM an hour before shift change, CNA 'V' reported the nurse was on break earlier in the shift and was unclear about when she found R801 halfway on the mattress. CNA 'V' reported that she recalled the nurse attempted to put a dressing on R801's head earlier in the shift around 1:00 AM or 1:30 AM because he had a small cut on his head. CNA 'V' kept going back and forth about whether R801 was on the mattress or the floor and did not provide a response when queried about the cut on R801's head. On 12/19/23 at 4:10 PM, an interview was conducted via the telephone with Physician 'T'. When queried about whether he was contacted about any falls that R801 had between 12/12/23 and 12/14/23, Physician 'T' recalled being contacted on 12/12/23 about a fall, but could not recall if he was notified of a fall on 12/13/23. Physician 'T' reported he was contacted by the nurse on 12/14/23 about R801 having a change in condition and said R801 was hypotensive (low blood pressure). Physician 'T' reported he was on his way to the facility and came and evaluated R801 and he was not responsive and bleeding from the back of the head. When queried about RN 'Q' administering two doses of IM Ativan within two and a half hours of each other, Physician 'T' reported it was ordered to be given as needed every 24 hours. Physician 'T' reported that although that dose could be used for some conditions, it could have contributed to increased drowsiness and increased risk of falling. Physician 'T' reported he would expect the nurse to contact him if the first dose was not effective. On 12/20/23 at 9:12 AM, an interview was conducted with the residents who resided in the room next to where R801 resided before being sent to the hospital. Their rooms were separated by an shared bathroom accessible from each room. When queried about any concerns or interactions with other residents, The residents reported they could hear R801 throwing things around in the bathroom and his room and stated, He was destroying the bathroom. The residents also stated, I heard he pushed (RN 'Q'), the nurse and also went into someone else's bed. The resident reported R801 never entered their room, but reported he was afraid if he did he would be combative and they would not be able to defend himself. Both the residents in the room next to the R801 reported they could hear R801 crash to the ground repeatedly stating, I heard he kept falling and hitting his head. He went to th[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 32568 Based on observation, interview and record review, the facility failed to implement an effective Quality Assurance & Performance Improvement (QAPI) program that identified quality concerns and implemented appropriate plans of action to correct quality deficiencies, resulting in a widespread systemic deficient practice related to maintaining a clean, comfortable, and homelike environment, a pattern of abuse and/or neglect investigations not being completed, completed thoroughly, and not being submitted to the State Agency, and ongoing issues with a malfunctioning door. This deficient practice has the potential to affect all 128 residents that resided in the facility. Findings include: During an abbreviated survey conducted 12/19/23 through 12/21/23, deficient practices were identified related to maintaining a clean, comfortable homelike environment; investigations of resident to resident abuse and elopement not being completed, thoroughly investigated, and submitted to the State Agency; and an elopement and ongoing issues with a malfunctioning door with resulted in an Immediate Jeopardy to the health and safety of the residents. On 12/21/23 at approximately 5:00 PM, the Administrator was interviewed regarding the facility's QAPI program. When queried about whether quality deficiencies were identified through the QAPI program for the environment, abuse/neglect investigations and submission to the State Agency, and maintenance of the doors after a resident elopement, the Administrator reported the following: The Administrator reported it was identified through the facility's QAPI program that investigations into allegations of abuse and neglect, including an investigation into a reported incident of elopement were not being submitted to the State Agency per regulatory requirements. The Administrator did not offer a response as to whether an action plan was developed or what has been done to improve the deficiency. The Administrator reported the facility had identified concerns with the environment, but there was turn around with staff and they were still working on it. The Administrator did not offer any explanation regarding the maintenance of the doors and was unable to provide any evidence that the facility was monitoring the door that was identified to not be alarming or locking. Review of a facility policy titled, Quality Assurance and Performance Improvement, revised on 10/2022, revealed, in part, the following: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data driven, Quality Assurance Performance Improvement (QAPI) program that focuses on indicators of the outcomes of car and quality of life .