STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235664	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #s: MI00141037 and MI00143377. Based on interview and record review the facility failed to inform a legal resident representative of changes in mental capacity and Physician ordered medication changes in a timely manner for one resident (R818) of one residents reviewed for notification of changes. Findings include: On 5/14/24 a concern submitted to the State Agency was reviewed which alleged R818's legal representative (LR) was not being informed of changes in treatments and mental capacity in a timely manner. On 5/14/24 the medical record for R818 was reviewed and revealed the following: R818 was initially admitted to the facility on [DATE] and had diagnoses including Heart failure, Dementia and Repeated falls. A review of R818's MDS (minimum data set) with an ARD (assessment reference date) of 2/13/24 revealed R818 required supervision with most of their activities of daily living. R818's BIMS score (brief interview for mental status) was 12 indicating moderately impaired cognition. A Durable Power of Attorney for Healthcare and Durable Power of Attorney for Finance forms both signed on 10/13/2020 were reviewed which indicated R818's daughter was to be the Durable Power of Attorney for both healthcare and finances should R818 be deemed incapacitated. A Determination of Capacity form signed by R818's attending Physician on 6/23/23 and a Psychologist on 6/22/23 documented that R818 did not have the cognitive capacity to participate in medical and financial decisions. Further review of R818's medical record did not reveal any conversations or discussions the facility had with R818's daughter that revealed R818 had been deemed incapacitated and that the Power of Attorney forms had been executed/enacted. Further view of the medical record also revealed the following treatment changes made by R818's attending Physician/Practitioner which contained no documentation that R818's daughter (made legal representative on 6/23/23) was made aware at the time the changes were made: 7/17/2023-Practitioner Progress Notes-Late Entry: pt (patient) seen for routine f/u (follow up) on multiple co-morbidities .-reduce Metformin to to 500 mg (milligrams) BID (twice daily) . (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/17/2024-Practitioner Progress Notes Patient was seen by video conferencing-with help of the nurse on duty /telehealth services rendered using Face time/ other video conferencing sites as available chief complaints/ History of present illness Evaluating pharmacy recommendations about recent medication review and lisinopril currently prescribed at 40 mg twice daily - suggested dose 40mg/d Assessment and plan Hypertension - patient currently has controlled blood pressure -however given lisinopril should be decreased to 40 mg Q (daily) daily per maximum recommended dosages will change hydralazine to 50 mg Q8 (every eight) hours - continue to monitor blood pressure shift and adjust medications if needed 3/17/2024-Nursing Progress Note Note Text: Orders confirmed with [Attending Physician] to keep magnesiumoxide 400 mg bid and decrease lisinopril 40 mg to qd (every day) and hydralazine 50 mg tid (three times a day), noted . On 5/15/24 at approximately 9:54 a.m., during a conversation with Social Worker A (SW A), SW A was queried regarding R818's daughter being informed of DPOA being executed and R818 being declared incapacitated and given a copy of the capacity determination to take to the bank to access R818's finances. SW A reported that they were unaware that R818's daughter was not informed of the capacity evaluation and subsequent results and had been provided a copy of the capacity declaration. SW A indicated that usually the Psychologist has that conversation with the family and discusses the capacity evaluation but that did not happen for R818. SW A was queried if R818's DPOA (daughter) should be informed of treatment changes since they were in charge of R818's healthcare and they indicated that they should have been after the capacity evaluation had been completed. No further documentation was provided that R818's legal representative was informed of the treatment changes to R818's medication regimen per the medical providers evaluations on 7/17/23 and 3/17/24 or the capacity determination was discussed with R818's legal representative at the time the changes occurred by the end of the survey.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #s MI00141144, MI00141160, MI00142537, MI00143525, MI00143276, and MI00144073. Based on observation, interview and record review, the facility failed to maintain a safe, clean, comfortable and homelike environment, affecting all 81 residents that reside in the facility, including R810, R814 and R815. Findings include: Review of multiple complaints reported to the State Agency included allegations that the facility was not clean, had offensive odors, bathrooms were moldy with lights not working, basement was flooded with mold concerns, there were electrical problems, and broken equipment. The facility was previously determined to be out of compliance for concerns with maintaining a safe, clean, comfortable environment during an abbreviated survey conducted on 3/14/24 with an alleged compliance date of 4/22/24. The observations identified during the current survey identified the facility was non-compliant at a widespread level, and was informed on 5/14/24 that the survey team had identified substandard quality of care regarding failing to maintain a safe, clean, comfortable and homelike environment for all residents. The pest control report for 11/7/2023 identified environmental concerns that documented, .Basement - Interior - excess water noted. Basement storage room house keeper director room. Standing water also black mold noted. In the basement many areas showing black mold. Keep area dry . Interviews and Observations from 5/14/24 to 5/15/24 included: On 5/14/24 at 9:25 AM, the exit door leading to the center courtyard was observed to have a broken door seal that was raised (not sealed) about an inch and the outside was visible from the inside hallway. It should be noted that there were many gnats throughout the facility hallways, in resident rooms, kitchen, dining rooms, and employee offices. The exit sign above the door to the outside patio area was observed dangling by a wire from the ceiling and the entire sign hung down with the arrow to the exit pointing towards the inside of the facility (away from the exit door). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/14/24 at 9:51 AM, observation of the facility's only ice machine was conducted with the Dietary Manager (DM 'B'). The ice machine is located in a small room attached to the main dining room. Upon entering the room, the lighting was very low and the ceiling light was pink in color with only one of the two fluorescent lights functioning. There was water observed all over the floor, a soiled blanket wadded up on the floor. There was an external water filter unit secured to the wall to the left of the ice machine that had no filter, and there was a long tube hanging down (not connected to the ice machine). The unit on the wall included a manufacturer label that read, Ecolab - Managed Water Quality Program. The ice machine itself (had a manufacturer label for Manitowoc) had a log taped to the left side of the machine that prompted staff to document when it had been cleaned, the log was blank. The ice machine was observed to have two dispensers, one for ice and one for water. Just under the dispensers was a metal grate to rest cup on which was covered in thick build-up of white, black and gray debris and the metal grate was peeling away to expose rusted metal underneath. The outside front of the ice machine was covered in white scaly debris. When asked who maintained cleaning of the ice machine, filter and room, DM 'B' deferred to the Maintenance Director. At 9:55 AM, the Administrator, DM 'B', and the Maintenance Director (Staff 'F') returned to the ice machine room. When asked about the current conditions, the Administrator reported he had not been made aware of the conditions of the room. The Administrator was requested to accompany for additional environmental observations. At 10:00 AM, the Administrator was asked about the broken exit door seal leading to the central courtyard and reported that would have to be replaced. When asked about the dangling exit sign, they reported they were not aware of that and denied anyone else letting them know. The flooring throughout the hallways and resident rooms revealed they were heavily soiled with build-up of dirt debris and trash scattered around. Several rooms did not have trash can liners. When asked about the frequency of cleaning, the Administrator reported they had housekeeping seven days a week from either 7:00 AM to 3:00 PM, or 8:00 AM to 4:00 PM and usually had two to three housekeepers on duty. When asked why there were so many concerns with the environment/housekeeping then, they did not offer any further response. There was a floor drain in the center of the 1 East hallway near the nursing desk and resident room which had a missing cover that created a crevice about four inches wide and one inch depth. When asked about the missing floor drain, the Administrator reported that must've just come off. There were used gloves on the floor just before the shower room towards the front of the 1 East unit. There were multiple blinds observed broken and hanging down. The Administrator reported they had put in a request for those. From the facility's front sidewalk, there were several rooms observed to have broken, ill fitted window blinds. At 10:05 AM, upon entering room [ROOM NUMBER], there was a very strong smell of cigarette ashes. The resident was not in the room at the time, but there was a clear storage container on the floor with three rotting plums, and on the window sill there was a small soda can with visible ash on top of the can and there was also a ceramic mug that contained a smearing of ash covering the entire inside of the mug. The Administrator offered no further response when questioned about these items. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Additionally, when asked about the missing cover bases and soiled flooring in room [ROOM NUMBER] and portions of the hallways, the Administrator reported at a minimum the floors should be cleaned daily. There was a missing floor tile in the center of room [ROOM NUMBER]. Observation behind the fire doors on the 1 East unit revealed a build-up of dirt/debris. The Administrator confirmed and offered no further response. At 10:10 AM, observation of the 1 [NAME] floor revealed a missing drain cover which exposed a hole approximately one inch wide. There were multiple soiled privacy curtains observed throughout the entire facility. When asked what the process was for when privacy curtains became soiled, the Administrator reported, Any time they're soiled they should be changed. The over bed table in room [ROOM NUMBER]-B was observed placed under the window and the top was broken and hung down to the left. There was also a broken bedside dresser with exposed particle board. The Administrator confirmed and reported that should have been removed. There was multiple areas of broken drywall throughout the facility's hallways and resident rooms. The Administrator reported the plan was to repair the walls. On 5/14/24 at 12:13 PM, R815 was observed laying in bed. During this interview, there were several gnats observed flying around the resident's bed and throughout the room. The bedside dresser was observed to have several broken drawers and when asked, the resident confirmed it had been like that for a while. R815's bed linens were observed to have several holes and stains. When asked how often the bed sheets were changed, R815 reported they weren't sure, but it had been a while. On 5/14/24 at 12:15 PM, there was a strong urine odor in room [ROOM NUMBER]. There were no residents in the room. The bed by the window was observed to have bed linens that were bunched up in a pile at the end of the bed, visible soiled with brown/gray colored debris. There was an oxygen concentrator machine running without any tubing connected. The unit itself was soiled with dried debris of an unknown substance. There was a tube feeding pole next to the bedside dresser. The entire base of the tube feeding pole and surrounding flooring was covered with a tan/brownish colored debris (old tube feeding formula). The flooring throughout the room was heavily soiled with dirt, debris and trash. On 5/14/24 at 12:17 PM, Unit Manager 'G' entered the room and confirmed the same observations for room [ROOM NUMBER]. When asked about the soiled tube feeding equipment, Unit Manager 'G' reported the resident liked to pull their feeding out. Upon further observation, the stone window ledge near the upper right side (near where head would be resting) was observed to be cracked with sharp edges and missing stone approximately 6-7 inches in width. Unit Manager 'G' reported they were not aware of that and would let the facility know. When asked if staff that provided care daily should've reported that, they offered no further response. On 5/14/24 at 12:22 PM, room [ROOM NUMBER] was observed with broken blinds and gouges in the dry wall under the window. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/14/24 at 12:26 PM, R814 was observed laying in bed and agreed to an interview. During this interview, there were several gnats flying around the resident. They reported that was a nuisance and had been a problem for a while now. The resident further reported they had been in the facility for four years and the facility was only getting worse. They reported their electrical outlets didn't work and had to use the emergency red outlets for their personal items. When asked about the light above their bed, they reported they couldn't reach it (the pull string was observed to be only three inches long). They further reported that light had not been working for a while now due to electrical issues and that the Administrator told them a replacement light was on order, but that has been a while and stated even if the light came, the issue was more than replacing the light, the electrical outlet isn't working. When asked about whether they were getting showers in the shower rooms and whether they had any concerns, R814 reported the lights weren't working for a while now and staff had to prop the door open to be able to see while showering which didn't give them privacy. They also reported the showers were horrible and had mold throughout. On 5/14/24 at 12:37 PM, upon attempting to enter the 1 [NAME] shower room, Nurse 'H' who was seated at the nursing desk stated that room was offline and this surveyor was not allowed to enter. When asked how long it had been offline, Nurse 'H' reported the Administrator told them today. Upon further observation of this shower room, there were no lights working, and there was a heavy build-up of a mold-like substance on the tiles and grout in the shower area. At 12:41 PM, the Administrator was asked about the 1 [NAME] shower room and reported they were informed of issue with the light not working and placed an order on 5/7/24. When asked when they had taken the shower room offline, they reported they weren't sure. The Administrator reported there were two other shower rooms on the 1 East unit that residents could use. At 12:45 PM, observation of one of two of the shower rooms on the 1 East unit revealed there was no light working on the right side of the shower room. The Administrator reported they were not aware of that. Upon looking at the smaller tiled shower stall to the left revealed several tiles and grout were covered in a dark, black, mold-like substance. When asked about the substance, the Administrator reported they weren't qualified to confirm if it was mold or not. When asked why it was in that matter if cleaned appropriately, they did not offer any further response. At 12:50 PM, observation of the second shower room revealed there were no lights or ceiling air vent working. The Administrator reported they were not aware of that. Upon further observation of the wall and floor tile, there were multiple areas of a dark, black, mold-like substance. The Administrator reported they were not aware of that. When asked what the process was to report concerns with equipment/environment, the Administrator reported there was an electronic reporting system or they tell Maintenance and he informs the Administrator. They were asked to provide any documentation of this, but none was provided by the end 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 5/14/24 at 1:00 PM, observation of the facility's basement revealed a strong, pungent mildew smell as soon as you enter the basement from the central stairwell. The mildew smell was also prevalent throughout the entire stairwell. When asked if there had been any concerns with flooding, the Administrator reported they had a flood and the floor was pulled up and pointed to the patching along the flooring was about three months ago. The entire perimeter of the hallway was observed to have missing floor cove molding and was observed to have dark black, mold-like spongy debris that covered the entire bottom portion of the walls that went up the wall approximately one foot. The hallway was heavily cluttered along the entire length of the hallway with boxes and other resident care supplies stored directly on the floor with no barrier/pallet, and oxygen concentrators and other various resident equipment and facility supplies stored directly on the floor. When asked about the items, the Maintenance Director reported those items were the resident supplies that came yesterday and the central supply person was in the process of moving them. When asked if they should be stored on the floor, the Administrator reported, Should be on a pallet. There were several other bags, supplies, oxygen concentrators and equipment stored on both sides of the hallway. The laundry room was observed to have the clean area fire door propped open with a door stopper and suction machine. When asked about whether the door should be propped open, the Maintenance Director reported that (suction machine) was a machine that was to be returned. The Administrator reported the door should not be propped and directed the Maintenance Director to close the door. Upon exiting the laundry area, the same fire door was unable to be opened from the inside of the laundry room and the Maintenance Director reported the door gets really stuck and can't open. The Administrator reported they were not aware of that concern. When asked about the process for linens and if they notice holes or in disrepair, the Administrator reported they had a process it should be pulled and can replace them. They were informed of the observations of bed linens with holes and stains. The Administrator was asked about the current environmental concerns and when asked what they had done since they were out of compliance with similar concerns, they reported they had only focused on the specific resident and issues that were cited. On 5/15/24 at 8:10 AM, upon entering the facility's basement, the strong, pungent, mildew odor remained. There was now a large area of standing water near the middle of the hallway that continued into the Central Supply room. There was a box stored directly on the hallway floor filled with various shoes and slippers. The Central Supply room was propped open by an unopened cardboard box of tube feeding formula directly on the floor near the standing water and resting against the wall directly on the black, spongy substance. The cardboard box was observed saturated. The Central Supply room which contained various resident supplies (tube feeding supplies, nutritional supplements, wound care treatments, covid-19 tests, over-the-counter medications, briefs, wipes, etc.) was observed to have heavily soiled flooring with white splatters of unknown substance, cardboard boxes lined some of the flooring that had visible moisture and tan colored substance. There were multiple cardboard boxes of supplies stored directly on the floor: One box was labeled Fluid resistant procedure facemask with earloops; One box was labeled Non woven drain sponges; and one box was labeled Medline Suction Catheter Kit - 14 FR and one labeled Medline Plastic Translucent Cups. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Throughout these observations of the basement and Central Supply room, there were multiple gnats flying around. The electrical room was observed to be filled with bags, mattresses, paint containers and trash littered throughout the entire floor and room which were impeding access to the electrical panels. The bottom portion of the wall near the floor was covered with the same dark black, mold-like spongy substance. There was also an oxygen concentrator, bags of clothing and other unidentifiable items and garbage debris scattered throughout the floor of this room. On 5/15/24 at 8:20 AM, Housekeeper 'J' was observed walking down the hallway and when asked about the current conditions of the facility's basement, they confirmed the same observations. When asked about the standing water, they reported that was coming from the seepage in the wall from the facility's outside drainage system. When asked who was responsible for ensuring the flooring was kept clean, and supplies were maintained in sanitary condition, Housekeeper 'J' reported that was the Central Supply staff. At 8:25 AM, the Maintenance Director arrived to the basement and when queried about the current conditions, they confirmed the same concerns. When asked about the standing water, they reported that was from the external drainage system and the facility was doing a bid to fix it. When asked what was being done in the meantime to address the mold-like substance, they reported they had started in the area near the elevator shaft. Upon observing the elevator shaft area, there was continued concerns with the walls covered with the dark black, mold-like, spongy substance. This was also the area where the oxygen storage tanks were stored (both used and unused). When asked about the storage of various resident care, nutritional, and respiratory supplies/equipment in areas that were compromised by water damage, the Maintenance Director offered no further response. On 5/15/24 at 10:29 AM, during a phone interview with Staff 'L', when asked whether there were any concerns with the facility's environment, they reported concerns with linens in that although they were washed, they were still full of stains and smelled like sh** still. They further reported there were constant floods in the basement that had black mold and thought that might be why staff and residents were constantly sick with respiratory issues. When asked about the lighting in the shower rooms, Staff 'L' reported they don't have lights in the shower rooms. They reported the Administrator was notified about it and he brought them a flashlight to use for a shower. They reported the showers were disgusting and had mold as well. They also reported some of the rooms on the center Gold hall did not have functioning lights and the Administrator told them to use a lamp, which was not effective to see when residents needed to be checked and/or changed at night. On 5/15/24 at from 10:45 to 11:00 AM, additional observations of the environment were conducted with the Maintenance Director to check the facility's ventilation system in the bathrooms. Observations revealed there were multiple resident bathroom ceiling vents (in rooms 110/112 and 140/142) that were covered with a heavy accumulation of dust. The Maintenance Director reported the vents should've been cleaned as part of the daily housekeeping. Review of the facility policies provided by the Administrator revealed only one for cleaning of resident rooms and did not address all concerns identified above. 38271 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #810 On 5/14/24 at approximately 11:47 a.m., R810 was observed in their room, up in their wheelchair. R810 was queried regarding any concerns pertaining to the facility environment and mold in the bathrooms. R810 reported that the facility has two bathrooms offline due to them not working and mold growing in them. R810 reported that the bathrooms were the facility shower rooms. R810 also reported that usually the linen changes are not done timely but were actually done that morning but before that had not been done in a week. On 5/14/24 the medical record for R810 was reviewed and revealed the following: R810 was initially admitted to the facility on [DATE] and had diagnoses including Paraplegia. On 5/14/24 at approximately 12:14 p.m., the facility ice machine located in the main dining room on the first floor was reviewed and revealed that the log documenting that it had been cleaned internally was blank and not filled out for any months.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272 This citation pertains to intake #MI00140360. Based on interview and record review the facility failed to implement their grievance policy and promptly address, investigate, follow up, and resolve concerns reported to the facility staff for one (R816) of two residents reviewed for grievances. Findings include: Review of a complaint submitted to the State Agency (SA) on 10/23/23, documented in part, the resident's entire wardrobe has come up missing after going to the laundry even though her name was on her clothes . complainant states she has been contacting the corporate office since June 2023 with no response and has been leaving messages for the facility administrator since August (2023) and hasn't received a return call or follow-up. Review of the clinical record revealed R816 was admitted into the facility on [DATE] with diagnoses that included Alzheimer's Disease and Aphasia. According to the Minimum Data Set (MDS) assessment dated [DATE], R816 scored 14/15 on the Brief Interview for Mental Status exam (BIMS), which indicated intact cognition. On 5/15/24 at 9:55 AM an interview was conducted with the Administrator. When queried about what they recalled regarding missing items for R816, they reported that the missing items were returned to the resident and did not recall the family being issued a check for reimbursement, further stating that even if the reimbursement check came from the corporate office he would have to sign off on it. Review of Direct Check Request revealed the facility paid the complainant $188.04 for Reimbursement of lost clothing on 11/8/23 (approximately five months after the complainant reported to the facility and to the corporate office the items were missing). The facility never produced a copy of the original grievance form. Review of the facilities policy titled Resident and family Grievances updated 12/23, documented in part The facility will make prompt efforts to resolve grievances .Definitions: Prompt efforts to resolve include facility acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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 - Some	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** 38271 This citation pertains to intake #'s MI00141071, MI00142083 and MI00143861. Based on observation, interview and record review the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for five residents (R807, R808, R809, R810 and R819) of seven residents reviewed for abuse/neglect/mistreatment. Findings include: R807 and R808 On 5/14/24 a FRI (facility reported incident) submitted to the State Agency was reviewed which alleged R807 attempted to get into R808's bed, touch their leg and made inappropriate and sexual comments on 10/29/23. R807 On 5/14/24 the medical record for R807 was reviewed and revealed the following: R807 was initially admitted on [DATE] and had diagnoses including Dementia, Anxiety and legal blindness. R807's MDS with an ARD of 10/28/23 revealed a BIMS score of zero indicating severely impaired cognition. A Nursing progress note dated 10/29/23 revealed the following: Nursing Progress Note Late Entry: . Resident touched his roommate on his leg upsetting roommate who felt it was a sexual advance Responsible party notified , Physician notified, Administrator notified , DON (Director of Nursing) notified . Immediate intervention implemented: roommate moved to another room . R808 On 5/14/23 the medical record for R808 was reviewed and revealed the following: R808 was initially admitted on [DATE] and had diagnoses including repeated falls and epilepsy. R808's MDS with an ARD of 1/22/24 revealed R808 had a BIMS score of 11 indicating moderately impaired cognition. A progress note dated 10/29/24 revealed the following: .Practitioner Progress Notes Note Text: [R808] was seen in the therapy gym using the bike when writer approached him to say hi. [R808] was very upset, stating that another resident [R807] had been trying to get in his bed last night and was touching his leg. [R808] says he was saying things of a sexual nature to him as well. [R808] was very upset in the therapy gym using multiple expletives and said if he tries that again I'll kill him. DON notified. 10/30/2023 Nursing Progress Note Late Entry: resident was touched on his leg by another resident and he felt this was a sexual advance which made resident upset causing him to state If he does it again. Resident relocated to another room. Resident denies any injury, or pain at this time. Responsible party notified , Physician notified, Administrator notified , DON notified . Immediate intervention implemented: Resident moved to a new room. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/30/2023 20:05 Nursing Progress Note Approx (approximately) 1000 while writer was picking up breakfast trays resident stated last night my roommate tried to touch my leg and get in the bed with me and stated I wanna f you. Resident room was changed. All responsible parties notified. A facility investigation pertaining to the allegation involving R807 and R808 revealed the mandatory five day investigation was not submitted to the State Agency until 2/1/24. On 5/15/24 at approximately 1:29 p.m., The Administrator/Abuse Coordinator was queried regarding the extensive delay in submitting the mandatory five day investigation to the State Agency for review and they reported they did know why it was not submitted within the mandatory timeframe but that they did an audit in February and submitted the investigation on 2/1/24 as a result of the audit. 41415 R's 810 & 819 Review of a Facility Reported Incident (FRI) reported to the State Agency (SA) on 3/29/24, documented in part . The incident occurred March 29, 2024, resulting in (R819's name) . being transported to (hospital name) by (Emergency Medical Services- EMS name), accompanied by two police officers . (R810 name) and (R819 name) was involved in a physical altercation with another resident . During the altercation, (R819 name) was struck in the middle of his forehead with an unknown object. As a result of the impact . a knot the size of a golf ball on his forehead, which turned black and blue and was bleeding . complained of pain . The Administrator who also serves as the facility's Abuse Coordinator did not submit the results of a five-day follow-up investigation to the SA for this incident. Review of a Nursing progress note (R819) dated 3/28/24 at 11:50 PM, documented in part, . pt (patient) was transported to (hospital name) by (EMS name) and accompanied by two police officers. Pt was in a physical altercation with another pt (room number) and was hit in the middle of his forehead with an unknown object . pt had a knot the size of a golf ball that turned black and blue with bleeding . and had c/o pain . Pt remains in the hospital . This indicated the incident happened on 3/28/24, not 3/29/24 as submitted to the SA by the Administrator. The incident was reported to the SA a day later on 3/29/24. Review of a facility policy titled Abuse, Neglect and Exploitation (revised 6/23) documented in part, . Reporting of all alleged violations to the Administrator, state agency . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . Review of a hospital After Visit Summary dated 3/29/24, documented in part, . Reason for Visit- Assault Victim . Diagnosis- Forehead contusion, initial encounter . On 5/14/24 the Administrator provided the investigation file for the incident that involved R810 & 819. The investigation file did not contain statements from the perpetrator, victim, or any potential witnesses. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Incident Details contained in the file documented in part . On March 29, 2024, (R819 name) was involved in a physical altercation with (R810 name) . (R810 name) was interviewed to gather his account of the incident. He acknowledged the altercation but did not provide clear details on how (R819 name) was struck . (R819 name) will be interviewed upon his return to the facility to obtain his perspective on the incident (the file did not contain an interview from R819) . Staff members who were in proximity to (room number) during the incident were interviewed. They provided details about hearing raised voices and quickly intervening to separate the residents (the staff names are not identified in the investigation and the file contained no statements from these staff members) . Conclusion: No ill effects for (R810 name) . remains in the nursing facility with no ill effects related to the incident . Both residents will continue to be closely monitored to prevent future incidents and ensure their safety . Current protocols for managing resident conflicts and ensuring safety will be reviewed and reinforced . Both residents will be offered counseling and support services to address any emotional or psychological impacts from the incident . The investigation did not note the root cause of the altercation and never identified the weapon utilized in the altercation. On 5/15/24 at 8:07 AM, the Administrator was interviewed and asked if they provided the full investigation for R819 and 810 altercation and the Administrator confirmed they did. The Administrator was asked where the statements obtained from the victim and staff were and they stated they did not have statements from them, that everything obtained was done verbally. The Administrator was then asked the names of the staff that were interviewed, and the Administrator stated they would follow up with the requested information. No further information was provided before the end of the survey. On 5/15/24 at 8:11 AM, R819 was observed standing in their room listening to music from their television. When asked about the incident with R810, R819 stated I can't answer that. R819 was then asked if the altercation had something to do with narcotic medication, R819 confirmed the altercation was regarding R810 demanding to have R819's pain medication. R819 stated . I wasn't going to give it to him (R810), and he started pounding me, and I was getting some hits in as well . I just ended up with a black eye . R819 confirmed they felt safe in the facility. The Administrator omitted the root cause of the altercation when they submitted the incident to the SA. Review of R819's March 2024 Medication Administration Record (MAR) documented an order for Hydrocodone-Acetaminophen 7.5-325 mg (milligram) tablet, as needed every eight hours for back pain. R810 was hospitalized on [DATE] and was not available for an interview. Review of the medical record for R810 revealed a diagnosis of an Opioid Dependence. Review of a LATE ENTRY Social Service note dated 4/2/24 at 4:18 PM, documented in part, . Wellness visit: Resident states he feels safe in the facility. He is able to protect himself. He is not worried about other residents. He reported he was not going to give his pain meds (medication) to another resident, because I need them. Resident states he did not have any concerns at this time . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/24 at 9:07 AM, the Social Service (SS) A personnel was interviewed and asked if their 4/2/24 note documented on 4:18 PM, was regarding the incident with R's 819 and 810 and SS A confirmed it was. When asked about the giving away of pain medication sentence, SS A reviewed their note and then stated they were informed at the morning meeting that (R810 name) had asked (R819 name) for their pain medications and (R819) did not want to give it to (R810). SS A explained that all of the Administration team including the Administrator and physicians attended the morning meeting. SS A was then asked what interventions have been implemented to prevent R810 to harass, threaten or physical abuse any other resident for their pain medications moving forward, and SS A did not provide an answer. On 5/15/24 at 9:32 AM, the Administrator and Director of Nursing (DON) was interviewed together and asked who the Abuse Coordinator for the facility was and the Administrator confirmed they were. When asked about the actual day the incident occurred between R's 819 and 810, the Administrator reviewed their file and stated March 29th, 2024. At that time the Administrator was read the note regarding the incident to have occurred on 3/28/24 and was asked why the incident was reported the next day and not timely to the SA, and the Administrator confirmed the incident should have been reported the same day to the SA. When asked why the altercation occurred between R's 819 & 810, the Administrator stated (R819 name) alleged (R810 name) wanted (R819) pain pills. When asked why they omitted that information on the incident submitted to the SA, the Administrator did not provide an answer. No further explanation or documentation was provided before the end of the survey. 49272 R809 Review of a Facility Reported Incident (FRI) reported to the State Agency (SA) on 12/27/23, documented in part .Staff reported that resident (R810 name) was in the hallway when resident (R809 name) approached him and they began to argue. During that time both residents made physical contact with each other. Staff immediately intervened and both residents were immediately separated .When (date and time) did the problem occur? 12/26/23 Review of a Nursing Progress note for R809 dated 12/26/23, documented in part Late Entry: Note: resident made physical contact with resident in (R810's room number). Resident was in hallway close to front door during the time of incident. Resident was separated and educated on the importance of not getting physically aggressive towards other residents or staff. Police was called and arrived @2201 . A review of the facility investigation pertaining to the allegation involving R809 and R810 revealed the mandatory five-day investigation was not submitted to the State Agency until 2/1/24 and the original FRI report was submitted one day after the incident occurred. On 5/15/24 at approximately 1:29 p.m., The Administrator/Abuse Coordinator was queried regarding the delay in submitting the mandatory five-day investigation to the State Agency for review and they reported they did know why it was not submitted within the mandatory timeframe. They then admitted an audit was completed in February and the facility submitted the investigation on 2/1/24 as a result of the audit. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facilities policy titled Abuse, Neglect and Exploitation updated 6/23, documented in part .The facility will implement the following: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within the specified timeframes .Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .

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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** 41415 This citation pertains to intake(s): MI00141071, MI00142083 & MI00143861. Based on observations, interviews, and record reviews the facility failed to ensure thorough investigations were completed for alleged allegations of abuse, failed to ensure the prevention of further potential abuse, and failed to timely submit the results of the investigations to the State Agency (SA) within five working days of the incident for five (R's 810, 819, 807, 808 & 809) of seven residents reviewed for abuse. Findings include: R810 & R819 Review of a Facility Reported Incident (FRI) reported to the State Agency (SA) on 3/29/24, documented in part .The incident occurred March 29, 2024, resulting in (R819's name) .being transported to (hospital name) by (Emergency Medical Services- EMS name), accompanied by two police officers .(R810 name) and (R819 name) was involved in a physical altercation with another resident .During the altercation, (R819 name) was struck in the middle of his forehead with an unknown object. As a result of the impact .a knot the size of a golf ball on his forehead, which turned black and blue and was bleeding .complained of pain . The Administrator who also serves as the facility's Abuse Coordinator did not submit the results of a five-day follow-up investigation to the SA for this incident. Review of a Nursing progress note (R819) dated 3/28/24 at 11:50 PM, documented in part, . pt (patient) was transported to (hospital name) by (EMS name) and accompanied by two police officers. Pt was in a physical altercation with another pt (room number) and was hit in the middle of his forehead with an unknown object . pt had a knot the size of a golf ball that turned black and blue with bleeding .and had c/o pain .Pt remains in the hospital . Review of the Incident Details contained in the file documented in part .On March 29, 2024, (R819 name) was involved in a physical altercation with (R810 name) .(R810 name) was interviewed to gather his account of the incident. He acknowledged the altercation but did not provide clear details on how (R819 name) was struck .(R819 name) will be interviewed upon his return to the facility to obtain his perspective on the incident (the file did not contain an interview from R819) .Staff members who were in proximity to (room number) during the incident were interviewed. They provided details about hearing raised voices and quickly intervening to separate the residents (the staff names are not identified in the investigation and the file contained no statements from these staff members) .Conclusion: No ill effects for (R810 name) .remains in the nursing facility with no ill effects related to the incident .Both residents will continue to be closely monitored to prevent future incidents and ensure their safety .Current protocols for managing resident conflicts and ensuring safety will be reviewed and reinforced .Both residents will be offered counseling and support services to address any emotional or psychological impacts from the incident . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 the Administrator provided the investigation file for the incident that involved R810 & R819. The investigation file did not contain statements from the perpetrator, victim, or any potential witnesses. The investigation did not note the root cause of the altercation and never identified the weapon utilized in the altercation. On 5/15/24 at 8:07 AM, the Administrator was interviewed and asked if they provided the full investigation for R819 and R810 altercation and the Administrator confirmed they did. The Administrator was asked where the statements obtained from the victim and staff were and they stated they did not have statements and that everything obtained was done verbally. The Administrator was then asked the names of the staff that were interviewed, and the Administrator stated they would follow up with the requested information. No further information was provided before the end of the survey. On 5/15/24 at 8:11 AM, R819 was observed standing in their room listening to music from their television. When asked about the incident with R810, R819 stated I can't answer that. R819 was then asked if the altercation had something to do with narcotic medication, R819 confirmed the altercation was regarding R810 demanding to have R819's pain medication. R819 stated . I wasn't going to give it to him (R810), and he started pounding me, and I was getting some hits in as well .I just ended up with a black eye . R819 confirmed they felt safe in the facility. R810 was hospitalized on [DATE] and was not available for an interview. Review of the medical record for R810 revealed a diagnosis of an Opioid Dependence. Review of R810's care plans revealed no intervention implemented to prevent further incidents of verbal and/or physical aggression to other residents with attempts to obtain their pain medications. On 5/15/24 at 9:32 AM, the Administrator and Director of Nursing (DON) was interviewed together and asked who the Abuse Coordinator for the facility was and the Administrator confirmed they are. When asked who completed the investigation for the incident with R's 810 & 819, the Administrator confirmed they had. When asked about the actual day the incident occurred between R's 819 and 810, the Administrator reviewed their file and stated March 29th, 2024. At that time the Administrator was read the note regarding the incident to have occurred on 3/28/24 and the Administrator acknowledged 3/28/24 to have been the correct date of the alleged incident. When asked why the altercation occurred between R's 819 & 810, the Administrator stated (R819 name) alleged (R810 name) wanted (R819) pain pills. When asked why they omitted that information on the incident submitted to the SA, the Administrator did not have an answer. The Administrator and DON was then asked what was implemented to prevent R810 to impulsively display verbal and physical aggression against any other resident in attempts to obtain their pain medications and the Administrator stated R810's behavior had been getting better and they have met with the Ombudsman to help transition R810 back to the community. The Administrator was again asked what interventions the facility's Interdisciplinary team implemented to prevent R810 potentially abusing any other resident for their pain medications, and the Administrator stated they moved R810's room and explained to R810 that they are working with the local law enforcement and if it happens again the resident will be detained. At 1:28 PM, a follow-up interview was conducted with the Administrator, and they were asked why they never submitted a five-day follow-up to the SA, and the Administrator stated they normally do and was unsure but would check into it and follow back up. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further explanation or documentation was provided before the end of the survey. 38271 R807 and R808 On 5/14/24 a FRI (Facility Reported Incident) submitted to the State Agency was reviewed which alleged R807 attempted to get into R808's bed, touch their leg and made inappropriate and sexual comments on 10/29/23. R807 On 5/14/24 the medical record for R807 was reviewed and revealed the following: R807 was initially admitted on [DATE] and had diagnoses including Dementia, Anxiety and legal blindness. R807's MDS with an ARD of 10/28/23 revealed a BIMS score of zero indicating severely impaired cognition. A Nursing progress note dated 10/29/23 revealed the following: Nursing Progress Note Late Entry: . Resident touched his roommate on his leg upsetting roommate who felt it was a sexual advance Responsible party notified , Physician notified, Administrator notified , DON (Director of Nursing) notified . Immediate intervention implemented: roommate moved to another room . R808 On 5/14/23 the medical record for R808 was reviewed and revealed the following: R808 was initially admitted on [DATE] and had diagnoses including repeated falls and epilepsy. R808's MDS with an ARD of 1/22/24 revealed R808 had a BIMS score of 11 indicating moderately impaired cognition. A progress note dated 10/29/24 revealed the following: .Practitioner Progress Notes Note Text: [R808] was seen in the therapy gym using the bike when writer approached him to say hi. [R808] was very upset, stating that another resident [R807] had been trying to get in his bed last night and was touching his leg. [R808] says he was saying things of a sexual nature to him as well. [R808] was very upset in the therapy gym using multiple expletives and said if he tries that again I'll kill him. DON notified. 10/30/2023 Nursing Progress Note Late Entry: resident was touched on his leg by another resident and he felt this was a sexual advance which made resident upset causing him to state If he does it again. Resident relocated to another room. Resident denies any injury, or pain at this time. Responsible party notified , Physician notified, Administrator notified , DON notified . Immediate intervention implemented: Resident moved to a new room. 10/30/2023 20:05 Nursing Progress Note Approx (approximately) 1000 while writer was picking up breakfast trays resident stated last night my roommate tried to touch my leg and get in the bed with me and stated I wanna f you. Resident room was changed. All responsible parties notified. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility investigation pertaining to the allegation involving R807 and R808 revealed the following: Incident Description: [R808] reported an incident that occurred during the previous night involving another resident, [R807]. [R808], while in the therapy gym, was approached by a staff member and expressed his distress over the incident. He stated that [R807] had tried to get into his bed and attempted to touch his leg, making inappropriate and sexual comments. This caused [R808] significant upset, leading to his use of multiple expletives in the gym. Upon hearing the report, immediate action was taken to address [R808's] distress. He was provided with a room change to ensure his sense of safety and comfort On the Administrator spoke with [R808] on the day of the incident to gather further details about the incident. [R808] reiterated that [R807's] actions and comments had made him uncomfortable and upset. Despite recognizing that [R807] might have been confused, [R808] found the situation distressing. During the interview, [R808] acknowledged his comment in the therapy emphasized that he did not want [R807] touching him but expressed feeling safe in his new room. Assessment of [R807]: An assessment was conducted to understand [R807's] behavior and mental state. Given his diagnoses of anxiety, schizophrenia, and dementia, it was considered that his actions could have been a result of confusion rather than malicious intent. Staff Interviews: Interviews with staff members present during the incident in the therapy gym and those involved in the room change were conducted. Staff confirmed [R808's] distress and his subsequent calming after the room change Further review of the facility provided investigation did not reveal any staff interviews or statements pertaining to the incident. There were also no other resident interviews to determine if R807 had displayed with same behaviors with any other residents that resided in the proximity to R807. On 5/15/24 at approximately 9:01 AM, during a conversation with the Administrator/Abuse Coordinator, The Administrator was queried regarding the lack of staff and resident interviews in the facility provided investigation and they indicated that having those interviews is part of the investigation and did not know why they did not have any of them completed for the incident between R807 and R808. 49272 R809 Review of a Facility Reported (FRI) reported to the State Agency (SA) on 12/27/23, documented in part .Staff reported that resident (R810 name) was in the hallway when resident (R809 name) approached him and they began to argue. During that time both residents to make physical contact with each other. Staff immediately intervened and both residents were immediately separated .When (date and time) did the problem occur? 12/26/23 Review of a Nursing Progress note (R809) dated 12/26/23, documented in part Late Entry: Note: resident made physical contact with resident in (R810's room number). Resident was in hallway close to front door during the time of incident. Resident was separated and educated on the importance of not getting physically aggressive towards other residents or staff. Police was called and arrived @2201 . On 5/14/24 the Administrator provided the investigation file for the incident that involved R809 and R810. The investigation file did not contain statements from the perpetrator, victim, or any potential witnesses. The investigation did not include any details of the mentioned physical contact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/24 at 8:07 AM, the Administrator was interviewed and asked if they provided the full investigation for R809 and R810's altercation and the Administrator confirmed they did. The Administrator was asked where the statements obtained from the victim and staff were and they stated they did not have statements and that everything obtained was done verbally. The Administrator was then asked the names of the staff that were interviewed, and the Administrator stated they would follow up with the requested information. Review of the facility policy titled Abuse, Neglect and Exploitation updated 6/23, documented in part An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .Investigations may include bur 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, Providing complete and thorough documentation of the investigation .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to .Responding immediately to protect the alleged victim and integrity of the investigation.

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	235664	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 38271 This citation pertains to intake #MI00142887 Based on observation, interview and record review the facility failed to prevent an unauthorized exit from the facility and appropriately assess for elopement risk for one resident (R813) of seven residents reviewed for accidents/supervision. Findings include: On 5/14/24 a facility reported incident (FRI) that was submitted to the State Agency was reviewed which alleged R813 eloped from the facility on 2/13/24 without knowledge of the facility staff and was found across a major five lane street displaying symptoms of intoxication. On 5/14/24 at approximately 11:55 a.m., R813 was observed in their room, laying in their bed. R813 was queried regarding their elopement on 2/13/24 and they reported that they wheeled themselves to the front desk and asked a staff person if they could go out and the staff person informed them that they did not care what they did so they signed out and left and indicated they did not remember much after that except the police were involved. On 5/14/24 the medical record for R813 was reviewed and revealed the following: R813 was initially admitted to the facility on [DATE] and had diagnoses including Disorganized Schizophrenia, Delusional Disorders and Wernicke's Encephalopathy. A review of R813's Minimum Data Set with an ARD of 2/6/24 revealed R813 was independent with most of their activities of daily living. R813's Brief Interview for Mental Status score was 15 indicating an intact cognition. R813 was noted to have a court appointed legal guardian. An IDT (Interdisciplinary Team) Review note dated 2/14/2024 revealed the following: Discussed resident at risk r/t (related to) recent elopement from facility and alcohol intoxication resident was educated that he cannot leave facility unassisted or without guardian permission, he voices wanting to reverse his guardianship however this was attempted previously and psych did not give clearance. IDT determined that a room change is feasible for resident to decrease future attempts . An elopement assessment dated [DATE] completed by a facility Nurse was reviewed and revealed R813 was deemed not at risk for elopement. Further review of the elopement assessment revealed the staff member inaccurately completed the assessment when they indicated that R813 had not made one (1) or more attempts to elope from either the previous or current residence in the past ninety (90) days . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided investigation pertaining to R813's elopement revealed the following: Resident Signed himself out at 2:55pm according to the Release of responsibility for leave of absence on dated and located at the front desk 2/13/2024 & went out without staff knowledge. Until At approximately 3:30pm police arrived at the nursing facility to report [R813] had been located across the street and that he was intoxicated and that he needed to be transported back to the nursing facility. Shortly after the administrator and driver arrived at the location of the resident. When the facility administrator arrived at the location of the incident, the ambulance was on the scene and stated that the they were not taking the resident to the hospital and that he should be taken back to the nursing home facility and provided with fluids. At that time the facility administrator arranged for the facility transportation to pick up the resident and transport him back to the facility. According to witness statement collected during the investigation the last staff member had seen [R813] between 2-2:30pm. Upon the resident arrival back to the facility Nurse [Name of R813's Nurse] Registered nurse reported - assessed for injuries, no injuries noted no sis (signs or symptoms) of pain or resp (respiratory) distress on arrival vs (vital signs) checked .[R813's Physician] notified, order to encourage fluid Guardian office notified talked to [Legal guardian], Administrator also aware about the incident will cont (continue). plan of care. Upon the residents arrival back to the facility [Name of Physician] resident was seen via telehealth and was physician noted the following: Patient was seen by video conferencing-with help of the nurse on duty /telehealth services rendered using DOXIMITY video conferencing site chief complaints/History of present illness Patient found outside the building/picked up by the police-going in his wheelchair. Likely patient had left the premises without informing anyone. Patient was inebriated/ brought back to the building- at [Name of facility]-all the vital signs are stable appears very intoxicated and not able to speak normally Review of systems does have hx (history) of alcohol abuse with no recent alcohol use or attempts at obtaining alcohol noted since admission to [name of facility] lab results / investigations /blood sugars Physical exam MS (mental status) - clearly appears intoxicated and not able to answer questions Vital signs stable On 5/14/24 at approximately 12:47 p.m., MDS Nurse H was queried regarding the Physician's order they created on 2/15/24 with an order date of 2/1/24 which indicated R813 could go to on LOA (leave of absence) . MDS Nurse H Stated they made an error when creating the order and the order date should have been 2/15/24 and not 2/1/24 and was the result of a care conference with the legal guardian on 2/15/24 in which the guardian gave permission for R813 to go on leave of absence with a facility staff member provided supervision. MDS Nurse H clarified that at the time of R813's elopement on 2/13/24 they did not have a Physicians order to leave the facility unattended by any facility staff. On 5/14/24 at approximately 1:11 p.m., during a conversation with R813's guardianship agency, the legal representative for R813 was queried if R813 had been permitted to leave the facility unattended on 2/13/24 and they indicated that they had never provided any instructions or permission for R813 to be outside the facility, unsupervised. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at approximately 2:38 p.m., the facility Administrator was queried regarding R813's elopement on 2/13/24. They Indicated that the police department had notified them that R813 was intoxicated and that the EMS (Emergency Medical System) had evaluated them and did not take them to the hospital. The Administrator indicated that R813 had signed themselves out without staff knowledge and as far as they knew, nobody was at the front desk supervising who went in or out. The Administrator indicated that R813 went out the door and was thought to have engaged the front door safety bar that must be pushed for 15 seconds until the door becomes unlocked. The Administrator indicated R813 was found across a major road slurring their words and appeared intoxicated. The Administrator was queried if R813 had permission to leave the facility unattended and they reported they did not. The Administrator was queried why R813 was assessed as not an elopement risk via the elopement assessment done on 5/5/24 and they indicated that the Nurse that did that assessment did it incorrectly and that R813 was on their elopement risk awareness program. On 5/15/24 a facility document titled Elopements and Wandering Residents was reviewed and revealed the following: Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk 4. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 5. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 6. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00141144. Based on observation, interview and record review, the facility failed to maintain sanitary conditions in the kitchen, label/date food items, and discard expired food items. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: Review of a complaint reported to the State Agency included allegations with food and kitchen maintenance. On [DATE] at 9:30 AM, observation of the facility's kitchen was conducted with the Dietary Manager (DM 'B') who reported they had worked at the facility for [AGE] years, and had been in their current role for two years. The reach-in refrigerator contained a large plastic container of yellowish orange liquid that had a sticker on the top that read it was prepared on ,d+[DATE] and to use by ,d+[DATE]. DM 'B' reported they had missed that when going through the refrigerator earlier. The walk-in freezer had a plastic tray stored on the top freezer shelf with three slices of cream pie that were uncovered and unlabeled/dated. DM 'B' reported that should not have been put in there like that. Review of the menu for the lunch meal for [DATE] included fried chicken and potato salad. DM 'B' reported there was no potato salad, and instead they were going to serve diced potatoes. The three-compartment sink was observed with a faucet that was running water over contents in a large stainless-steel bin. Upon further observation, the food that was being thawed by the running water were two large bags of frozen diced potatoes with a manufacturer's use-by date of [DATE] on each bag. The compartment to the right of the frozen food was observed to have several cleaning supplies including a container of (name brand bleach mildew remover) and several other storage buckets. Throughout the entire kitchen, the flooring was observed to have several sticky areas (shoes sticking to floor) and various debris, the walls near the juice machine were observed to have visible splatters on the surrounding wall tile and box of juice concentrate stored below the juice machine. DM 'B' was asked about the thawing of the diced potatoes in the three-compartment sink and whether that should be occurring and reported no, the diced potatoes should've been pulled out of the freezer a couple days in advance and then thawed in the refrigerator. When asked why they were still in use if the manufacturer's date indicated it was good until [DATE], DM 'B' reported they should have not been used was unable to offer any further explanation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When asked about who was responsible for maintaining the cleaning of the flooring in the kitchen, DM 'B' reported they mopped daily and at night but a thorough cleaning had not been done for a while. When asked who would do the thorough cleaning, DM 'B' reported that was supposed to be done by Maintenance. According to the 2017 FDA Food Code section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, .(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the 2017 FDA Food Code section ,d+[DATE].17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 30675 This citation pertains to intake #s MI00141144, MI00143525, and MI00144073. Based on observation, interview and record reviews, the facility failed to ensure appropriate infection control practices with regards to linen storage. This deficient practice has the potential to affect all residents in the facility. Findings include: Review of multiple complaints reported to the State Agency included concerns with infection control practices and linens. On 5/14/24 at 10:00 AM, the Administrator was asked to observe the environment. On the 1 East unit, there were three linen carts observed in the hallway. The medium sized linen cart was covered with a pink cover that was ill-fitted and there was a large rip which exposed the contents of the cart. Further observation of the contents stored inside the cart revealed multiple other non-linen items stored within the cart including briefs, gloves, wipes, lotions, and cleansers. The Administrator reported they had just received the new linen covering this week and reported the wrong size may have been ordered and proceeded to try to fit the cover in place. When asked if there should be any items other than linens stored on the linen cart, the Administrator reported there should be nothing else stored on there. On the 1 [NAME] unit, there were two linen carts. Observation of the larger linen cart revealed there were several non-linen items stored on the cart which included resident clothing, wipes, lotions, cleansers, and a turquoise-colored denture container that was not labeled and contained a clear, gooey substance. The Administrator asked staff passing by whose clothing those were and the staff reported they were community clothes and when the Administrator asked about the substance in the container, the same staff reported they weren't sure but was like that when they came on shift. Observation of the smaller blue linen cart revealed there were also several non-linen items stored on the cart which included briefs and wipes. According to the facility's policy titled, Infection Prevention an Control Program dated 1/2024: .Laundry and direct care staff shall .store .linens to prevent the spread of infection .Clean linen shall be delivered to resident care units on covered linen carts with covers down .Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 30675 This citation pertains to intake #MI00143431. Based on observation and interview, the facility failed to ensure that essential electrical equipment was maintained in safe operating condition. This has the potential to affect multiple residents throughout the facility. Findings include: On 5/14/24 at 9:25 AM, the exit signage on the ceiling was observed dangling by a wire and the entire sign hung down with the arrow to the exit pointing towards the inside of the facility (away from the exit door). On 5/14/24 at 9:30 AM, an observation of the kitchen was conducted with the Dietary Manager (DM 'B'). When asked if there were any electrical concerns, or equipment not working in the kitchen, the DM reported their steamer had been down, was waiting on a new part, and further reported this was previously cited during the annual survey in October 2023. Observation of an outlet on the wall located to the left of the steamer was observed to have brown stain on the top outlet with what appeared to be from electrical/fire damage. When asked about the outlet and whether it was used, DM 'B' reported they did and had no issues. When asked if anyone had reported any concerns with anything such as an electrical fire in the outlet, they reported no. DM 'B' confirmed the current state of the outlet and further reported they had not noticed the outlet looking like that until just now. On 5/14/24 at 9:51 AM, observation of the only ice machine was conducted with DM 'B'. The ice machine is located in a small room just off the main dining room. Upon entering the room, the lighting was very low and the ceiling light was pink in color with only one of the two fluorescent lights functioning. There was water observed all over the floor, a soiled blanket wadded up on the floor. There was what appeared to be an external filter unit secured to the wall to the left of the ice machine that had no filter, and there was a long tube hanging down, not connected to the ice machine. The machine contained manufacturer label that read, Ecolab - Managed Water Quality Program. The ice machine itself (had a manufacturer label for Manitowoc) had a log taped to the left side of the machine that prompted staff to document when it had been cleaned - the log was empty. The ice machine was observed to have two dispensers, one for ice and one for water. Just under the dispensers was a metal grate to rest cup on which was covered in thick build-up of white, black and gray debris and the metal grate was peeling away to expose rusted metal underneath. The outside front of the ice machine was covered in white scaly debris. When asked who maintained cleaning of the ice machine and filter, the DM deferred to the Maintenance Director. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 at 9:55 AM, the Administrator, DM 'B', and the Maintenance Director returned to the ice machine room and confirmed the same observations. When asked about the current conditions, the Administrator reported he had not been aware of the state of the room. When asked to see the ice machine filter, the Maintenance Director reported there was an issue and the unit secured to the wall was an external filter in which Ecolab had been out and stated, Was out here, supposed to come back and put in filter, but didn't come back to replace. The Administrator reported they thought the ice machine had an internal filter and was requested to follow-up to confirm. (There was no additional documentation or follow-up about the ice machine provided by the end of the survey.) When asked about whether they thought the ice machine was in sanitary condition to provide ice, the Administrator reported, Shouldn't be like that. There was no documentation of any policies for maintaining essential care equipment provided for review by the end of the survey.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 30675 This citation pertains to intake #MI00141144. Based on observation, interview and record review, the facility failed to maintain an effective pest control program, resulting in visible gnats in the rooms of R814, R815, and throughout the entire facility. Findings include: Observations included: On 5/14/24 at 9:25 AM, the exit door leading to the center courtyard was observed to have a bottom door seal that was broken (not properly sealed) which the outside light and walkway was visible from inside (approximate open area of one inch missing). There were multiple observations of gnats throughout the facility hallways, stairwells, resident rooms, kitchen, dining rooms, and employee offices. On 5/14/24 at 9:30 AM, an observation of the facility's kitchen was conducted with the Dietary Manager (DM 'B'). Throughout the entire kitchen, the flooring was observed to have several sticky areas (shoes sticking) and garbage debris, the walls near the juice machine were observed to have visible splatters on the surrounding wall tile and box of juice concentrate stored below the juice machine; there were gnats observed throughout the kitchen as well including in the walk-in refrigerator, meal prep area, and dish room. When asked about the concern with the gnats and what had been done, DM 'B' deferred to the Maintenance Director and offered no explanation. On 5/14/24 at 10:00 AM, the Administrator was asked about the improper door seal leading to the central courtyard and confirmed the same observation. They reported the door seal would have to be replaced. (This had been identified as a concern during the pest control service on 2/26/24, 3/25/24, and 4/22/24 and as of this survey has not been addressed.) On 5/14/24 at 12:13 PM, R815 was observed laying in bed. During this interview, there were several gnats observed flying around the resident's bed and throughout the room. On 5/14/24 at 12:26 PM, R814 was observed laying in bed and agreed to an interview. During this interview, there were several gnats flying around the resident. They reported that was a nuisance and had been a problem for a while now. On 5/14/24 at 1:22 PM, the Administrator was requested to provide pest control logs and reports since October 2023 (previous recertification). (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/15/24 at 8:10 AM, upon entering the facility's basement, the strong, pungent, mildew odor remained. There was now a large area of standing water near the middle of the hallway that continued into the Central Supply room. There was a box stored directly on the hallway floor filled with various shoes and slippers. The Central Supply room was propped open by an unopened cardboard box of tube feeding formula directly on the floor near the standing water and resting against the wall directly on the black, spongy substance. The cardboard box was observed saturated. The Central Supply room which contained various resident supplies (tube feeding supplies, nutritional supplements, wound care treatments, covid-19 tests, over-the-counter medications, briefs, wipes, etc.) was observed to have heavily soiled flooring with white splatters of unknown substance, cardboard boxes lined some of the flooring that had visible moisture and tan colored substance. There were multiple cardboard boxes of supplies stored directly on the floor: One box was labeled Fluid resistant procedure facemask with earloops; One box was labeled Non woven drain sponges; and one box was labeled Medline Suction Catheter Kit - 14 FR and one labeled Medline Plastic Translucent Cups. Throughout these observations of the basement and Central Supply room, there were multiple gnats flying around. Review of the documentation provided revealed although there were monthly pest control visits, there was no documentation provided of any facility pest control logs maintained by the facility such as staff or resident reports of concerns with insects/pests such as gnats provided by the end of the survey. The pest control report for 2/26/24 identified Structural concerns that could cause pest problems that read: .Front Door - Introduction Point - hole/gap noted Gap under door . The pest control reports for 3/25/24, 4/22/24 identified Structural concerns that could cause pest problems that read: Front Door - Introduction point - hole/gap noted Gaps between and on bottom of doors Exclusion measures here will reduce the number of pests entering the area .Rear Door .hole/gap noted Gaps under door in kitchen .Side Door .hole/gap noted Gap under door (no specific location was identified) . The facility was requested for a facility policy for pest control, however there was no documentation provided by the end of the survey.