

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Grandville		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 Wilson Ave Grandville, MI 49418	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410</p> <p>Based on interview and record review, the facility failed to monitor a diabetic resident's blood sugars with insulin administration for 1 resident (Resident #105) of 3 residents reviewed for diabetic care, resulting in the potential for unnoticed hyperglycemia and hypoglycemia and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #105 admitted to the facility on [DATE] with pertinent diagnoses which included diabetes mellitus and congestive heart failure.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 2/24/2024 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #105 was moderately cognitively impaired.</p> <p>Review of Resident #105's May 2024 blood sugar documentation in the electronic medical record revealed blood sugar checks were being performed once a day in April of 2024 and then stopped on May 3, 2024 with no blood sugars being taken from May 3, 2024 through May 9, 2024.</p> <p>Review of Resident #105's May 2024 Medication Administration Record (MAR) revealed his order for Admelog (short-acting insulin) was discontinued on 5/1/2024. Further review revealed Resident #105 continued to receive 20 units of insulin glargine (long-acting insulin) every morning from May 3, 2024 through May 9, 2024 without blood sugar monitoring.</p> <p>Review of Resident #105's Progress Notes, dated 5/1/2024 at 12:13 PM, revealed Physician J reviewed Resident #105's blood sugar documentation and made adjustments to his insulin orders because of consistently low fasting blood sugar levels. Further review revealed that he decreased the Lantus (insulin glargine) dose to 20 units every morning and stopped the Admelog. Further review revealed Physician J wanted blood sugar monitoring to continue.</p> <p>In an interview on 5/22/2024 at 3:00 PM, Physician J reviewed his documentation from 5/1/2024 and reported he stopped Resident 105's short acting insulin on 5/1/2024 but wanted to continue blood sugar monitoring as resident continued to receive long-acting insulin. Upon further review of the electronic medical record, Physician J reported the order for blood sugar checks was connected to the Admelog order that he discontinued on 5/1/2024. Physician J stated, You have uncovered a process issue. We will have to discuss this at the team meeting.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/22/2024 at 3:10 PM, Licensed Practical Nurse (LPN) H reported nursing staff should check blood glucose levels prior to administering insulin. LPN H stated, I would never give insulin whether long-acting or short-acting without a blood sugar check . If I had an order for insulin without a blood sugar check, I would contact the medical provider.</p> <p>In an interview on 5/22/2024 at 3:15 PM, former Director of Nursing (DON) A stated she was absolutely concerned that blood sugar checks were not performed that were intended by the physician. DON A reported she instructed nursing staff that blood sugar checks were a vital sign and did not need a physician order to check. DON A reported there was apparently a communication issue between medical providers and nursing staff that she would investigate.</p> <p>In an interview on 5/23/2024 at 10:50 AM, Resident #105 reported the medical providers had been making adjustments to his insulin orders. Resident #105 reported his blood sugar checks were stopped and restarted and he did not remember staff discussing this with him.</p> <p>In an interview on 5/23/2024 at 12:11 PM, former DON A reported she investigated Resident 105's blood sugars and determined the order to monitor blood sugar levels was accidentally stopped when Physician J discontinued the short acting insulin order on 5/1/2024.</p> <p>Review of facility policy/procedure Diabetic Management: Hyper/Hypoglycemic Events, revised January of 2024, revealed .Residents with diabetes mellitus will be monitored and treated for hypoglycemia and/or hyperglycemia according to Clinical Practice Guidelines and per physician orders .</p>