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 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Grandville	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)

F 0604

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31771

This citation pertains to MI00147646

Past Non-Compliance was determined appropriate by the state agency for this citation. Plan outlined below.

Based on interview and record review the facility failed to protect the resident's right to be free of Abuse from physical restraints for one resident (R101) of six residents reviewed for abuse.

Findings:

Review of the Facility Reported Incident (FRI) revealed on the morning of 10/15/24 in the Garden Unit R101 was discovered by oncoming staff to be tightly wrapped in a blanket from the waist down preventing freedom of movement. The FRI reflected the assigned staff member had left the facility without notifying the nurse on duty and before the oncoming shift had arrived.

Review of the medical record reflected R101 admitted to the facility 2/19/18 with pertinent diagnoses that included Alzheimer's Disease, Dementia, and Anxiety. Review of the Minimum Data Set (MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 5 indicating R101 is severely cognitively impaired. This MDS also reflected R101 was incontinent and had displayed rejection of care and behaviors toward others. The Care Plan for R101 reflected one to two staff are required to check and change (incontinence briefs).

On 10/29/24 at 9:25 AM an interview was conducted with Certified Nurse Aide (CNA) G in a Conference room. CNA G reported when she arrived for her shift on 10/15/24 at approximately 6:00 AM she went to the Garden unit to get report from CNA D who was assigned the night shift. CNA G reported she learned the previous CNA had left early so she began resident rounds. CNA G reported when she checked R101 she lifted the top blanket to discover the Resident was wrapped tightly in a blanket from the waist down. CNA G reported she could not get her fingers between the blanket and the Resident's skin without causing pain. CNA G reported that R101 cannot communicate well but she recognizes pain. CNA G reported she summoned Licensed Practical Nurse (LPN) C before removing the blanket. CNA G reported she had to roll R101 side to side to get the blanket from around her without causing pain. CNA G reported R101 was wet, and the incontinence brief was on backwards. CNA G reported R101 has a history of being a digger on her brief and will dig out the brief lining. CNA G reported that R101 was not able to say how she ended up with the blanket wrapped tightly around her.

(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

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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	

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 9:59 AM a telephone interview was conducted with LPN C. LPN C acknowledged being called to the room of R101 by CNA G. LPN C reported that R101's arms were free but that her lower body was wrapped in a blanket like when you swaddle a baby really tight. LPN C reported after ensuring R101 was not injured she informed the Nursing Home Administrator (NHA) and the Director of Nursing (DON) of the findings. LPN C reported R101 is a regular check and change and, in her experience, R101 has never used the call light. On 10/29/24 at 10:13 AM a telephone interview was conducted with LPN B. LPN B reported she was in an all-staff meeting following her night shift that included covering the Garden Unit and another hall. LPN B reported she had been in the room of R101 between 4:00 and 5:00 AM and that R101 was sleeping and covered with a blanket. LPN B reported that CNA D did not inform her she was leaving before the end of her shift. On 10/29/24 at 10:25 AM an interview was conducted with the DON. The DON reported she was in an all-staff meeting when LPN C informed her that R101 was found in bed restrained by a blanket. The DON reported staff interviews began immediately. The DON reported that staff training on Abuse and Restraints were added to the all-staff meeting in progress and added to the other all-staff meetings slated for later that day. On 10/29/24 at 10:36 AM an interview was conducted with the NHA. The NHA reported on the morning of 10/15/24 she was informed by LPN C about how R101 was found that morning. The NHA reported an investigation was immediately started, staff were interviewed, and all notifications were made including to the state agency. The NHA reported staff education began that morning and continued until all staff received the education. The NHA reported CNA D left her assignment without the knowledge or permission of her immediate superior:the nurse on duty. The NHA reported that proper CNA shift change resident to resident rounds were not completed. The NHA explained that oncoming and off going CNA's are to round with each other room to room and resident to resident to ensure all tasks had been completed and observations and report on the status of each resident is conveyed to the next shift. The NHA reported CNA D, newly hired, was suspended pending investigation and was ultimately terminated from the facility and reported to the state agency. Review of the facility report of the incident submitted to the state agency reflected a description of the incident and a telephone interview with CNA D by the NHA. The report reflected CNA D asserted R101 may have gotten herself tangled up in that (blanket) because she was not wrapped up in that when I left, she just had it on top of her like a lap blanket. She might have been rolling around and got herself that way because she kept trying to get out of the bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 11:23 AM an telephone interview was conducted with CNA D. CNA D reported on the morning of 10/15/24 she had left the facility early due to a personal matter. CNA D reported she had completed rounds by herself and had informed the nurse she was leaving. CNA D reported during the night she had checked the brief of R101 by lifting the blanket that was covering her. CNA D reported she did not have to remove it completely because R101 was dry all night. CNA D reported she was later told how the blanket had been found on R101 and that it was considered a restraint. CNA D reported she did not think the blanket was a restraint because the Resident could move her arms. CNA D reported R101 was dry all night and that the CNA from the previous shift must have wrapped the Resident in the blanket. CNA D reported she did not complete shift to shift resident rounds with the off going CNA at the start of her shift. CNA D did not explain how she could check the Resident's brief during her shift if the Resident had been wrapped tightly in a blanket from the hips down since the previous shift. On 10/29/24 at 4:25 PM an interview was conducted in the conference room with CNA H. CNA H reported she was assigned the Garden Unit on the afternoon shift of 10/14/24 and was relieved by CNA D who arrived about 1000 PM. CNA H reported shift to shirt resident rounds are to be conducted with the oncoming staff at shift change bur that CNA D refused to do the rounds. CNA H stated you can't make them do them (shift to shift rounds). CNA H reported she had last checked on R101 about 9:30 PM and that the Resident was sleeping on her side facing the wall. CNA H reported the brief was dry and that one indicator of a wet brief is that there will be a blue line on the brief when you look under the blanket. Review of the Employee file for CNA D revealed a background check had been completed on 9/5/24, Elder Abuse training completed on 9/12/24, and Abuse training completed on 9/19/24. On 10/29/24 the surveyor verified the following interventions were put into place and were effective to bring the facility into compliance: - All staff were educated on the facility policy for Abuse and Abuse Reporting beginning 10/15/24. - All residents affected and/or potentially affected were assessed and no negative outcomes were noted. - The facility had been conducting random weekly resident audits to screen for signs/symptoms/or self-reports of abuse or neglect. Process to ensure it was being properly followed and no concerns were noted. - Process reviewed at QA meeting. During this survey, this surveyor reviewed documentation, conducted interviews, and made observations the preceding interventions were completed prior to the abbreviated survey and no continuing issues related to this citation were noted. A determination of past non-compliance was approved by the state agency as of 10/15/24.