STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235039	A. Building B. Wing	07/17/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 31771 Based on observation, interview, and record review, the facility failed to maintain a safe and clean homelike environment for two facility Residents (R42 and R23). R42 Review of the Electronic Medical Record (EMR) Admission Record reflected R42 originally admitted to the facility 3/6/23 with pertinent diagnoses that include Repeated Falls, Unsteadiness on Feet, and Morbid Obesity. Review of the MDS dated [DATE] reflected R42 requires partial/moderate assistance with transfers but is non-ambulatory and is confined to a motorized wheelchair for mobility. The medical record reflected R42 is cognitively intact and is her own responsible party. On 7/15/24 at 10:42 AM in the room of R42 it was observed that all flat surfaces to include over the bed table, dresser/ nightstand and counter tops were full and stacked in an unorganized manner with the resident's belongings. An observation and interview were conducted on 7/15/24 at 3:18 PM with R42 in her room. It was observed that the room remained cluttered on all surfaces to include the second unoccupied bed in the room. R42 indicated she had to get her things organized and indicated staff had not offered to assist her with this. On 7/15/24 at 3:47 PM an interview was conducted with the Director of Nursing (DON). The DON reported R42 is very particular about her things but she noticed last week that R42 was spreading out with her belongings onto the other bed in the room. The DON reported that she was told R42 had been educated about the ongoing clutter issue in her room. The DON reported she is not aware if anyone has offered to help the Resident to organize her personal belongings and doesn't know if the current state of her room is Care Planned. Review of the Care Plan for R42 reflected an intervention of Respect my personal space without any further direction or information. However, this intervention was implemented by Social Services under the Focus title of I have a history of trauma . and not by care staff. No Care Plan Focus or interventions were found regarding maintaining a home-like room environment or the desire of R42 to protect the cluttered state of her room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR Progress Notes, to include Care Conference Summaries, did not reveal any documentation on the cluttered condition of the Resident's room, that this is a preference for R42, or that staff had educated or offered to help organize the belongings. On 7/16/24 at 11:56 AM an interview was conducted with R42 in her room. The Resident's clutter remained throughout the room. The Resident again indicated an intention to organize her belongings. R42 reported that Housekeeping does come into her room but that they do not clean, really. On 7/17/24 at 10:35 AM an observation was noted on the condition of R42's room. The clutter persists as previously observed despite the discussion with the DON on 7/15/24 at 3:47 PM. 37577 Resident #23 (R23) Review of an Admission Record revealed R23 was a [AGE] year old female, admitted to the facility on [DATE], with pertinent diagnoses of Huntington's disease, she received all nutrition and hydration via tube feeding, and cognitive communication deficit. R23 had severe cognitive impairment, depended on staff to meet all her needs, and was Spanish speaking. During an observation on 07/15/24 at 9:48 AM, R23 had a laminated communication board that sat on the overbed table. The board was coated in a light brown sticky substance, similar to tube feed formula. Upon further exam, there was a second laminated communication board but it was stuck to the top board. The two communication boards were pulled apart and the second communication board was also coated in the light brown sticky substance. During the following additional observations, the laminated communication boards were found to be covered with a light brown sticky substance: 07/15/24 at 2:26 PM, 07/15/24 at 4:35 PM, 07/16/24 at 8:04 AM, 07/16/24 at 12:55 PM, and on 07/17/24 at 7:54 AM. Review of a Kardex for R23 (a quick reference guide for staff to utilize that lists a resident's care needs) reflected: I am able to communicate by use of the picture boards and my family when they are in the building.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 This citation pertains to Intake # MI00145106 Based on observation, interview, and record review, the facility failed to facilitate administration of, and monitor, a bowel preparation protocol for one Resident (R30) and get him to an appointment for a scheduled colonoscopy, resulting in the resident becoming distraught due to lack of staff assistance to meet his medical needs. Findings: Review of the Minimum Data Set (MDS) dated [DATE] reflected R30 admitted to the facility 3/2/23 and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the Resident was cognitively intact. Section E of the MDS, which reviews Behavior, reflected R30 had displayed verbal behaviors toward others less than daily. Review the Electronic Medical Record (EMR) Admission Record reflected R30 has pertinent diagnoses that include Schizoaffective Disorder and Irritable Bowel Syndrome. The EMR also reflected that R30 can make his own decisions. On 7/16/24 at 11:19 AM an observation and interview were conducted with R30 in his room. R30 reported on 6/14/24 he was scheduled to have a colonoscopy at 1:30 PM transported by the facility bus at 1:00 PM. R30 reported he had completed most of the bowel cleaning preparation that began with timed administration by a second shift nurse the previous day. R30 reported early on the morning of 6/14/24 the night shift nurse handed to him a bottle of pills he was to self-administer to complete the preparation. R30 reported he took nine of the twelve pills with the expected effect but fell asleep before completing the regimen. R30 reported he woke up on his own at 12:30 PM soiled in stool and in a state of panic because he was to leave shortly for the procedure. R30 reported no nurse had returned to monitor his physical status or to ensure proper self-administration of the preparation. R30 reported no staff awakened him to ensure he was dressed and ready to leave for the appointment. Using his walker, R30 reported he then went to the hall and asked for help from two Certified Nurse Aides (CNA) who told him they were busy with routine tasks. R30 acknowledged he verbalized unkind words and walked toward the front entrance of the building leaking stool and shoeless. R30 reported at the front counter he verbalized more unkind words to the receptionist and the bus driver who were at the counter, left the building and sat on a bench by the transport bus. R30 reported the police subsequently arrived and talked to him. R30 reported he told the police he was upset the facility did not wake up in time for an important procedure. R30 reported he told the police he was soiled and shoeless because no one would help him get cleaned up and ready. R30 reported the police eventually left and he returned to his room missing the appointment. R30 reported no staff, nurses, Medical Providers, or Administration, has discussed the incident with him or informed him if the procedure had been rescheduled stating It's like all this never happened. R30 reported he had to clean himself up and that staff did not offer to assist. R30 stated I was totally on my own, that was so upsetting that they would leave me like that. R30 reported he was not aware of ever being assessed for self-administration of medication and produced an empty bottle of medication. This bottle (image retained) reflected that it had contained sodium sulfate, magnesium sulfate and potassium chloride tablets a common bowel-cleansing agent. R30 further reported that shortly after the incident of 6/14/24 he was informed he was being involuntarily discharged which he felt was related to the incident. R30 reported this has since been reversed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR for R30 reflected Doctor's Orders which confirmed R30 was to board the facility bus on 6/14/24 at 12:45 PM for a 1:30 PM for a colonoscopy and endoscopy, and a staff member was to remain with the resident during the procedure. The Doctors Orders also reflected R30 was placed on a clear liquid diet and begin a bowel preparation protocol beginning 6/13/24 and ending on 6/14/24. Review of the Medication Administration Record (MAR) for R30 for June 2024 reflected nurse documentation the bowel preparation medication had been administered. Review of the EMR did not reveal an assessment for self-administration of medication had been completed for R30. Review of the EMR Progress Notes for R30 did not reveal any documentation on 6/13/24 or 6/14/24 prior to the scheduled appointment time of monitoring during the bowel preparation, the Resident's physical status, or reminders to the Resident of readiness for impending procedure. Review of the EMR Progress Notes revealed an administrative entry dated 6/14/24 at 3:13 PM. The entry reflected R30 was reported to have been kicking and throwing items in the hall and yelling and swearing making other residents fearful. The entry reflected staff were unable to de-escalate the Resident's behavior. The entry reflected the police responded and were also unable to redirect the Resident's behavior. Review of the police report dated 6/14/24 at 12:47 PM reflected a complaint of a resident Currently in hallway cussing and throwing things. The responding police officer's documentation reflected Subject calm on arrival. Disagreement over transport for procedure at hospital. The police report reflected the officer then spoke with staff and left the facility approximately twenty minutes after arriving. After the entry of 6/14/24 at 3:38 PM the EMR Progress Notes reflected no further entries until 6/17/24 at 4:45 PM by Social Services. The entry reflected Resident served a 30-day involuntary discharge notice today due to history and recent events of violent outbursts . The entry reflected R30 acknowledged his actions and was tearful and apologetic. The entry reflected a possible path to a resolution of the issue. Review of the Doctor's Orders for R30 reflected a future colonoscopy/ endoscopy procedure scheduled for 9/3/24. Review of the Progress Notes for R30 from 6/17/24 to 7/16/24 did not reflect any documentation that the incident of 6/14/24 had been reviewed, investigated, or discussed with staff or R30. The Progress Notes did not reflect efforts to determine the root cause or what preventative measures were missed. The Progress Notes also did not reflect that R30 was aware the appointment had been rescheduled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 4:30 PM an interview was conducted in the conference room with the Director of Nursing (DON) Nursing Home Administrator (NHA) regarding the incident of 6/14/24 with R30. The DON and the NHA were informed of the Resident's version of the incident. That a bowel preparation had been initiated and evidence had been provided that R30 was expected to self-administer the second half of the protocol. Additionally, that the medical record did not reflect any staff monitoring or reminders to the Resident. Furthermore, that R30 reported he had awakened on his own to find himself incontinent of stool in his clothes, short on time, and unable to obtain assistance to get ready. Also, that R30 reported following the incident, he remained soiled, and no one offered to assist with care. The medical record Progress Notes did not provide any documentation why R30 did not make it to a procedure he had completed a preparation for, was offered help by care staff when soiled, or if R30 was informed the procedure was rescheduled. The NHA reported that R30 is independent, but that care would be provided to any resident if they asked. Both the DON and the NHA reported that R30 is known to not be awakened in the morning. The NHA reported she does not know if this is Care Planned but was told this by a long time CNA. The NHA reported R30 was approached by staff 15 minutes before the time to leave for the appointment. The NHA reported R30 did not feel he had time to get cleaned up and he became aggressive. The NHA stated a lot of things went wrong prior to the appointment that resulted in R30 becoming upset. The NHA reported that staff are informed when a resident's has an appointment. The NHA reported in the past R30 has either refused the prep or had the procedure canceled. The NHA also reported that discharging the Resident had been discussed but since that time there has been a big shift in his demeanor and R30 is more gentle. The Care Plan for R30 was reviewed. No Care Plan Focus or Intervention was found that reflected R30 was not to be awakened in the morning.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observations, interviews, and record review, the facility failed to implement care to prevent skin break down and maintain range of motion related to a severe contracture for 1 Resident (R6), resulting in R6 having intermittent skin irritation and the potential for skin breakdown. Findings included: Review of R6's face sheet dated 7/15/24, revealed she was admitted on [DATE] and had diagnoses that included: Hemiplegia and hemiparesis (paralyzed one side of body) following unspecified cerebrovascular disease affecting left non-dominant side, moderate protein-calorie malnutrition, diabetes mellitus with diabetic neuropathy (affection nerves), and unspecified symptoms and signs involving cognitive functions following unspecified cerebrovascular disease. R6 was not her own responsible party. R6 was observed in bed on 7/15/24 at 9:54 AM. R6's left hand was in a fist position. (no air space between finger or palm of her hand). R6 was observed in bed on 7/16/24 at 1:48 PM. R6's left hand was in a fist position. (no air space between finger or palm of her hand). During an interview with R6's Certified Nurse Aide (CNA) C on 7/16/24 was asked how she cares for R6's left hand. CNA C said R6 used to have a splint but since her splint was discontinued R6 has had some issues with the hand getting pink. CNA C said she charted in the electronic medical record today that R6 had pink skin in her left hand and reported this to Registered Nurse (RN) A. During an interview with Unit Manager (UM) B and RN A on 7/16/24 the surveyor confirmed that CNA C had reported R6's hand concern to RN A. UM B said she would contact R6 physician about the concern. On 7/17/24 at 8:30 AM R6's left hand was in a fist position. (no air space between finger or palm of her hand). CNA D and E came in to provide morning care. CNA D was able to do range of motion with R6's left hand. R6's hand could be opened to about a 1/4 fist size (open 1 to 1 and 1/2 inches. The palm was pink and moist. One fingernail stuck out about 1/4 from the end of R6's finger. When asked what could be done to prevent R6's fingernails to be away from R6's palm of her hand and to keep it dry, CNA D took a clean washcloth, rolled it up and placed in in the open space between R6's fingers and palm of her hand. R6 remained comfortable throughout the care. Review of R6's nursing progress note dated 7/16/24 at 4:31 PM revealed UM B, Made (name of R6's nurse practitioner (NP)) aware of L (left) palm redness, increased pain and contracture. During an interview with UM B on 7/17/24 at 11:15 AM, UM B said R6's NP would be addressing R6 left hand concerns today. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's Caregiver Education Tracking dated 4/18/24 revealed the following education was provided: please provide hand hygiene daily and keep fingernails short. Please provide PROM (passive range of motion) to LUE (left upper extremity) as tolerated 1 - 2 x daily. Check skin integrity issues and report to nurse. (see observation 7/16/24 at 8:30 AM, one fingernail was 1/4 inch long). Review of R6's care plan revealed an impaired skin integrity related to impaired mobility dated 6/4/24. None of the active interventions included interventions for the care of R6' left hand. Review of R6's ADL (activities of daily living) care plan initiated on 6//5/24 revealed no active interventions in place to maintain R6 left hand range of motion, keep her nails trimmed or promote skin integrity.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37577 Based on observation, interview, and record review, the facility failed to maintain an environment that was free from potential accidents and hazards for 7 of 7 residents (Resident #23, Resident #37, Resident #4, Resident#42, Resident #6, Resident #46, and Resident #58) reviewed for accidents and hazards. Findings: Resident #23 (R23) Review of an Admission Record revealed R23 was a [AGE] year old female, admitted to the facility on [DATE], with pertinent diagnoses of Huntington's disease, she received all nutrition and hydration via tube feeding, and cognitive communication deficit. R23 had severe cognitive impairment, depended on staff to meet all her needs, and was Spanish speaking. During an observation on 07/15/24 at 11:51 AM, R23 laid in bed with eyes open. The blue fall mat sat folded up on the floor at the foot of the bed. The call light touch pad was clipped to the top of the mattress over R23's left shoulder, out of sight and out of reach of the resident. During an observation on 07/16/24 at 12:55 PM, R23 laid in bed with eyes open and the tube feed running. The call light touch pad was draped over the top of the mattress, with the touch pad hanging off the mattress, out of sight and out of reach of R23. During an interview on 07/17/24 at 2:20 PM, the Administrator indicated that R23 was capable of using the touch light call pad. Review of the facility policy Call Light System, last reviewed 06/2023, reflected: (5) with each interaction in the resident's room, staff will ensure the call light is within reach of the resident. Resident #37 (R37) Review of an Admission Record revealed R37 was an [AGE] year old female, admitted to the facility on [DATE], with pertinent diagnoses of Dementia, fall with hip fracture just prior to admission to the skilled nursing facility, difficulty walking, and unsteadiness on feet. During an observation on 07/15/24 at 9:24 AM, R37 laid in bed resting with eyes closed. The call light touch pad laid at the foot of the bed out of reach of the resident. A sign posted on the wall near R37 read: STOP use call light and wait for assistance. R37's wheelchair was placed next to the bed and the wheels were not locked. During an observation on 07/16/24 at 8:14 AM, R37 laid in bed resting with eyes closed. The call light touch pad and cord were curled up at the foot of the bed, out of reach of R37. The wheelchair was placed near the middle of the bed and was not locked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/17/24 at 7:48 AM, R37 laid in bed resting with eyes closed. The call light touch pad sat at the end of the bed under the covers, out of sight and out of the reach of R37. The wheelchair sat bed side and was not locked. Review of the EHR (electronic health record) for R37 revealed the resident sustained a fall with wrist fracture on 02/22/24 and a self-reported unwitnessed fall on 03/10/24. Review of a Care Plan for R37 related to safety interventions to prevent falls indicated: Be sure my call light is within reach. Resident #4 (R4) Review of an Admission Record revealed R4 was an [AGE] year old female, admitted to the facility on [DATE], with pertinent diagnoses of Alzheimer's, glaucoma, and disorientation. R4 had severe cognitive impairment. During an observation on 07/15/24 at 9:21 AM, R37 self propelled in her wheel chair out of the common area, near the nurses offices, toward the hallway away from the dining area. On the right side of the hall was a hoyer lift and on the left side of the hall was a housekeeping cart, narrowing the area in which any resident could pass. The right front wheel of R37's wheelchair got caught on the long arm of the hoyer lift closest to her. R37 made several attempts to free her wheelchair from the hoyer lift, including bending over and leaning forward out of the wheelchair. Three staff persons walked past R37 and did not assist her free the wheelchair from the leg of the hoyer lift. Out of concern for the resident's safety, this surveyor alerted staff to the situation and staff assisted R37. Review of the EHR for R37 reflected an unwitnessed fall on 06/14/24. 31771 Resident #42 (R42) Review of the Electronic Medical Record (EMR) Admission Record reflected R42 originally admitted to the facility 3/6/23 with pertinent diagnoses that include Repeated Falls, Unsteadiness on Feet, and Morbid Obesity. Review of the MDS dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R42 is cognitively intact. Review of the Care Plan for R42 revealed a Focus area of I am at increased risk for falls (related to) decreased mobility and multiple comorbidities initiated 3/7/23. Review of the interventions to prevent falls included Grip strips to floor by bed to increase to traction with transfers initiated 12/27/23. Review of the Kardex (a summary of a resident's care needs) for R42 reflected the intervention of Grip strips to floor by bed . as also indicated in the Care Plan. Review of the Incident Report dated 7/15/24 at 7:05 AM reflected R42 was found on the floor by her bed. The report indicated R42 did not have any footwear on at the time. The report did not indicate a review to ensure all Care Planned interventions were in place at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/24 at 11:56 AM an interview was conducted with R42 in her room. R42 reported she fell the previous morning getting out of her bed. It was observed that there were no grip strips next to the bed of R42 as indicated on the Care Plan and Kardex. The room of R42 was observed to have extensive clutter mostly on flat raised surfaces but many personal items and possible trip hazards were observed to be on the floor along edges of and under furniture. Grip strips were observed to be on floor near an adjacent wall appearing that the bed may have been moved to the current location without relocating the grip strips. On 7/17/25 at 10:26 AM The Nursing Home Administrator (NHA) reported that the previous week the Environmental Services Director had moved the furniture in the room of R42 and failed to relocate the grip strips at the bed's new location. The NHA was asked if staff were expected to regularly ensure fall precautions were in place. The NHA indicated all staff are expected to always follow the Care Plan. 28101 Resident #6 (R6) Review of R6's face sheet dated 7/15/24, revealed she was admitted on [DATE] and had diagnoses that included: Hemiplegia and hemiparesis (paralyzed one side of body) following unspecified cerebrovascular disease affecting left non-dominant side, moderate protein-calorie malnutrition, diabetes mellitus with diabetic neuropathy (affection nerves), and unspecified symptoms and signs involving cognitive functions following unspecified cerebrovascular disease. R6 was not her own responsible party. R6 was observed on 7/16/24 at 8:20 AM, receiving morning care from Certified Nurse Aide (CNA) E. CNA E raised R6's bed to waist height to provide care and then discovered she did not have all the supplies she needed to do care. CNA E left the bed at waist height and left the room to gather supplies (no other staff in the room). When CNA E returned to do care, she independently turned R6 on her left side. Review of R6's fall care plan revealed and intervention for bed height, low as I allow dated 1/5/22. Review of R6's ADL (Activities of Daily Living) care plan dated, 6/5/24 revealed R6 required extensive assistance of 1-2 person for bed mobility. During an interview with Registered Nurse (RN) F on 7/17/24 at 9:15 AM, the observation of R6 being left unattended while her bed was waist high and the CNA rolling the resident away from her without staff being on the other side of bed was share. RN F reviewed the facility nursing procedure guidebook and verified residents that are dependent for bed mobility require another person on the opposite side of the bed when rolling the resident away from them for safety reasons. RN F all said it was not safe to walk away from R6's bed when it was in a high position. RN F said she would start staff education. Resident #46 (R46) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R46's face sheet dated 7/17/24 revealed she was admitted to the facility on [DATE] and had diagnoses that included: Alzheimer's disease, and muscle weakness. She was not her own responsible party. R46 was observed on the 300-nursing unit, in the main dining room on 7/15/24 at 12:30 PM eating independently. No staff were in the room. Review of R46's progress note dated 4/14/24 at 2:11 PM revealed, Residents diet downgraded to minced and moist. Noted coughing at mealtime. Review of R46's ADL (Activities of Daily Living) care plan last revised on 11/13/23 (not up to date) revealed she required set up supervision with eating. Resident #58 (R58) Review of R58's face sheet dated 7/17/24 revealed she was admitted to the facility on [DATE] and had diagnoses that included: Anoxic brain damage and dysphagia (difficulty swallowing). She was not her own responsible party. R58 was observed on the 300-nursing unit, in the main dining room on 7/15/24 at 12:30 PM eating independently. No staff were in the room. Review of R58's Kardex (nursing care guide) dated 7/17/24 revealed that R58 required 1:1 feeding assistance, she required minced and moist textured foods. On 7/15/24 at 12:43 PM, the Activity Director (AD) I was assisting pass meal trays to the residents in 300 halls. AD I was asked if staff are to be supervising residents eating in the main dining area. AD I said she was not certified in doing the Heimlich maneuver (first aid used to dislodge food or objects in a person's airway), residents are to be supervised by the certified nurse aides. AD I went looking for staff and returned with CNA C. CNA C was asked if she was assigned supervise residents in the 300-hall main dining room today and CNA C was not aware of anyone having an assignment to supervise residents in the main dining room. During an interview with the Nursing Home Administrator (NHA) on 7/17/24 at 9:00 AM the observations of resident not being supervised while eating on 7/15/24. The NHA said she was not aware if the facility dining policy included supervision or the status of residents needed to be supervised in the main dining room. Review of the facility Dining Service policy dated revised 1/05/21 revealed, 3. Necessary staff will be available to assist in passing out meals either in rooms or dining areas. There was no indication of a need to supervise residents at risk for choking or special needs, or assigning staff to remain in the dining room when residents are eating.

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	235039	A. Building B. Wing	07/17/2024

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Mission Point Nsg & Phy Rehab Ctr of Grandville	3400 Wilson Ave Grandville, MI 49418

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview, and record review, the facility failed to complete a thorough assessment of PTSD (post-traumatic stress disorder) and develop and implement an individualized care plan for 1 resident (Resident #60). Findings: Review of the facility Admission Record reflected R60 admitted to the facility on [DATE] with a diagnosis of PTSD. The resident was not their own responsible party and had a Legal Guardian (LG H). Review of an Admission H and P (History and Physical) dated 6/10/24, documented by Medical Director (MD) J reflected Past Medical and Surgical History: F43.12 - Post-traumatic stress disorder, chronic, F72 - Severe intellectual disabilities . H54.8 - Legal Blindness, as defined in the USA . R44.3 Hallucinations, unspecified, Z62.819 - Personal history of unspecified abuse in childhood. The narrative indicated R60 had been hospitalized from March 28th until June 7th (2024) According to a brief hospital note, she has a past history of bilateral blindness, bilateral deafness, developmental delay, glaucoma, history of enucleation of the right eye, history of sexual abuse in childhood. She had a tube shot placed in her left eye for pressure control. She admits that she has very poor vision remaining in the left eye. I believe she says she lived in Hopkins but I wasn't sure. She had no acute Complaints or concerns at this time. She seemed distracted. She was looking through her bag of things. I asked her if she had any type of syndrome and she said she did not know what that was. She was cooperative for the assessment. We will have more details once we receive the discharge summary. She had no knowledge of her medications. Plan: uncertain dx (diagnosis) based on meds she is on; SSRI (selective serotonin reuptake inhibitor) and atypical antipsychotic, awaiting reports. General assessments and (Behavioral Health) consult. Review of a hospital inpatient Psychiatry Consultation available to the facility via a connected electronic health information system/medical record reflected R60 was evaluated by the psychiatry department on 4/4/2024. The first paragraph in the assessment revealed (R60) is a [AGE] year-old female with severe intellectual disability with mental cognition of [AGE] year-old. She was brought to the hospital for decline in function and AMS (altered mental status). Family reported history of childhood trauma. Patient could have chronic PTSD and there could be a relapse in her PTSD symptoms. It is reported that she has psychotic symptoms and withdrawn behaviors for the past month. The only recent stressful event is demise of her biological father. The assessment indicated that a medical work up, including lab work, physical exam, and imaging studies did not yield any potential source of AMS. Neurology was consulted as recommended MRI was done, did not show any acute intracranial abnormality. The report indicated that (LG H) noticed that one night she was in bed slumped over as if someone was spanking her, as if she was enacting her childhood trauma. Her biological father used to physically abuse her and her brother by spanking with belts. Inquired about any acute stressors. (LG H) says she might have heard her (LG H) talk about her father's death. Her father passed away and although father was abusive, she used to run to her father and hug him whenever he came by to visit her. The report did not indicate R60 had a diagnosis of bipolar disorder. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the entire Care Plan initiated on 6/8/2024 did not reveal a Focus for R60's history of PTSD with goals and interventions to meet any of R60's needs related to this diagnosis. An ADL (Activity of Daily Living) care plan specified No Male Care Giver was added to the interventions on 6/26/2024 (18 days after admission to the facility). During an observation on 7/16/2024 at 9:19 AM, R60 was seated on the edge of her bed with a breakfast tray in front of her. R60 appeared calm and did not verbally interact with the surveyor. R60's roommate's adult son entered the room and began speaking with R60's roommate. R60 became visibly upset, curled into the fetal position on her bed and began crying loudly. Certified Nurse Aide (CNA) L was asked if she knew why R60 was not allowed to have a male caregiver, and she did not. CNA L was not aware R60 had a history of childhood abuse, and this was why no male care givers was allowed. CNA L and CNA M checked on R60 and observed her in the fetal position, crying, and assisted R60 into a small dining room across the hall and reported the issue to the nurse on duty. R60 was observed minutes later and had calmed down after reassurance from the CNAs that she was alright. During a telephone interview on 7/16/2024 at 10:01 AM, LG H indicated that R60 had an extensive history of physical and emotional abuse at the hand of R60's father. LG H said that R60 lived with him for the first [AGE] years of her life and was removed from his care, coming to live with LG H for the last [AGE] years. LG H reported that she had emphasized to the facility that there be no male visitors in addition to no male caregivers in order to keep R60 safe. LG H described what led to R60's hospitalization and confirmed there was no medical reason for R60's AMS and reported that R60's father had passed away and that may have been a trigger for her reenacting abusive acts. During an interview on 7/16/24 at 1:13 PM, Social Services Director (SSD) K and the Director of Nursing (DON) reported they did not have a lot of information about R60 prior to admission at the facility. The DON acknowledged the history of childhood sexual abuse in the clinical record and PTSD noted in the hospital discharge paperwork. The DON said the facility could have done a better job of assessing and care planning for R60's PTSD.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on interview and record review, the facility failed to provide collaborative hospice care for l Resident (R6) of 2 Residents reviewed for hospice care, resulting in the potential for unmet needs. Findings included: Review of R6's face sheet dated 7/15/24, revealed she was admitted on [DATE] and had diagnoses that included: Hemiplegia and hemiparesis (paralyzed one side of body) following unspecified cerebrovascular disease affecting left non-dominant side, moderate protein-calorie malnutrition, diabetes mellitus with diabetic neuropathy (affection nerves), and unspecified symptoms and signs involving cognitive functions following unspecified cerebrovascular disease. R6 was not her own responsible party. During an interview with Certified Nurse Aide (CNA) C on 7/16/24 at 1:48 PM, CNA C was asked when R6 receives hospice care and what care they provide. CNA C went to the communication board on the unit, and she was not able to locate a hospice care calendar for R6. CNA C recalled a hospice care giver came into care for R6 in the last 2 weeks but was not aware of what care they provided. CNA C said hospice staff came in today, but she was not aware of the care or services provide. During and interview with Registered Nurse (RN) A and Unit Manager (UM) B on 7/16/24 at 2:15 PM, they denied speaking to or knowing R6 had any hospice care worker in the building today. They were not able to locate any hospice schedule or note for any care of services provided since R6 had been in hospice care. During an interview with the Nursing Home Administrator (NHA) on 7/17/24 at 9:15 AM, the NHA shared the facility made a special contract with R6's hospice provider on 7/16/24 and that provider was not one of their standard hospice providers. The NHA said when she contacted R6's hospice provider she found out that their password the facility electronic medical charting system was not working. The NHA said she received some records and R6's hospice schedule yesterday. (after being questioned the day before) Review of R6's hospice care plan dated 7/10/24 revealed the name of R6's hospice service. The only intervention documented was, Please refer to my hospice provider with any changes in my condition. There was no indication of services hospice was planning on providing for R6. Review of R6's hospice agreement with the facility was signed on 6/26/24. Page 8 of the agreement revealed, 2. Medical Record and Documentation of Services Provided. The SNF (skilled nursing facility) medical record shall include a record of all inpatient services and events, which shall document the services were furnished in accordance with this Agreement, and a copy of the discharge summary and, if requested, a copy of the medial record shall be provided to Hospice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview, and record review, the facility failed to implement infection prevention measures for 1 Resident (Resident #6) of 2 Residents reviewed for Foley Catheter, resulting in the potential for infection. Findings included: Review of R6's face sheet dated 7/15/24, revealed she was admitted on [DATE] and had diagnoses that included: Hemiplegia and hemiparesis (paralyzed one side of body) following unspecified cerebrovascular disease affecting left non-dominant side, moderate protein-calorie malnutrition, diabetes mellitus with diabetic neuropathy (affection nerves), and unspecified symptoms and signs involving cognitive functions following unspecified cerebrovascular disease. R6 was not her own responsible party. On 7/17/24 at 8:05 AM, R6 was observed in bed. R6's urinary collection bag/tubing and biliary drain bag (medical device used to collect bile (digestive fluids) was observed to be in contact with the floor. CNA (certified nurse aide) E entered the room. CNA E was asked if R6's collection bags should be in contact with the floor. CNA E said no however, she knew R6's bed should be in a low position and was not sure what to do. CNA E left the room and returned to the room with a clean towel and placed the towel on the floor and then placed R6's collection bags on the towel. CNA E provided morning care; she placed the bags on the bed. While providing care CNA E stepped on the towel she was using for the collection bags multiple times. During an interview with Registered Nurse (RN) F on 7/17/24 at 9:10 AM, RN F confirmed R6's collection bags should not be in contact with the floor for infection prevention reasons and said staff education would be provided. Review of CNA E's Record of Verbal Counseling Session dated 7/17/24 revealed, Cath (catheter) bag was seen on floor. Bili (Biliary) drain on floor. All drain bags will be placed off the floor, in proper position. (There was no indication how R6's bed could be in the lowest position and how to maintain keeping the bags in proper position). Review of R6's biliary drain care plan dated 6/28/24 revealed interventions that included, empty bag every shift, monitor every shift for signs and symptoms of infection and monitor vital signs as ordered. There was no indication of proper placement for drainage. Review of R6's indwelling suprapubic catheter care plan dated 6/28/24 revealed, position catheter bag and tubing below the level of the bladder and cover for dignity. Review of R6's fall care plan revealed and intervention for bed height, low as I allow dated 1/5/22.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38905 Based on observation and interview, the facility failed to maintain general cleanliness and repair. This resulted in the potential for contamination of linens and domestic water. Findings Include: During a tour of the facility, with Maintenance Director (MD) G, starting at 12:23 PM on 7/15/24, the following environmental concerns were noted: Observation of the Beauty shop hair wash sink was found to not have proper backflow prevention on the hose for the hair sprayer. The hose was able to drop below the overflow rim of the sink and be a submerged inlet with no inline atmospheric vacuum breaker. Observation of the 200 Hall linen closet found an open wire rack shelving with no bottom barrier on the bottom rack to protect against contamination from cleaning or accumulation of debris on the floor. At this time the floor underneath the clean linen was found with a heavy accumulation of dust and paper trash debris. During a tour of the Garden utility room it was found that underneath rack storage shelving found accumulation of dust along with paper and packaging debris. During a tour of the Garden janitors closet it was found that the chemical pre-dispense system was installed on a cold water line with no wasting tee to help maintain the integrity of the hose bib vacuum breaker. During a tour of the 300 shower room it was found that three slings were stored on the back wall floor with numerous slings hung up but also having dangling portions on the floor. An interview with MD G at 2:52 PM found that the slings shouldn't be touching or on the floor and he was unsure why there were so many at that location. During a tour of the 300 clean linen closet it was found that no bottom barriers were present on the bottom portion of the wire rack and an accumulation of dust and debris was evident on the floor of the unit. Observation of the lakeshore dining room found a large hole under the sink counter that leads plumbing lines into the wall. The size of the hole was roughly 10x8. At 3:10 PM an interview with MD G stated he was new to the facility and was not familiar with the hole under the sink.