STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/10/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview, and record review the facility failed to treat residents in a dignified manner for two (R42 and R94) of two residents reviewed for dignity/respect. Findings include: R42 On 7/8/24 during the initial tour of the facility, R42 was observed lying in their bed. The resident was alert and able to answer questions asked. When asked about life in the facility, R42 reported that a few weeks ago they felt they were forced to take a shower. R42 explained that they normally like to have bed baths and often can care for themselves, but a few weeks ago staff insisted that they get up out of bed and shower. Due to their size, R42 reported the facility did not have a shower chair that would accommodate them, and they had to take a shower in their regular wheelchair. R42 stated that they did not feel comfortable in that chair and feared that they might slide out. R42 noted that they had asked for another wheelchair with extended depth. A review of R42's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: depressive disorder, carcinoma, and heart disease. A review of the Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact) and required extensive one person assist for most Activities of Daily Living. A 30-day look back on R42's TASK report indicated the resident had received only bed baths. A nursing note authored by Unit Manager Nurse S dated 6/28/24 indicated the resident had received a shower. Again, the TASK report noted a bed bath was provided on 6/28/24, not a shower. On 7/10/24 at approximately 9:11 AM, an interview was conducted with a staff member who asked to remain anonymous. The staff member reported that they had worked with R42 on several occasions. When asked about the resident's shower preferences, the staff member reported that the resident preferred bed baths. The staff member was able to show the Surveyor the largest shower chair available at the facility and noted that the resident would not fit in the chair. They indicated that they were aware that the resident received a shower in their wheelchair and not a shower chair. The staff member indicated that they believed the resident was pressed to take a shower and was aware that it was not their preference. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at approximately 10:00 AM, an interview was conducted with Nurse S. Nurse 'S noted that the resident did receive a shower on 6/28/24 and the resident sat in their wheelchair as the other shower chair would not accommodate the resident. On 7/10/24 at approximately 10:24 AM, Maintenance Supervisor (MS) P was asked if they had ordered a shower chair that would accommodate R42. MS P noted that they believed they had ordered one, however they did not provide evidence that the chair was ordered prior to the end of the Survey. On 7/10/24 at approximately 12:50 PM, an interview was conducted with the Administrator. The Administrator reported they were aware of the shower that was provided on 6/28/24. They stated that a new mattress had been received for R42 and the facility believed it would be a good idea to have the resident get out of bed so they could put the new mattress and as the resident does not often get out of bed. Further, if the resident was going to get out of bed it it would be a good time to provide a full shower as the facility had been working on eliminating odors. They noted that the resident used their own wheelchair as the facility did not have a proper sized shower chair. The Administrator indicated that at that time, they were not aware the resident felt forced to take a shower, however they noted that they talked with R42 again and they did indicate they felt forced to take a shower. R94 On 7/8/24 at 9:56 AM, R94 was observed sitting on the bed. R94 was asked about care at the facility. R94 explained some of the Certified Nursing Assistants (CNA's) would argue with them about taking a shower, or sometimes refuse to give them a shower. R94 was asked if it was a particular CNA that would argue with them. R94 explained they did not know who the CNA's were, as they would not tell them their names, and they were blind and could not identify them. A facility policy titled, Promoting/Maintaining Resident Dignity (2/24) was reviewed and documented, in part: . Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains and enhances resident's quality of life by recognizing each resident's individuality .Compliance Guidelines: .All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights staff must report, document and act upon information regarding resident preferences . explain care or procedures to the resident before initiating the activity .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to ensure allegations of abuse were reported to the Abuse Coordinator and the State Agency (SA) for one (R7) out of two residents reviewed for abuse, when R7 reported to numerous staff that R28 threatened them. Findings include: On 7/8/24 at approximately 9:15 AM, R7 was observed lying in bed. The resident was alert and able to answer all questions asked. When asked if they felt safe in the facility, R7 reported that they do now, but indicated a few weeks ago, R28 who at one time was their roommate, threatened to stab them in the eye with a fork. R7 indicated that they reported the incident to a number of staff, including the Social Worker. R7 further reported that R28 was threatening staff and other residents and currently was not in the facility as they believed R28 was sent out for psychiatric help. A review of R7's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: type II diabetes, heart failure and bipolar disorder. A review of the resident's Minimum Data Set (MDS) dated [DATE] noted that the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition). There was no indication in the resident's clinical record relating to allegations of abuse by R28. A request was made for any Incident/Accident (IA) reports pertaining to R7. No documents pertaining to the allegation noted by R7 was provided by the end of the survey. A review of R28's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: schizophrenia, anxiety and delusional disorders. A review of the R28's MDS (4/25/24) noted the resident had a BIMS score of 13/15 (cognitively intact cognition). A Behavior Note dated 6/20/24 (4:50 AM) documented, in part: .R28 is observed pacing the hallways back and forth and appears verbally aggressive .shouting throughout the hallways stating, I don't need to listen to you .What additional interventions were put in place to keep others safe? (no answer was provided) . A nurses note dated 6/20/24 (10:45 PM) documented, Res was experiencing an acute behavior change .new order to send resident our <sic> for evaluation . On 7/9/24 at approximately 12:03 PM, an interview was conducted with SW L. When asked if they were aware of the allegation made by R7 that R28 had threatened to stab them, SW L reported that about a month or so ago they were aware that R28 threatened R7. SW L reported that they told the Administrator. On 7/9/24 at approximately 12:32 PM, an interview was conducted with the Administrator/Abuse Coordinator. When asked if they were aware that R7 alleged that R28 threatened to stab them in the eye, they noted that staff had not reported the allegation. The Administrator noted that had it been brought to their attention they would have investigated the allegation and reported it to the SA if they had been made aware of the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Abuse, Neglect and Exploitation (6/23) was reviewed and documented, in part: . Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident Definitions: Abuse: means the willful infliction of injury intimidation Instances of abuse .Cause physical harm, pain or mental anguish. It includes verbal abuse .Willful means the individual must have acted deliberately . Investigation .an immediate investigation is warranted when .reports of abuse .occur .Investigation may include Identifying staff responsible for the investigation .the facility Administrator is the Abuse Coordinator . Reporting .Reporting of all alleged violations to the Administrator, stage agency .within limited timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to ensure a comprehensive plan of care was revised and modified to reflect resident centered and individualized plan of care for one resident (R10) of four residents reviewed for accidents/hazards. Findings include: On 7/08/24 at approximately 9:06 a.m., R10 was observed in their room, up in their bed. R10 was queried if they previously had any falls and they reported yes. R10 was queried if the facility did anything for them after falling and they indicated they did not know. At that time, R10 was observed in bed without any fall mats and did not have a concave mattress. On 7/9/24 at approximately 8:57 a.m., R10 was observed in their room, laying in their bed. R10 was still observed without a concave mattress or floor mats next to their bed. On 7/10/24 at approximately 9:11 a.m., R10 was observed in their room, laying in their bed. R10 was again, observed without a concave mattress or floor mats. On 7/8/24 the medical record for R10 was reviewed and revealed the following: R10 was initially admitted to the facility on [DATE] and had diagnoses including Protein Calorie-Malnutrition and Anorexia. A review of R10's MDS (minimum data set) with an ARD (assessment reference date) of 5/14/24 revealed R10 was dependent on facility staff for most of their activities of daily living. R10's BIMS score (brief interview for mental status) was four, indicating severely impaired cognition. A review of R10's comprehensive plan of care revealed the following: Focus-I am at an increased risk for falls CONCAVE MATTRESS AND FLOOR MATS FOR PREVENTION. Date Initiated: 09/27/2023 . Interventions-Bed: I need the following room accommodations:(Specify: Low Bed, Mats on the Floor, winged mattress locked bed wheels).Date Initiated: 11/03/2023 . A Physician's order dated 10/31/23 revealed the following: CONCAVE MATTRESS FOR PREVENTION On 7/10/24 at approximately 9:13 a.m., Nurse Manager A (NM A) was queried regarding R10 not being provided the concave mattress and floor mats that were indicated as part of their comprehensive plan of care and they reported they would have to see why they did not have the items as indicated. On 7/10/24 at approximately 10:00 a.m., during a follow up conversation with NM A, NM A reported that R10 had a higher risk of falling in November 2023 when the interventions were added as part of their plan of care but since then they had a status change and were no longer a high fall risk. NM A indicated that the interventions were removed from R10's room before they had started working in the facility (a few months ago) and that the plan of care was never updated to reflect R10's change in status. NM A indicated that the MDS Nurse and themselves were going to go through all the careplans for the residents and revise them to reflect their current needs. (continued on next page)

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	235187	A. Building B. Wing	07/10/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 a facility document titled Care Planning was reviewed and revealed the following: .5. The comprehensive care plan is developed from the RAI (resident assessment instrument) scheduled and is reviewed and revised by the IDT (interdisciplinary team) as necessary

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on observation, interview, and record review, the facility failed to ensure nursing services met professional standards for medication administration documentation for one resident (R49) reviewed for professional standards. Findings Include: A clinical record review revealed R49 was admitted to the facility on [DATE] with diagnoses that included: Diabetes, right below the knee leg amputation, morbid obesity, atrial fibrillation (abnormal heart rhythm), and hypertension. R49's most recent Brief Interview for Mental Status (BIMS) score was 15/15 indicating they were cognitively intact. On 7/9/24 at 8:55 AM, An observation of medication administration was conducted with Licensed Practical Nurse (LPN) T for R49. LPN T presented R49 ordered medications Eliquis (medication to thin the blood) 5 milligram (mg) & Ferrous Sulfate (Iron supplement) 325 mg, at which time was refused by the resident. On 7/10/24 at 9:15 AM, A record review of the Medication Administration Record (MAR) revealed, ordered Eliquis and Iron was administered on 7/9/24 at 8:00 AM by LPN T. On 7/10/24 at 9:37 AM, LPN T was interviewed and confirmed Eliquis and Iron medications were not provided to R49. LPN T reviewed the MAR and further acknowledged that it was signed as given and was not given. LPN T replied they must have been nervous during observation and signed off as administering on accident. On 7/10/24 at 11:05 AM, The Director of Nursing (DON) was informed, and observed taking notes, LPN T documented Eliquis and Iron were administered on 7/9/24 and later admitted that the documentation was done in error, and confirmed R49 did not take. Review of the facilities policy title; Medication Administration dated 7/2019 documented: .Medications are administered as prescribed in accordance with good nursing principles and practices .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to ensure shaving per personal preference was provided for two (R94 and R54) of two residents reviewed for activities of daily living (ADL's). Findings include: R94 On 7/8/24 at 9:56 AM, R94 was observed sitting on the bed. It was observed R94 had stubble that was approximately 0.5-1 cm in length. R94 was asked if he wanted to have a beard. R94 explained he wanted to be clean shaven, but was blind and could not do it himself, and some of the Certified Nursing Assistants (CNA's) would refuse to shave him. When asked if there was a particular CNA, R94 explained he did not know, as they would refuse to tell him their names, and he could not identify them. Review of the clinical record revealed R94 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: low vision right eye category 1, blindness left eye category 3; conductive hearing loss; and anxiety disorder. According to the Minimum Data Set assessment dated [DATE], R94 was cognitively intact, had severely impaired vision and required assistance of staff for ADL's. On 7/9/24 at 10:55 AM, R94 was sitting in a wheelchair in his room, and it was observed R94 was clean shaven. R94 was asked if he had received a shower. R94 explained he was supposed to get a shower that day, but someone had come and given him a shave the night before and that he was happy to be clean shaven. R54 On 7/8/24 at 9:20 AM, R54 was observed lying in bed. R54 had a full beard, approximately 2 inches in length. R54 was asked if he wanted to have a beard. R54 explained he wanted to be clean shaven, but no one would shave him. Review of the clinical record revealed R54 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: stroke with paralysis of the left side, diabetes and schizoaffectve disorder. According to the MDS assessment dated [DATE], R54 had moderately impaired cognition and was dependent on staff for ADL's. It should be noted that the picture of R54 in the Electronic Medical Record showed only slight stubble. On 7/9/24 at 8:38 AM, R54 was lying in bed, and it was observed R54 had a clean shaven face. R54 was asked about his beard. R54 explained he wanted to be clean shaven, and was happy not to have a beard. On 7/10/24 at 8:13 AM, CNA I was interviewed and asked how often residents are shaved. CNA I explained usually residents were shaved with every shower, but they could get it daily if they asked to be shaved. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 10:58 AM, the Director of Nursing (DON) was interviewed and asked how often residents' should be shaved. The DON explained residents that wanted to be shaved should be shaved every time they get a shower, or when needed. Review of a facility policy titled, Activities of Daily Living (ADLs) dated 2/25/24 read in part, .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care . A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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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** 47283 This citation pertains to intake #: MI00143890 Based on observation, interview and record review facility failed to consistently monitor blood glucose levels for one (R67) of one Resident with a diagnosis of type 2 diabetes, resulting in the potential for complications from abnormal blood sugar levels. Finding include: A record review revealed that R67 was a long-term resident of the facility, originally admitted to the facility on [DATE]. R67 had a recent hospitalization on [DATE] and they were readmitted back to the facility on [DATE]. R67's admitting diagnoses included anxiety disorder, depression, type 2 diabetes mellitus with diabetic neuropathy, and chronic kidney disease. R67 had cognitive deficits and had public guardian appointed by the court. A complaint received by the State Agency revealed that the complainant had concerns about the facility's monitoring and management of R67's diabetes. An initial observation was completed on [DATE] at approximately 10:15 AM. R67 was observed in their bed eating breakfast. R67 was reported that they were having a hard time feeding themselves and stated, I cannot get it into my mouth. This surveyor notified the staff member and staff assisted with breakfast. Approximately 11:55 AM, the surveyor heard an announcement via their overhead public address (PA) system that there was a medical emergency and facility protocol was initiated. Local emergency medical services (EMS) arrived at the facility and attempted to resuscitate R67 and they were unsuccessful. Per the EMS report, R67 had a cardiac arrest and had expired at the facility. Review of R67's Electronic Medical Record (EMR) revealed a practitioner note dated [DATE] that read in part, This is (age and gender omitted) with his history of hypertension, chronic kidney disease stage-4, diabetes mellitus-type-2 (DM-II) .was found to have COPD (Chronic Obstructive Pulmonary Disease), treated with steroids and antibiotics . Assessment and plan section of the practitioner note included DM-II with peripheral neuropathy. Sliding Scale Insulin, Blood Glucose Monitoring (BGM), currently stable . Further review of the progress notes revealed a physician progress note dated [DATE]. The note under assessment included, DM-II with peripheral neuropathy. Sliding Scale Insulin, Blood Glucose Monitoring (BGM), currently stable . A follow-up physician progress note dated [DATE], under the assessment section read in part, Diabetes Mellitus - no hypoglycemic event. Monitor blood sugars . Review of the physician orders after R67 readmission to the facility did not reveal any orders to monitor R67's blood sugar despite unstable blood sugars prior to hospitalization . Review of R67's blood sugar monitoring report and physician orders prior to admission to the hospital revealed the following entries: [DATE] at 20:39 - 191.0 mg/dL (milligrams/deciliter) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 17:42 - 150.0 mg/dL [DATE] at 21:14 - 135.0 mg/dL [DATE] at 20:57 - 93.0 mg/dL [DATE] at 20:45 - 77.0 mg/dL [DATE] at 20:36 - 59.0 mg/dL [DATE] at 16:59 - 429.0 mg/dL [DATE] at 11:10 - 167.0 mg/dL The report revealed that there was no blood sugar monitoring done for R67 after [DATE]. R67 did not have any blood sugar monitoring from [DATE] - [DATE] (12 days). Prior to hospitalization , R67's blood sugars were monitored multiple times during the day and they were receiving sliding scale insulin (sliding scale varies the dose of insulin based on the current blood glucose level). Review of the discharge summary from the hospital dated [DATE] included the following medication with a note that read, Insulin lispro subcutaneous 4 times/day (with meals and at bedtime): Glucose level: mg/dL. ,d+[DATE] - 0 units ,d+[DATE] - 0 units ,d+[DATE] - 2 units 251- 300 - 3 units Notify physician if: Patient is made NPO or feeding is stopped and insulin orders have not been adjusted. Blood glucose level is less than 70 mg/dL or greater than 300 mg/dL. Last dose: [DATE] at 22:00. Further review revealed R67 had an unwitnessed incident on [DATE]. R67 was observed sitting on the floor on their right side and they did not know how it happened. Review of vital signs after the unwitnessed event revealed that there was no blood sugar monitoring done despite their active diagnosis of diabetes and their history of unstable blood sugar. Review of the EMS report from [DATE] revealed that R67 had a blood glucose level of 264 mg/dL. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing was completed on [DATE] at approximately 1:45 PM. The DON was queried about the blood sugar monitoring for R67. The DON was queried why the facility was not monitoring R67's blood sugar when they had unstable blood sugars with an active diagnosis of diabetes with recent discontinuation of insulin with multiple physician/practitioner progress notes that indicated that R67 needed blood sugar monitoring. The DON reported they would check with the practitioner/physician. The DON later came and reported that the practitioner wanted to monitor the HgbA1C (hemoglobin A1c test - a blood test that shows the average blood sugar level over the past ,d+[DATE] months). There was no physician order or progress note addressing the rationale. It must be noted that R67 was diagnosed with diabetes prior to their original admission of the facility and had been on sliding scale insulin until [DATE]. An interview with the Unit Manager S was completed on [DATE] at approximately 2:45 PM. During the interview they were queried about blood sugar monitoring for R67 after they were readmitted to the facility on [DATE]. Unit manager S reviewed the EMR and confirmed that they did not monitor the blood sugar for R67. They were not sure and it might have been a possible glitch in their EMR system. They noted that they would reach out to the practitioner and report back. An interview with the Nurse Practitioner (NP) U was completed on [DATE] at approximately 2:45 PM. NP U was queried on why R67's sliding scale insulin had not been reordered and blood sugar monitoring after their readmission to the facility on [DATE] with an active diagnosis of diabetes. NP U reported that R67's HgA1C was within normal limits (5.7) while they were in the hospital and they had discontinued the insulin. When queried why R67's blood sugar was not monitored, NP U reported that they were just recommending monitoring the HgA1C. When queried further about the physician follow up notes that read no hypoglycemic event, monitor blood sugars no further explanation was provided. NP U also confirmed that if they were recommending HgA1C monitoring the frequency of monitoring and details of their recommendation would reflect in their progress notes and orders. NP U was notified that their rationale does not reflect on their documentation and R67 did not have any orders to monitor their blood sugar since [DATE], they reported that they understood the concerns. A facility policy/protocol on blood sugar monitoring was requested via e-mail and was not provided prior to survey exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/10/2024

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on observation, interview, and record review, the facility failed to provide an appropriate support surface bed for one resident (R45) of two residents reviewed for pressure injuries, resulting in an avoidable facility acquired unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar), pressure ulcer and unnecessary pain. Findings Include: On 7/8/24 at 11:55 AM, a clinical record review identified R45 developed an unstageable pressure ulcer, not present on admission. R45 was admitted to the facility on [DATE] with medical diagnoses that include opioid abuse, hypertension, anemia, chronic kidney disease, and rheumatoid arthritis. R45 is independent with Activities of Daily Living (ADL's), including self-mobility with assistive devices. The most recent Brief Interview for Mental Status (BIMS) score was 15/15, indicating R45 was cognitively intact. On 7/8/24 at 11:55 AM, R45 was observed appropriately dressed, sitting up on the side of the bed eating breakfast. After introductions, R45 shared how the pressure sore on his left buttock developed. R45 quickly stated, That should of never happened, and I am still upset it has not healed. R45 went on to explain that they were admitted in July 2023,made multiple verbal complaints to staff that the bed mattress did not have support, and the bar from the bed frame kept applying pressure to the buttock area. R45 stated, The bar under the mattress was applying so much pressure, I would pull my clothing out of the closet, bunch it up, and place it underneath my buttock area to provide a support barrier from the bed frame. On 7/8/24 at 1:45 PM, a dressing change observation of the left buttock was conducted with Licensed Practical Nurse (LPN) M and LPN O. R45 independently stood up and removed clothing covering the left buttock. The dressing was observed to be dated 7/6/24. The dressing was removed and revealed moderate amounts of seropurulent (cloudy yellow color) drainage on the gauze. The wound was observed at a Stage III Pressure Ulcer (full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissues). The length was approximately four centimeters (cm), and the wound bed was pink and macerated. The wound margin was pink and well defined. Upon completion of the dressing change, R45 stated the dressing should be changed every day, but sometimes the nurses do not do it. LPN N replied that dressing changes were believed to be done as needed, and every other day. LPN N reviewed the electronic medical record orders and verified the most recent dressing change order dated 6/24/24 at 14:44 documented: Left Buttock Every Night shift for wound care and as needed. The Treatment Administration Record (TAR) documented the dressing change was done on 7/7/24, and the dressing removed was dated 7/6/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 8:39 AM, R45 confirmed a formal grievance was not submitted to the facility, but the previous maintenance manager and any staff that took care of him, were aware the bed was not right, and the bar continued to press onto my backside. R45 stated, One day, I complained of pain in my left buttock area, and when the nurse saw it, they said 'you have a pressure sore'. When that was said, I was so mad! I kept telling the staff the bed was not right and nothing was done. I am still upset because this was preventable, and no one would listen to me. On 7/10/24 at10:28 AM, Maintenance Plant Operations Manager O confirmed the facility did not have historical maintenance requests documented with the previous maintenance manager for R45. On 07/10/24 at 12:31 PM, Wound Care Nurse Practitioner (NP) O was contacted and inquired if the previous Wound Care provider shared how the pressure sore developed. NP O confirmed there was never verbal conversation with the previous wound care provider, just glad to see it was improving. On 7/10/24 at 1:20 PM, LPN N was questioned how they identified the wound was facility acquired. LPN N stated, The skin was always intact until that day, [R45] asked to have me look at it. When inquired if R45 ever reported to LPN N the bed was a problematic, LPN N confirmed nothing was ever mentioned to her personally but had overheard other staff mention he complained the bed was a problem. Clinical record review revealed on 1/20/24, a skin assessment was conducted and identified the skin was intact. A Braden Score (tool to assess the risk of developing pressure ulcers or injuries) was calculated and totaled 19 (score 19-23: No Risk) which indicated R45 was not at risk for developing skin breakdown. A Progress note from LPN N dated 1/25/24 at 10:34 AM documented: No orders noted for left buttock open area, only for prevention. Area cleaned, dried, and covered with border gauze. Physician aware, wound consult ordered. On 1/26/24, Wound Care Consultation revealed: Visit Type: Established Patient New Wound. Patient is alert and oriented, continent, and walks per staff. Initial Wound Assessment: Left Buttock is Unstageable Pressure Injury full thickness skin and tissue loss. Measurements are 7.2 cm length X 6 cm width X 0.8 cm depth with an area of 43.2 square cm. There is moderate amount of serosanguinous (composed of blood and clear yellow liquid) drainage noted and has mild order. Margin is undefined and wound bed has 26-50% slough, 26-50% epithelization. Peri wound skin was friable (thin skin, fragile) and moist. On 7/10/24 at 3:49 PM, The Director of Nursing (DON) was informed of a facility acquired pressure ulcer was identified for R45. The DON acknowledged this information and was observed taking notes of the concern. Review of the facilities policy title: Skin and Pressure Injury Risk Assessment and Prevention dated 2/2024 documented: .Basic or routine care interventions could include .Provide appropriate, pressure-redistributing, support surfaces .

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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** 47283 Based on observation, interview, and record review facility failed to implement interventions to maintain or prevent further decline in range of motion for one (R3) resident of three Residents reviewed for range of motion/positioning resulting in a potential for further decline in range of motion or worsening of contracture. Findings include: A record review revealed R3 was a long-term resident of the facility and was originally admitted on [DATE]. R3's admitting diagnoses included seizures, stroke, osteoarthritis, abnormal posture, and muscle weakness. Based on the Minimum Data Set (MDS) assessment dated [DATE], R3 had a Brief Interview for Mental Status (BIMS) score of 3/10, indicative of significant cognitive impairment. An initial observation was completed on 7/8/24 at approximately 9:00 AM. R3 was observed in the bed with their eyes closed. R3 did not respond when called their name. The observation was completed from R3's right side. R3's right arm was resting partly on their chest. R3's elbow was bent and the fingers in a clenched position. R3 had long fingernails that were brown in color. The nails of index, middle, and ring fingers were touching the palm of their hand. The exposed area of the palm did not appear clean. There were no braces or palm protectors on or near the bed. Multiple follow-up observations were completed on 7/8/24 at approximately 10 AM, 11:45 AM, 2 PM, and 4:15 PM. During 10 AM observation R3 was awake. They were complaining of pain all over the body. R3's right elbow was bent and right hand was contracted and the fingernails were touching the palm of their hand. The nails were brown and they appeared in the same condition as during the initial observation. This surveyor asked R3 if they were able to move their hand and they did not respond. During the follow up observations completed later that day at the above times, R3's elbow and hand appeared in the same position as earlier. They did not have any brace or palm protector or any other interventions to maintain the range of motion and prevent complications from the contractures. On 7/9/24, at approximately 8:50 AM R3 was observed in their bed. R3 was awake and they did not have any brace or palm protector on their right hand. Later that day follow up observations were completed at approximately 10:30 AM and 11:45 AM. R3 was observed in the bed in a facility provided gown. Right hand did not have any brace or palm protector and the fingernails were touching the palm of the hand. Review of R3's Electronic Medical Record (EMR) revealed a physician order dated 9/16/22 that read, soft carrot or palm protector to right hand as tolerated to maintain skin integrity and another physician order dated 9/7/21 that read, Apply right hand splint for 4-6 hours daily, monitor skin integrity. R3's comprehensive care plan revealed an intervention that read I will have assistive devices and braces. Review of R3's Kardex (Care plan for Certified Nursing Assistants - CNA) under the dressing section read, CNA maintenance program: Apply green/soft carrot/palm protector on right hand to maintain skin integrity as per patient's tolerance. (continued on next page)

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	235187	A. Building B. Wing	07/10/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the document/report current care record revealed that section for staff to sign off on tasks for palm protector/soft carrot application on R3's right hand. An interview with CNA R was completed on 7/9/24 at approximately 11:55 AM. During this interview R3 was in their bed and did not have any brace or splint on their right hand. CNA R was queried about R3 and the care they had provided. CNA R reported that they had completed the morning care for R3. The surveyor queried CNA R about the brace for R3's right hand. CNA R confirmed that R3 had used a brace and they were not able to locate the brace in the room and added that it might be in laundry and they would check and follow-up. Later they reported that they located the brace they tried to apply and they were unsuccessful. An interview with the Director of Nursing (DON) was completed on 7/9/24 at approximately 1:45 PM. The DON was queried about the facility process to monitor the orders for splints/braces/nursing maintenance program etc. The DON reported that CNAs completed the task as ordered. When queried on how they were monitoring the CNAs following the orders and completed the task (per Kardex/care plan). The DON reported that the nurses were supposed to check and make sure that CNAs were following the orders. The DON was notified on the multiple observations completed for R3 on 7/8/24 and 7/9/24 when they did not have a brace on their right hand and the concern that staff had signed off on the task report as completed when R3 did not have their brace on during all the above observations. The DON reported that they understood the concern. An interview was completed with unit manager S on 7/9/24 at 3:10 PM. Unit manager S was notified of the concern and multiple observations completed on 7/8/24 and 7/9/24. Unit manager S reported that staff should have completed the task as ordered and they understood the concern and would follow up with their staff. A facility provided document titled Range of Motion with a revision date 1/1/22 read in part, Policy Explanation and Compliance Guidelines: 1.The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventive care. 2.Assessment for Range of Motion a. The resident's range of motion (such as current extent of movement of his/her joints and the identification of limitations) will be assessed on admission/readmission, quarterly, and upon significant change. b. Residents who exhibit limitations in range of motion, initially and thereafter, will be referred to the therapy department for a focused assessment of range of motion and/or restorative nursing program. c. Nursing assistants will report any significant changes in range of motion, as noted during daily care activities, to the resident's nurse when any changes are noted. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.Care Planning. a. Based on the comprehensive assessment, the facility will provide interventions, exercise sand/or therapy to maintain or improve range of motion. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: I. Appropriate services (specialized rehabilitation, restorative, maintenance). ii. Appropriate equipment (braces or splints). iii. Assistance as needed (active assisted, passive, supervision). c. Care plan interventions will be developed and delivered through the facility's restorative program, or through specialized rehabilitative services as ordered by the attending practitioner. d. Interventions will be documented on the resident's person-centered care plan/restorative care plan. e. A nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions. Refusals of care or problems associated with range of motion exercises will be documented in the medical record .

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	235187	A. Building B. Wing	07/10/2024

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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** 49083 Based on observation and interview, the facility failed to ensure an environment was free from accident hazards regarding storage of sharp objects in four of four emergency carts observed resulting in the increased risk of all residents sustaining an avoidable accident. Findings Include: On 7/9/24 at 10:39 AM, The emergency cart stored on the 100 Hallway was observed with a small screwdriver lying on top of the of the cart. The drawers were unlocked and revealed one disposable razor, two suture removal kits containing sterile scissors and suture forceps, and one sharps containing used syringes. On 7/9/24 at 10:45 AM, The emergency cart stored in the hallway in front of room [ROOM NUMBER] was observed unlocked. The top drawer opened contained two disposable razors and the second unlocked drawer contained bandage scissors. On 7/9/24 at 11:20 AM, The emergency cart stored on the 229 hallway was observed with a red sharps container containing used syringes. On 7/9/24 at 11:45 AM, The emergency cart stored on the locked unit in front of room [ROOM NUMBER] was observed with the drawers unlocked and revealed one disposable razor, one suture removal kit containing sterile scissors and suture forceps. The top of the cart was observed containing a black bag storing emergency suction equipment and supplies. Further observation identified a Resident walking down the hall and wandered to the emergency cart. The Resident pulled opened the top draw and then closed it multiple times. The Resident then lifted the black bag containing the suction equipment off the cart and continued to carry it down the hall. 07/09/24 01:52 PM-The Director of Nursing (DON) was informed of the of sharp items observed in unlocked emergency carts and the observation of a Resident opening the drawers and walking away with emergency medical equipment. On 7/9/24 at 2:56 PM, The DON and Licensed Practical Nurse (LPN) Unit Manger A acknowledged and were observed inspecting the emergency carts. The DON commented that the emergency carts would be stored in the locked medication rooms until they figure out what to do.

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	235187	A. Building B. Wing	07/10/2024

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview, and record review, the facility failed to monitor weight and ensure timely interventions were implemented to prevent significant weight loss for one resident (R10) of four residents reviewed for nutrition, resulting in a 13.5% weight loss from February 12, 2024 to May 1st, 2024. Findings include: On 7/08/24 at approximately 9:06 a.m., R10 was observed in their room, laying in their bed with enteral formula infusing. R10 was observed with food debris on their hospital gown and was queried if they had lost any weight and they indicated they did. On 7/8/24 the medical record for R10 was reviewed and revealed the following: R10 was initially admitted to the facility on [DATE] and had diagnoses including Protein Calorie-Malnutrition and Anorexia. A review of R10's MDS (minimum data set) with an ARD (assessment reference date) of 5/14/24 revealed R10 was dependent on facility staff for most of their activities of daily living. R10's BIMS score (brief interview for mental status) was four, indicating severely impaired cognition. Section K indicated weight loss was no or unknown. A review of R10's comprehensive plan of care revealed the following: Focus-I have the potential for a nutritional/hydration problem r/t (related to) COPD (Chronic obstructive pulmonary disease), Depression , Dysphagia, Obesity, Tube feed, CHF (Congestive heart failure), HTN (Hypertension) . anorexia .I am on enteral feeds- rate has been decreased slightly to improve po (by mouth) intake. Date Initiated: 10/03/2023 .Interventions-Monitor my weight. Date Initiated: 10/03/2023 .Report any significant weight changes I have to my physician and Me/DPOA (durable power of attorney)/Guardian. Date Initiated: 10/03/2023 . A Nutritional assessment dated [DATE] revealed the following: Category: At risk for malnutrition .1b. Most Recent Weight: 205.1 Date: 12/25/2023 .1f. Weight History/Changes: Wt (weight) appears stable near ~200lbs (pounds) .1f. Weight History/Changes: Wt appears stable near ~200lbs .16a. My nutrition goals while here are: maintain my nutritional status as evidenced by tolerating enteral nutrition, weight to remain stable, and no s/s (signs/symptoms) of dehydration through next review date A Nutritional assessment dated [DATE] revealed the following: Category: At risk for malnutrition .1b. Most Recent Weight Weight: 211.1 Date: 02/12/2024 .1f. Weight History/Changes: Wt appears stable near ~200lbs .Focus: I have the potential for a nutritional/hydration problem r/t Intervention: Monitor my weight .16a. My nutrition goals while here are: to tolerate my enteral feedings & to have wt stability through next review Further review of the assessment revealed the weight utilized to measure weight stability in the assessment was the weight on 2/12/24 at 211.1 lbs. (continued on next page)

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	235187	A. Building B. Wing	07/10/2024

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A dietary progress note dated 4/4/24 revealed the following: Dietary Note-2/12: 211.1lbs, BMI (body mass index) 34.1 indicating obesity Class I. Resident seen bedside w/TF (tube feeding) running at rate .Res (resident) & nursing staff report no new nutritional concerns or questions at this time. Recto (recommend) continue w/POC (plan of care). Monitor wt, skin, labs, TF tolerance. RD (Registered Dietician) to follow Further review of the note revealed the RD was still utilizing the weight documented on 2/12/24 of 211.1 lbs. A Practitioner Progress Note dated 4/11/24 revealed the following: Note Text: seen for eval (evaluation) c/o (complained of) toe pain dysphagia, not interested in oral intake, continue with TF . A review of R10's recorded weights revealed the following: 2/12/2024-211.1 lbs (pounds), 4/12/2024-188 lbs (significant 10.94 % loss) 5/1/2024-182.6 lbs (additional 2.87% loss) 6/1/2024- 182.6 lbs . Further review of R10's weights revealed no documented weight in March 2024. A second review of R10's dietary and medical provider progress notes and assessments revealed no notes or assessments were completed after the significant weight loss of 10.94% (188 lbs) was documented on 4/12/24 for the month of April assessing the identified weight loss. A dietary note dated 5/3/24 (after the May 1st weight showing a further 2.87% weight loss from April) revealed the following: 5/3/2024-Dietary Note CBW (current body weight): 182.6lbs, Wt triggered for sig (significant) loss. Res is reported to be tolerating TF. Writer notified PA (Physicians assistant). Recommended adjusting TF to: Jevity 1.5 (a formula with higher fiber content) @ 65mL/hr x 18hr = 1170mL, 1755kcal, 75g/pro, 889mL/h2o. Flush 45mL/hr x 18hr = 810mL/h2o = ~1699mL/h2o total (before med flush). Monitor any s/s of TF intolerance. Continue to monitor wt. RD to follow On 7/9/24 at approximately 2:05 p.m., during a conversation with Registered Dietician Q (RD Q), A of R10's weight significant weight loss was conducted. RD Q indicated that weights for all residents should be done monthly at a minimum and that when the weight in March was missed they had to use the last known weight which was on February 11th for their assessment on 3/25 so they could only assume R10 had not lost weight. RD Q indicated they have had a problem obtaining weights in facilities. RD Q was queried if they had been informed of R10's significant weight loss as indicated by their weight on 4/12 at 188 and they indicated that they did not know. RD Q was then queried if they had been made aware of the additional weight loss noted on the 5/1/24 weight of 182.6 and they reported that they did not remember but that they reviewed it on 5/3 and changed the tube feeding order so someone must have informed them. RD Q was queried if it was their expectation to be informed of any significant weight loss to reassess for the cause of the weight loss and they indicated that it was and that the electronic medical record will provide an alert of weight loss but that it must have been missed. On 7/10/24 at approximately 2:46 p.m., The facility Administrator indicated that the facility had identified a problem with weights being completed and monitored in June 2024 and had completed a past non-compliance with compliance date of 7/8/24 in which they had already completed a quality assurance/performance (QAPI) improvement meeting addressing it. (continued on next page)

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	235187	A. Building B. Wing	07/10/2024

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 7/10/24 a facility document titled Weight Monitoring was reviewed and revealed the following: 4. Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident ' s assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. 5. Weight will be obtained upon admission, readmission and weekly for the first four weeks after admission and at least monthly unless ordered by the physician. 6. Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight to determine if a re-weight is necessary. 7. A significant change in weight is defined as: a. 5% change in weight in 1 month (30 days) b. 7.5% change in weight in 3 months (90 days) c. 10% change in weight in 6 months (180 days) .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review the facility failed to ensure that a resident with Post Traumatic Stress Disorder (PTSD) was assessed to identify and implement interventions to mitigate triggers and received care and services that accounted for experiences for one (R54) of one resident reviewed for trauma informed care. Findings include: On 7/8/24 at 9:20 AM, R54 was observed lying in their bed. R54's left arm was held tight against their chest with their hand fisted against their neck. When asked if they could move their left arm, R54 explained they could not move their left arm or their left leg. Review of the clinical record revealed R54 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: stroke with left side paralysis, PTSD and schizophrenia. According to the Minimum Data Set (MDS) assessment dated [DATE], R54 had moderately impaired cognition. Review of R54's comphrensive care plan revealed there was no focus, goal or interventions/tasks for PTSD. Review of R54's assessments revealed there was no assessment for trauma informed care. Review of R54's Psychiatric (Psych) progress notes revealed R54 had been seen by Psych on 10/11/23, 2/23/24, 2/27/24, 4/25/24, and 5/10/24, however, none of the evaluations had addressed PTSD. On 7/9/24 at 12:08 PM, the Social Work Director (SWD) was interviewed and asked if a trauma informed care assessment had been completed for R54. SWD explained the assessment had not been done. SWD was asked why it had not been completed when R54 had a PTSD diagnosis. SWD explained R54 had been admitted with that diagnosis and the assessment had not been done. SWD was asked why R54 did not have a PTSD care plan. SWD explained the care plan would be triggered by the assessment, so since the assessment had not been done, the care plan was never implemented. SWD was asked who was responsible for the trauma informed care assessment. SWD explained Social Work did the assessment. When asked how staff would know if R54 had triggers for their PTSD, SWD had no answer. On 7/10/24 at 12:52 AM, the Administrator was interviewed and asked about R54 never being assessed for their PTSD diagnosis. The Administrator explained R54 should have had the trauma informed care assessment upon admission, and determine if there were triggers that staff needed to be aware of. Review of a facility policy titled, Trauma Informed Care revised 4/2024 read in part, .Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social emotional, or spiritual well-being . The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that me be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools . The facility will identify triggers which may re-traumatize residents with a history of trauma .

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	235187	A. Building B. Wing	07/10/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on interview and record review, the facility failed to ensure record of the attending physician's response to the pharmacy recommendations for one (R63) of five residents reviewed for monthly medication regimen reviews. Findings include: A review of R63's clinical record noted the resident was admitted to the facility on [DATE] with diagnoses that included: dementia, breast cancer and anorexia. A review of the resident's most recent Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 9/15 (moderate impaired cognition). A monthly Medication Regimen Review (MRR) dated 2/15/24 was noted in the resident's electronic record and noted, in part: please see report . There was no report and/or response found in R63's clinical record. On 7/9/24 at approximately 1:54 PM, an interview was conducted with the Director of Nursing (DON). The DON was informed that no report was found in the resident's electronic record. The DON noted that they were fairly new to the facility and would attempt to locate the report. On 7/10/24 at approximately 10:57 AM, the DON reported that they were not able to locate the report or indicate the possible concern regarding the MRR dated 2/15/24. The DON noted that it should have been addressed. On 7/10/24 at approximately 3:47 PM, a request was made for the facility policy pertaining to MRRs. Nothing was provided by the end of the survey.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49083 Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent. Two medication errors were observed from a total of 29 opportunities noted for one resident R49 of five residents observed for medication administration resulting in a medication error rate of 6. 9%. Findings include: On 7/9/24 at 8:55 AM, an observation of medication administration was conducted with Licensed Practical Nurse (LPN) T for R49. LPN T presented R49's ordered medications Eliquis (medication to thin the blood) 5 milligram (mg) & Ferrous Sulfate (Iron supplement) 325 mg, at which time was refused by the resident. On 7/10/24 at 9:15 AM, a record review of the Medication Administration Record (MAR) revealed, ordered Eliquis and Iron was administered on 7/9/24 at 8:00 AM by LPN T. On 7/10/24 at 9:37 AM, LPN T was interviewed and verbally confirmed Eliquis and Iron medications were not provided to R49 after the surveyor observation. LPN T reviewed the MAR and further acknowledged that it was signed as administered and was not given. On 7/10/24 at 11:05 AM, the Director of Nursing (DON) was informed, and observed taking note, LPN T signed off medications Eliquis and Iron and were not administered to R49. Review of the facility policy titled; Medication Administration dated 7/2019 documented: .If a regularly scheduled medication is withheld refused Documentation of the dose not administered is completed .An explanatory note is entered .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on interview and record review the facility failed to ensure laboratory services were provided and/or obtained timely as ordered by the physician for two (R63 and R65) out of two residents reviewed for laboratory services. Findings include: A review of R63's clinical record noted the resident was admitted to the facility on [DATE] with diagnoses that included: dementia, breast cancer and anorexia. A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 9/15 (moderate impaired cognition). Continued review of the R63's clinical record noted the resident was receiving Depakote Sprinkles 125 MG (a drug used to treat those with bipolar disease and to prevent seizures). A Pharmacy recommendation dated 4/7/24 noted as the resident takes Depakote, they suggested obtaining valproic acid levels (valproic levels need to be maintained for those on Depakote to ensure seizures, mood swings and side effects do not occur) to monitor the resident. An order dated 4/8/24 documented, .Order category: Laboratory .Type of lab . Valporic <sic>acid level . No laboratory results could be found in R63's clinical record. On 7/9/24 at approximately 1:54 PM, an interview was conducted with the Director of Nursing (DON). It was reported to the DON that no laboratory services pertaining to Valproic acid levels was found in the resident's clinical record. The DON noted that they would try to obtain laboratory results if possible. On 7/10/24 at approximately 10:57 AM, the DON reported that they were not able to obtain laboratory results per the order dated 4/8/24. 38271 Resident #65 On 7/8/24 the medical record for R65 was reviewed and revealed the following: R65 was originally admitted to the facility on [DATE] and had diagnoses including Paraplegia and Muscle weakness. A review of R65's MDS (minimum data set) with an ARD (assessment reference date) of 5/31/24 revealed R65 had lower extremity impairment on both sides and needed assistance from facility staff with most of their activities of daily living. A pharmacy recommendation dated 3/7/24 revealed the following: Resident takes depakote. No valproric acid level in the chart. Suggest getting valproric acid level to monitor therapy. Further review of the recommendation indicated the medical provider agreed with the recommendation and that labs were ordered on 3/27/24. A Physician's order dated 3/27/24 revealed the following: a1c (blood glucose), cmp (comprehensive metabolic panel), cbc w diff (complete blood count with differential), TSH (Thyroid stimulating hormone), lipid panel, vit D (vitamin D), valp (valproric) acid level . (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the laboratory (lab) results from 3/27/24 revealed no results from the ordered labs on 3/27/24. A second Physician's order dated 4/19/24 revealed the following: a1c, cmp, cbc w diff, TSH, lipid panel, vit D, valp acid level . A review of the lab results with a collection date of 4/26/24 revealed the valporic level as 7 indicating it was low with a reference range of 50-100. On 7/9/24 at approximately 1:53 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding why the pharmacy recommendation dated 3/7/24 and lab results from the Physician's order dated 3/27/24 were not available to review in the medical record and The DON indicated they would have to check and see if they had any results from the ordered lab tests. On 7/10/24 at approximately 10:58 a.m., during a follow-up conversation with the DON, the DON was queried if they had any results for the lab ordered on 3/27/24 and they indicated that they had no results for labs ordered on 3/27/24 until after the repeat order on 4/19/24. The DON was queried why there was a month delay in obtaining the laboratory diagnostics and they indicated they did not know. On 7/10/24 a facility document tilted Laboratory, Radiology, and other Diagnostic Services was reviewed and revealed the following: Policy: The facility will provide laboratory and radiology services when ordered in accordance with state law. Policy Explanation and Compliance Guidelines: 1. The facility will provide or obtain laboratory, radiology or other diagnostic services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented for nine (R2, R10, R17, R32, R37, R45, R50, R52 and R70) of nine residents reviewed for EBP. Findings include: Review of a facility policy titled, Enhanced Barrier Precautions revised 3/2024 read in part, .An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO (multi-drug resistant organism) . Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room . R17 On 7/8/24 at 9:16 AM, R17 was observed to be lying in bed, a urinary catheter bag was hanging from the side of the bed. R17 was asked if they had any wounds. R17 explained they had a wound on their right hip. No EBP sign was posted, and no personal protection equipment (PPE) was observed in or near R17's room. Review of the clinical record revealed R17 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: stroke, multiple sclerosis and neuromuscular dysfunction of bladder. According to the Minimum Data Set (MDS) assessment dated [DATE], R17 had intact cognition, a pressure ulcer and an indwelling urinary catheter. Review of R17's physician orders revealed no order for EBP. On 7/9/24 at 8:36 AM, observation of R17's room revealed a sign announcing EBP was on the door and an three drawer isolation cart was located just inside the door of the room. On 7/9/24 at 10:55 AM, Certified Nursing Assistant (CNA) G was interviewed and asked if they had been trained on what the EBP sign meant that was posted on the doors of resident rooms. CNA G explained they had been trained on EBP a long time ago, but this was the first they had seen the signs posted. When asked when the training had been, CNA G explained it was probably April or May 2024. R52 On 7/8/24 at 9:43 AM, R52 was observed lying in bed. A tube feed pump was observed providing enteral nutrition to R52. R52 did not respond to any questions asked. No EBP sign was posted, and no PPE was observed in or near R52's room. Review of the clinical record revealed R52 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: stroke, gastrostomy status and dysphagia (difficulty swallowing). According to the MDS assessment dated [DATE], R52 had severely impaired cognition, had a feeding tube and was dependent on staff for all activities of daily living (ADL's). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/9/24 at 8:34 AM, observation of R52's room revealed a sign announcing EBP was on the door and an three drawer isolation cart was located just inside the door of the room. On 7/9/24 at 12:56 AM, Housekeeper H was interviewed and asked if they they knew what the EBP signs posted on resident doors meant. Housekeeper H explained they had been trained on EBP quite a while ago. 34275 R2 On 7/8/24 at approximately 10:14 AM, R2 was observed to be lying in bed sleeping. The resident was observed receiving tube feeding (a flexible tube that goes directly into the resident stomach). No EBP sign was posted, and no personal protection equipment (PPE) was observed in or near R2's room. 38271 Resident #37 On 07/08/24 at approximately 9:17 a.m., R37 was observed in their room, up in their bed. R37 was queried if they had any wounds and they indicated that they had multiple wounds. At that time, no PPE bins or transmission based precaution signage indicating EBP were to be utilized were noted near R37's room. At that time, R37 was also observed to have a PICC line (A peripherally inserted central catheter). Resident #10 On 07/08/24 at approximately 9:06 a.m,. R10 was observed in their room, laying in their bed with enteral infusing. At that time, R10 was not observed to have any signage near door or any PPE indicated they should be protected by staff utilizing enhanced barrier precautions. 47283 R32 On 7/8/24 at approximately 9:05AM, R32 was observed in their bed. R32 was receiving their tube feeding (a flexible tube that was surgically placed directly on the stomach to receive nutrition and hydration). No EBP sign was posted in the room. The were no personal protection equipment (PPE) was observed in or near R32's room. Review of R32's Electronic Medical Record (EMR) did not reveal any orders or care plans for EBP. An interview was completed with LPN V on 7/8/24 at approximately 10 AM. LPN V was queried if R32 were following any special precautions while providing care for R32. LPN V reviewed the Electronic Medical Record (EMR) for R32 and reported that they did not see any order and R32 was not on any precautions. They added that they were using gloves when they handled the tube feeding. R50 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/8/24 at approximately 10:15 AM, R 50 was observed in their bed. R32 had a urinary catheter and the bag was placed on the left side of the bed. No EBP sign was posted in the room. The were no personal protection equipment (PPE) was observed in or near R50's room. Review of R50's EMR did not reveal any orders or care plans for EBP. R70 On 7/8/24 at approximately 9:15 AM, R70 was observed in their bed. R70 was receiving their tube feeding (a flexible tube that was surgically placed directly on the stomach to receive nutrition and hydration). No EBP sign was posted in the room. The were no personal protection equipment (PPE) was observed in or near R70's room. Review of R70's EMR did not reveal any orders or care plans for EBP. 49083 Resident 45 R45 was admitted to the facility on [DATE] with medical diagnoses: opioid abuse, hypertension, anemia, chronic kidney disease, and rheumatoid arthritis. R45 had a Brief Interview for Mental Status score of 15/15 indicating cognitively intact. On 1/25/24, R45 was identified as developing a facility acquired pressure ulcer to the left buttock and required dressing changes. On 7/8/24 at 1:45 PM, A dressing change observation for R45 of the left buttock was conducted with Licensed Practical Nurse (LPN) M and LPN N. Upon entering R45's room, Enhanced Barrier Precaution (EBP) signage and available Personal Protective Equipment (PPE) was not observed. LPN N was present, and LPN M was observed performing the dressing change without donning required PPE. LPN M removed the dressing and revealed moderate amounts of seropurulent (cloudy yellow color) drainage on the gauze. The wound was observed as a Stage III Pressure Ulcer (full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissues), the length was approximately four centimeters (cm), and the wound bed was macerated (softening and breakdown of the skin due to moisture). On 7/8/24 at 2:30 PM, LPN N was questioned about Enhanced Barrier Precautions. LPN N replied if residents were on contact precautions, then PPE is worn. LPN N stated there was mention of EBP a while ago, then further confirmed no knowledge of Enhanced Barrier Precautions were required and implemented on 4/1/24 for R45.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 39592 Based on interview and record review, the facility failed to maintain an effective antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic administration, employee health illness log, and infection mapping for the month of May 2024 resulting in the potential of uncontrolled spread of infectious organisms. Findings include: Review of a facility policy titled, Antibiotic Stewardship Program revised 1/2024 read in part, .It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . On 7/10/24 at 2:32 PM, review of the facility's infection control program with the Director of Nursing (DON), who served as the Infection Control Nurse revealed for the month of May 2024 there was one Monthly Infection Control Log (Line List) that had three residents names on it, however, none of the lines were completed. Another Line List sheet contained one resident with the entire line filled out. No infection mapping or employee health illness log were found. The DON was asked about the documentation for May 2024. The DON explained she had started at the facility at the end of May 2024 and had discovered there had been no antibiotic stewardship done in May 2024 by the previous DON. The DON was asked about the second Line List sheet that contained one resident and was completely filled out. The DON explained she had started that sheet when she started at the facility due to the antibiotic stewardship program in May 2024 had been a mess and they had revamped the program. On 7/10/24 at 4:00 PM, the Administrator was interviewed and asked about the antibiotic stewardship program. The Administrator explained they had identified a problem with the program in May 2024 and had completed a past non-compliance with a compliance date of 6/1/24 in which they had already completed a quality assurance/performance (QAPI) improvement meeting addressing it.