STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235214	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to ensure a resident was assessed for the safe self-administration of medication and to have medication kept at bedside for one (R8) of one resident reviewed for self-administration of medication. Findings include: On 3/18/25 at 10:53 AM, the door to R8's room was closed. Upon entry into the room, the resident was seated upright on the side of the bed holding a small clear plastic vial. A nebulizer machine (a small machine that turns liquid medicine into a mist that can be inhaled) was observed on a table next to the bed. When asked about the small vial, R8 stated that was for their breathing treatment. When asked if the nurse had given that to the resident for them to do themselves, R8 stated Yes, it's for me to do. Review of the clinical record revealed R8 was admitted into the facility on [DATE] with diagnoses that included: schizoaffective disorder, acute on chronic systolic heart failure, chronic obstructive pulmonary disease (COPD), asthma and dyspnea. According to the Minimum Data Set (MDS) assessment dated [DATE], R8 scored 13/15 on the Brief Interview for Mental Status (BIMS) exam which indicated they had intact cognition. Further review of the clinical record revealed there was no assessment, care plan, or physician order completed to indicate R8 was able to safely administer their own breathing treatment. Review of the care plans, orders and assessments revealed none for resident's ability to self-administer breathing treatment. The care plan for I have altered respiratory status/potential for difficulty with breathing r/t (related to) COPD, Asthma. - initiated 1/4/25, revised 1/6/25 included an intervention for Administer medication/puffers as ordered. Monitor for effectiveness and side effects. The physician orders included: Albuterol Sulfate HFA (Hydrofluoroalkane) Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Micrograms/Acutation) (Albuterol Sulfate) 1 puff inhale orally every 6 hours as needed for wheezing. This order started on 1/5/25. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/SML (Milligrams per Symptom-monitored Loading Dose) 1 applicatorful inhale orally every 6 hours for copd. This order started on 3/4/25. Review of the Medication Administration Records for the above treatments revealed Nurse 'C' documented administration of the ipratropium-albuterol solution 0.5-2.5 (3) MG/ML on 3/18/24 at 12:00 PM and 6:00 PM. Nurse 'B' had documented administration at 12:00 AM and 6:00 AM. On 3/19/25 1:45 PM, an interview was conducted with the Director of Nursing (DON) who reported they had been in their role as of January 2025. When asked about the facility's process for self-administration, the DON reported there should be an assessment, physician order and care plan. The DON was informed of the observation for R8 on 3/18/25 and they reported they would have to follow-up. On 3/19/25 at 2:35 PM, an interview was conducted with Nurse 'C'. Nurse 'C' confirmed they were assigned to R8 yesterday and had taken over for Nurse 'B' who worked the evening prior as well as the evening of 3/18/25. When asked about R8's breathing treatment and their process for administration, Nurse 'C' reported they usually give it to the resident, stand outside the room and make sure it's done. When asked if they would give the nebulizer vial to the resident to do themselves, Nurse 'C' reported I would not personally give him anything like that. He's alert, but has confusion. Nurse 'B' was attempted to be interviewed by phone, but there was to return call. According to the facility's policy titled, Resident Self-Administration of Medication dated 2/2025: .A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely .No medication shall be left unattended without the residents' knowledge that it has been left there for them .The care plan must reflect resident self-administration and storage arrangements for such medications .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 Based on observation, and interview the facility failed to offer a shower for one of one resident (R39) reviewed for accommodation of needs, resulting in R39's bathing preferences to be unrecognized. Findings include: On 3/18/25 at 10:30 AM, R39 was observed in their room and reported that she loved the facility, had no issues and the staff took great care of their needs, however R39 reported that they would like to take a shower. R39 expressed that the facility did administer bed baths but stated that it was nothing better than the actual water from the shower. R39 stated that the reason they were unable to shower was because their wheelchair did not fit into the shower room. A review of the record revealed that R39 was admitted to the facility on [DATE] with the diagnosis of schizoaffective disorder, bipolar, difficulty walking and morbid obesity. The Minimum Data Set (MDS) completed on 1/14/25 showed that R39's Brief Interview for Mental Status score (BIMs) of 15, which indicated high function cognitive ability. On 3/19/25 at 9:10 AM, the Director of Nursing (DON) was asked why couldn't R39 take a physical shower. The DON replied that the resident received bed baths so R39 did not miss being bathed. The DON was asked why couldn't R39 get a shower in the shower room or their bedroom and the DON replied that she would investigate why they did not receive showers. On 3/19/25 at 12:10 PM, R39 was asked that if staff were to offer them a shower would they take one, R39 replied, Yes. On 3/20/25 at 12:03 PM, the DON followed up on R39 getting showered and stated that they were working with therapy to find solutions to get R39 in the shower as their wheelchair did not fit through the doorframe. It should be noted that the resident was admitted to the facility in October of 2024. There was no additional information provided by the exit of survey.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review, the facility failed to ensure an updated annual review of a Do-Not-Resuscitate (DNR) order with a legal guardian was in place for one (R32) of three residents reviewed for advance directives. Findings include: According to MCL 700.5314 [NAME] and duties of guardian, effective 2/3/14, amended 2/6/18, .(d) The power of a guardian to execute, reaffirm, and revoke a do-not-resuscitate order on behalf of a ward is subject to this subdivision. A guardian shall not execute a do-not-resuscitate order unless the guardian does all of the following: (i) Not more than 14 days before executing the do-not-resuscitate order, the guardian visits the ward and, if meaningful communication is possible, consults with the ward about executing the do-not-resuscitate order. (ii) The guardian consults directly with the ward's attending physician as to the specific medical indications that warrant the do-not-resuscitate order. (e) If a guardian executes a do-not-resuscitate order under subdivision (d), not less that annually after the do-not-resuscitate order is first executed, the guardian shall do all of the following: (i) Visit the ward and, if meaningful communication is possible, consult with the ward about reaffirming the do-not-resuscitate order. (ii) Consult directly with the ward's attending physician as to specific medical indications that may warrant reaffirming the do-not-resuscitate order . Review of the clinical record revealed R32 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: major depressive disorder, schizoaffective disorder and bipolar disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R32 had moderately impaired cognition. The clinical record also indicated R32 had a legal guardian and was a DNR. Review of a Medical Treatment Decision Form for R32 revealed a signature in the box for DNR Do Not Resuscitate, signed by R32's guardian and dated 1/24/24. Review of R32's progress notes revealed no documentation of communication between R32's guardian and R32's physician regarding R32's continued DNR status. On 3/19/25 at 12:19 PM, Social Worker (SW) D was interviewed and asked why R32's DNR order had not been reaffirmed since it was over the annual time frame. SW D explained she was not aware a DNR order from a guardian required annual review. When asked about the lack of communication between R32's guardian and physician, SW D had no answer. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Residents' Rights Regarding Treatment and Advance Directives revised 2/2025 revealed it did not address the specific requirements for guardians to reaffirm annually or the communication between the guardian and physician.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review the facility failed to ensure the appropriate Notice of Medicare Non-Coverage (NOMNC) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) were provided and completed for three (R44, R49 and R59) of three residents reviewed for beneficiary notification, resulting in the residents and/or representatives to be uniformed of the potential private pay charges for continued services at the facility, and the inability to file an appeal. Findings include: Review of the documentation provided by the facility for the beneficiary notices included only three residents (R44, R49 and R59). R44 The worksheet identified R44 had a Medicare A discharge date of [DATE] and was marked as the resident remained in the facility. Review of the clinical record revealed R44 was initially admitted into the facility on [DATE], discharged on [DATE] and readmitted on [DATE] under Medicare A skilled care. R44's payer source changed from Medicare A to private pay on 11/28/24. Review of the documentation provided by the facility for R44's beneficiary notices revealed there was no SNFABN completed when R44 came off skilled care on 11/28/24. R49 The worksheet identified R49 had a Medicare A discharge date of [DATE] and was marked as the resident remained in the facility. Review of the clinical record revealed R49 was initially admitted into the facility on [DATE], discharged to hospital on 1/4/25 and readmitted on [DATE] under Medicare A skilled care. R49's payer source changed from Medicare A to Medicaid on 3/13/25. Review of the documentation provided by the facility for R49's beneficiary notices revealed there was no SNFABN completed when R49 came off skilled care on 3/13/25. Additionally, the facility utilized a previous version of the NOMNC that had been approved 12/31/2011. [The current CMS (Centers for Medicare & Medicaid Services) 10123-NOMNC was updated effective January 2025 (Form CMS 10123-NOMNC OMB approval 0938-0953 Exp. 11/30/2027.] R59 The worksheet identified R59 had a Medicare A discharge date of [DATE] and was marked as the resident remained in the facility. (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the clinical record revealed R59 was initially admitted into the facility on [DATE]. The resident discharged on [DATE] and readmitted on [DATE] under Medicare A skilled care. R59's payer source changed from Medicare A to Medicaid on 11/11/24. The resident had another discharge on 12/23/24 and readmitted on [DATE] under Medicare A skilled care. R59's payer source changed from Medicare A to Medicaid on 1/25/25. Review of the documentation provided by the facility for R59's beneficiary notices revealed there was no NOMNC or SNFABN completed upon the most recent completion of skilled care services from 12/29/24 to 1/25/25. Additionally, there was no SNFABN completed when R59 came off skilled care on 11/11/24. On 3/20/25 at 10:32 AM, an interview was conducted with Nurse 'C'. When asked about whether R44, R49 and R59 had been issued a SNFABN with the NOMNC as they all remained in the facility upon completion of their skilled care, Nurse 'C' reported they were only issued the NOMNC. Nurse 'C' further reported the facility's process changed about four months ago and it was changed to now be completed by the Business Office. They reported they would have the Business Office Manager (Staff 'E') come to discuss further. On 3/20/25 at 11:30 AM, an interview was conducted with Staff 'E'. They reported they had worked at the facility since 2021 and recently taken over the beneficiary notices. When asked about the process for completing the NOMNC and SNFABN forms, Staff 'E' reported there have been several changes with the facility's process and it used to be the social worker, then the MDS nurse, then the Business office and they now became aware the forms they used were not the correct forms and also became aware of the need to issue SNFABN notices for residents that remained in the facility. According to the documentation provided by the facility for the policy for beneficiary notices, only the instructions for completion of a SNFABN were provided. The document titled, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) Form CMS-10055 (2024) documented, .These abbreviated instructions explain when and how the SNF ABN must be delivered. Please also refer to the Medicare Claims Processing Manual, Chapter 30, Section 70 for general notice requirements and detailed information on the SNF ABN. Information on the ABN (Form CMS R-131) can be found on the ABN webpage: http://www.cms.gov/Medicare/Medicare-General Information/BNI/ABN.html Medicare requires Skilled Nursing Facilities (SNFs) to issue the SNF ABN to Original Medicare, also called fee-for-service (FFS), patients prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial. The SNF ABN provides information to the patient so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to protect residents personal privacy for two (R1 and R5) of two residents reviewed for privacy. Findings include: On 3/18/25 at 9:44 AM, R1 and R5, roommates, were observed sleeping in their beds. The privacy curtain between the beds was observed to only have the mesh top part attached to the ceiling track, the bottom, solid part, which provides privacy was gone. On 3/18/25 at 10:11 AM, R1 was observed sitting in their wheelchair in the room. R5 was observed sleeping in their bed. R1 was asked about the missing privacy curtain. R1 explained it had been removed to clean it. When asked how long it had not been there, R1 explained it had been off for a while. R1 was asked about privacy when getting dressed or changed. R1 explained staff would close the door to the hall. Review of the clinical record revealed R1 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: heart disease, dementia and anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R1 had moderately impaired cognition and required the assistance of staff for activities of daily living (ADL's). Review of the clinical record revealed R5 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: dementia, stroke and heart disease. According to the MDS assessment dated [DATE], R5 had severely impaired cognition and was dependent on staff for ADL's. On 3/19/25 at 10:53 AM, Housekeeper (HK) L was interviewed and asked who at the facility took down and/or put up privacy curtains. HK L explained sometimes Housekeeping did it, and sometimes Maintenance did it. HK L was asked if the whole curtain was taken down, or just the solid part unbuttoned from the mesh top. HK L explained they would unbutton the bottom part as the mesh top really didn't get dirty. When asked if he knew about the privacy curtain being removed in R1 and R5's room, HK L explained he had not removed it. On 3/19/25 at 1:47 PM, the Environmental Services Manager (ESM) was interviewed and asked about the privacy curtain in R1 and R5's room. The ESM explained he had not known the privacy curtain was missing, so when he was told about it, he put one up between the beds. The ESM was asked if he knew who had taken the privacy curtain down. The ESM explained he did not know, but it was usually Maintenance or one of the male Housekeepers. On 3/19/25 at 2:35 PM, the Housekeeping Supervisor (HKS) was interviewed and asked about the privacy curtain in R1 and R5's room. The HKS explained the facility did not have any extra privacy curtains, when one needed cleaning, they had to take it down, send it to laundry and then put it back up. When asked how long that took, the HKS explained it took an hour to wash and an hour to dry. The HKS was asked if she knew who took it down, or when it was taken down. The HKS explained she did not know. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 8:50 AM, Laundry Aide (LA) M was interviewed and asked about the process for laundering privacy curtains. LA M explained they washed all the towels and linens, then privacy curtains, then residents' clothing. LA M was asked approximately how long it usually took for the privacy curtains to be washed and dried. LA M explained it usually took about a half-a-day before they were done. When asked if there were any extra privacy curtains, LA M explained there were no extra curtains. On 3/20/25 at 9:36 AM, an interview was conducted with the acting Administrator, the Regional Director of Operations (RDO). The RDO was informed of the concern of the lack of a privacy curtain between R1 and R5's beds for an unknown amount of time. The RDO explained there were extra curtains, and one should have been put up immediately. The RDO was informed that Maintenance, Housekeeping and Laundry personnel were not aware there were extra curtains. The RDO explained he was not aware staff did not know about the extra curtains. The RDO was asked regardless if there were extra curtains or not, should not something be put up between the beds to maintain privacy during ADL care. The RDO agreed privacy should be maintained.

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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** 39592 Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, homelike environment for one (R44) of nine residents reviewed for environment. Findings include: On 3/18/25 at 10:00 AM, R44 was observed lying in bed sleeping. R44 was observed to have closely cut hair of uniform length. On 3/18/25 at 12:03 PM, R44 was again observed lying in bed sleeping. R44 was dressed, had a mechanical lift sling positioned under them. A bottle of shampoo/body wash was observed on the windowsill. The head of the bed was elevated and on the floor, under the head of the bed was a pile of hair, approximately four inches in diameter. Review of the clinical record revealed R44 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: metabolic encephalopathy, vascular dementia and anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R44 had severely impaired cognition and required the assistance of staff for activities of daily living (ADL's). Review of R44's progress notes revealed a Discharge Note dated 3/18/25 at 7:20 PM that read in part, Resident was transferred to (local hospital) . On 3/19/25 at 10:40 AM, observation of R44's room and bed revealed the pile of hair was still under R44's bed. On 3/20/25 at 10:46 AM, the Housekeeping Supervisor (HKS) was interviewed and informed of the observation of a pile of hair under R44's bed even after being discharged from the facility. The HKS explained the expectation was that routine daily cleaning included sweeping the entire floor, including under the bed and behind furniture. Review of a 30 Day Look Back for R44's Shower/Bathing/Bed Bath task revealed documentation that R44 received a bed bath by Certified Nursing Assistant (CNA) P on 3/17/25. On 3/20/25 at 11:06 AM, CNA P was interviewed by phone and asked if they had cut R44's hair when they gave R44 a bed bath. CNA P explained they had not cut R44's hair. On 3/20/25 at 11:21 AM, a phone call was made to CNA Q, who had been assigned to R44 on 3/18/25 and a voice mail was left. No return call was made prior to the end of the survey. Review of a facility policy titled, Safe and Homelike Environment dated 1/11/21 read in part, .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for 11 residents (R#'s 37, 41, 43, 7, 19, 18, 33, 40, 36, 21, and R25) of 19 residents reviewed for abuse/neglect/mistreatment. Findings include: R19 On 3/18/25 the medical record for R19 was reviewed and revealed the following: R19 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Myocardial infarction. A progress note dated 2/25/25 revealed the following: Nursing Progress Note-Late Entry: Note Text: Medication was not administered at night-time on 2/25. Resident monitored for change in condition. No adverse reaction noted. Resident is stable Responsible party notified , Physician notified, Administrator notified , DON (Director of Nursing) notified . Immediate intervention implemented: Resident monitored for change in condition. A review of R19's February 2025 Medication Administration Record (MAR) revealed the following medications that documented as not administered on 2/25/25: Melatonin Oral Tablet 3 MG (milligram) (2100 dose), SEROquel Oral Tablet 50 MG (2000 dose), Apixaban Oral Tablet 2.5 MG (2100), Hydrocodone-Acetaminophen Tablet 5-325 MG (2000), Lorazepam Gel 0.5 mg 1 ML (milliliter) (2200). On 3/19/25 at approximately 3:57 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding multiple medications not being administered for multiple residents residing on the first floor during the evening of 2/25/25. The DON reported that they had a Nurse (Nurse S) who was mandated to stay over their shift from 7:00 p.m. until 11 p.m. and Nurse S did not pass any medications to the residents on the first floor during that period of time. The DON reported they came in to provide relief shortly after 11:00 p.m. on 2/25/25 and started passing medications but could not pass the ones that had already been missed. The DON was queried why NurseS did not administer any medication and they reported that the Nurse informed them they were on the phone with pharmacy regarding a new admission. The DON indicated the Nurse was terminated as a result of the negligence and they did an investigation and implemented monitoring and notification to the Physician for each of the residents effected. The DON also reported they had provided in-service education to all Nursing staff regarding the importance of ensuring all medications are administered per Physician orders and that they were monitoring for continued compliance. At that time, a request a list of the resident effected by the practice was requested. On 3/20/25 at approximately 9:55 a.m., the DON provided the list of residents affected by Nurse S not administering medications on 2/2/5/25 and the termination documentation for Nurse S. On 3/20/25 the February 2025 Medication Administration Records for the additional effected residents were reviewed and revealed the following medications that were not administered on 2/25: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37: Atorvastatin Calcium Tablet 20 MG (2100 dose), LATANOPROST 0.005% EYE DROP (2100), DORZOLAMIDE-TIMOLOL EYE DROP (2200), metFORMIN HCl Oral Tablet 500 MG (2000). R41: Artificial Tears Solution 1 % (2100), Atorvastatin Calcium Oral Tablet 20 MG (2000), Montelukast Sodium Tablet 10 MG (2100), Senna Tablet 8.6 MG (2000), Eliquis Oral Tablet 5 MG (2100), dilTIAZem HCl Tablet 30 MG (2100). R43: Aricept Oral Tablet 5 MG (2100), Atorvastatin Calcium Oral Tablet 10 MG (2100). R7: Atorvastatin Calcium Oral Tablet 40 MG (2100), Ramelteon Tablet 8 MG (2100), Memantine HCl Oral Tablet 5 MG (2200). R18: Brimonidine Tartrate-Timolol Solution 0.2-0.5 % (2200), Dorzolamide HCl-Timolol Mal Solution 22.3-6.8 MG/ML (2100), prednisoLONE Acetate Suspension 1 % (2200). R33: Atorvastatin Calcium Oral Tablet 40 MG (2100), Flomax Oral Capsule 0.4 MG (2130), Latanoprost Ophthalmic Solution 0.005 % (2100), Docusate Sodium Capsule 100 MG (2100), Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2- 0.5 % (2000) Keppra Oral Tablet 500 MG (2100), Senna Tablet 8.6 MG (2100), Vimpat Oral Tablet 200 MG (2000), Brimonidine Tartrate Ophthalmic Solution 0.2 % (2100), Refresh Liquigel Ophthalmic Gel 1 % (2100). R40: Senna Oral Tablet 8.6 MG (2100), Famotidine Oral Tablet 20 MG (2100), Gabapentin Capsule 100 MG (2000), Sodium Bicarbonate Oral Tablet 650 MG (2100), ZyPREXA Oral Tablet 5 MG (2100), diazePAM Oral Tablet 2 MG (2200), Valproic Acid Oral Solution 250 MG/5ML (2200). R36: Atorvastatin Calcium Oral Tablet 10 MG (2100), Melatonin Oral Tablet 5 MG (2100), Senna Tablet 8.6 MG (2100), traZODone HCl Oral Tablet 100 MG (2100), Bactrim DS Tablet 800-160 MG (2100), buPROPion HCl ER (SR) Oral Tablet Extended Release 12 Hour 150 MG (2200), Magnesium Oral Tablet 400 MG (2200), metFORMIN HCl Oral Tablet 500 MG (2200), Metoprolol Tartrate Oral Tablet (2200), Carbidopa-Levodopa Oral Tablet 25-100 MG (2200). R21: Lorazepam Gel 0.5 mg 1 ML (2000). R25: traZODone HCl Oral Tablet 150 MG (2000), lamoTRIgine Oral Tablet 200 MG (2100), levETIRAcetam Oral Tablet 500 MG (2100), guaiFENesin Oral Liquid 200 MG/5ML (2100), Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (2100) Morphine Sulfate Oral Solution 20 MG/5ML (2200). On 3/20/25 the facility investigation into the incident was reviewed and revealed the following: Description of Incident: During chart reviews it was noted that signatures in EMAR (electronic medication administration record) and EMAR documentation was not consistent with medication administration orders. Summary of Findings: Signature in EMAR and EMAR were not consistently signed when medications were ordered. Action is taken for residents involved: A review was completed for the Month of February to review omissions of signatures in EMAR documentation. Residents identified having significant medications involved were assessed to determine any concerns related to potential missed medications. Appropriate individuals were notified and resident monitoring initiated as appropriate (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A statement by the DON pertaining to the incident revealed the following: I [DON] at [Facility] Reviewed February MARS related to concern with medication administration. Those areas that were not signed as given were addressed with the appropriate staff. Physician was notified and resident were assessed for potential adverse effects . On 3/20/25 at approximately 2:40 p.m., during a conversation with the acting facility Administrator, the Administrator was queried regarding all the residents not being administered their medications on the evening of 2/25/25. The Administrator indicated they were not the Administrator at the time the neglect occurred but indicated they would have reported the incident to the State Agency. The case was reviewed with the Administrator and they were queried if in reviewing the case if they believed the incident was neglectful and they indicated they believed it was. A facility document titled Abuse Neglect and Exploitation was reviewed and revealed the following: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included 1. Nurses identified were provided with one on one education related to specific concerns. 2. A review of the Month of February EMAR (electronic medication administration record) was completed to identify any significant medications that may not have been provided per order. 3. Re-education of current licensed nurses on Medication Administration Documentation were provided. Nurses not receiving education by the date of compliance will receive the education on the next day of work. 4. DON/designee will review EMAR I x weekly x8 weeks to assure compliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review, the facility failed to report an incident of neglect to the State Agency for 11 residents (R#'s 37, 41, 43, 7, 19, 18, 33, 40, 36, 21, and R25) of 19 residents reviewed for abuse/neglect/mistreatment. Findings include: [Cross Reference F-600] R19 On 3/18/25 the medical record for R19 was reviewed and revealed the following: R19 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Myocardial infarction. A progress note dated 2/25/25 revealed the following: Nursing Progress Note-Late Entry: Note Text: Medication was not administered at night-time on 2/25. Resident monitored for change in condition. No adverse reaction noted. Resident is stable Responsible party notified , Physician notified, Administrator notified , DON notified . Immediate intervention implemented: Resident monitored for change in condition. A review of R19's February 2025 Medication Administration Record (MAR) revealed the following medications that documented as not administered on 2/25/25: Melatonin Oral Tablet 3 MG (milligram) (2100 dose), SEROquel Oral Tablet 50 MG (2000 dose), Apixaban Oral Tablet 2.5 MG (2100), Hydrocodone-Acetaminophen Tablet 5-325 MG (2000), Lorazepam Gel 0.5 mg 1 ML (milliliter) (2200). On 3/19/25 at approximately 3:57 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding multiple medications not being administered for multiple residents residing on the first floor during the evening of 2/25/25. The DON reported that they had a Nurse (Nurse S) who was mandated to stay over their shift from 7:00 p.m. until 11 p.m. and Nurse S did not pass any medications to the residents on the first floor during that period of time. The DON reported they came in to provide relief shortly after 11:00 p.m. on 2/25/25 and started passing medications but could not pass the ones that had already been missed. The DON was queried why NurseS did not administer any medication and they reported that the Nurse informed them they were on the phone with pharmacy regarding a new admission. The DON indicated the Nurse was terminated as a result of the negligence in failing to administer all the medications and they did an investigation and implemented monitoring and notification to the Physician for each of the residents affected. The DON also reported they had provided in-service education to all Nursing staff regarding the importance of ensuring all medications are administered per Physician orders and that they were monitoring for continued compliance. At that time, a request a list of the resident effected by the practice was requested. The DON was queried if they had identified neglect committed of behalf of Nurse S and they indicated they did not at that time and and the incident was not reported to the State Agency. On 3/20/25 at approximately 9:55 a.m., the DON provided the list of residents affected by Nurse S not administering medications on 2/2/5/25 that included (R#'s 37, 41, 43, 7, 19, 18, 33, 40, 36, 21, and R25) and the termination documentation for Nurse S. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/25 the facility investigation into the incident was reviewed and revealed the following: Description of Incident: During chart reviews it was noted that signatures in EMAR (electronic medication administration record) and EMAR documentation was not consistent with medication administration orders. Summary of Findings: Signature in EMAR and EMAR were not consistently signed when medications were ordered. Action is taken for residents involved: A review was completed for the Month of February to review omissions of signatures in EMAR documentation. Residents identified having significant medications involved were assessed to determine any concerns related to potential missed medications. Appropriate individuals were notified and resident monitoring initiated as appropriate On 3/20/25 at approximately 2:40 p.m., during a conversation with the acting facility Administrator, the Administrator was queried regarding all the residents not being administered their medications on the evening of 2/25/25. The Administrator indicated they were not the Administrator at the time the neglect occurred but indicated they would have reported the incident to the State Agency for review. The case was reviewed with the Administrator and they were queried if in reviewing the case if they believed the incident was neglectful and they indicated they believed it was. A facility document titled Abuse Neglect and Exploitation was reviewed and revealed the following: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property Reporting/Response A. The facility will implement the following: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. 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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. 48680 Based on observations, interview, and record review the facility failed to transcribe medication orders correctly from the hospital resulting in one resident (R10) missing prescribed dosages of antibiotic medication (a medication used to treat infection). Findings include: On 3/18/25 at 10:10 AM, R10 was observed in bed. When R10 was asked how their stay at the facility was, the residents was not coherent. A review of R10's medical record revealed that the Brief Interview for Mental Status score (BIMS) completed on 3/3/25 was a 00, which indicated severe impaired cognition. A further review of the record showed that R10 was admitted to the facility initially on 7/15/2019 with the diagnosis of vascular dementia, history of falling and aphasia. Additional review of R10 record revealed that, they were admitted to the hospital on 2/15/25 for a fall and pain to the lower extremity and discharged from the hospital on 2/20/25 back to the facility. With in the discharge instruction paperwork R10 was to receive an antibiotic called Ciprofloxacin (Cipro) 500 milligrams (mg) every 12 hours for 5 days. In review of the medical administration record the antibiotic was not transcribed and there was no progress note to indicate that the physician had discontinued the treatment. On 3/20/25 at 10:45 AM, an interview with the facility's Infection Control Preventionist (ICP) was conducted, and they were asked why the Cipro was not ordered as the hospital intended for R10. The ICP, reported that they had just received the hospital paperwork on the 17th of February and noticed that the antibiotic was not ordered and intended to contact the physician to see what they would recommend since the medication was missed. The ICP was asked should the medication had been transcribed as ordered from the hospital. The ICP replied, It should have. On 3/20/25 at 12:03 PM, an interview with the Director of Nursing (DON) was conducted. The DON was asked should medications be transcribed as ordered from the hospital to a resident's medication administration record. The DON reported that medications should be transcribed as ordered and if for what ever reason a provider changed an order, the nurse who is verifying medications with the provider is to document that a change was made in a progress note. There was no additional information provided at the exit of survey.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure a Change in Condition level one screening Form DCH (Department of Community Health/3877) was submitted to the local Community Mental Health Services Program (CMHSP) for a level two OBRA (Omnibus Budget Reconciliation Act) evaluation upon a change in the resident's condition for one (R61) of two residents reviewed for Preadmission Screening/Annual Resident Review (PASARR). Findings include: Review of the clinical record revealed R61 was admitted into the facility on [DATE] and readmitted on [DATE] with a new diagnosis of schizophrenia. According to the Minimum Data Set (MDS) assessment dated [DATE], R61 scored a 15/15 on the Brief Interview for Mental Status (BIMS) exam which indicated intact cognition. The schizophrenia diagnoses was not included in section I of the MDS assessment. Review of R61's physician orders included an order with a start date of 1/31/25 for Seroquel (an antipsychotic medication) oral tablet 50 MG (Milligrams) - give 1 tablet by mouth every 12 hours for schizophrenia. Further review of the most current level one (3877) form dated 3/26/24 revealed the section for screening criteria had an X marked next to question 1 which read, Yes The person has a current diagnoses of X Mental Illness or X Dementia (both were marked with an X'; question 2 which read, Yes The person has received treatment for X Mental Illness; question 3 which read, The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.; and question 4 which read, There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgement. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. The section to explain any Yes responses read, DX (Diagnosis): Psychotic disorder with delusions due to known physiological condition, unspecified mood [affective] disorder, Parkinson's disease with dyskinesia, Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, receives Seroquel, Xanax, Depakote, mirtazapine, and escitalpram. There was no documentation that identified a change of condition 3877 form had been completed upon the addition of the new schizophrenia diagnosis upon readmission on 12/27/24. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R61's OBRA PASARR Correspondence letter dated 3/26/24 documented, .does not meet criteria for a serious mental illness, developmental disability, intellectual disability, or related condition under the PASARR provisions but may have a less than serious mental illness .This does not alter the nursing facility's requirement for completing the annual Level I (DCH-3877) or reporting significant changes to the CMHSP or their contract agency .[R61] has no apparent history of SPMI (Serious and Persistent Mental Illness), no Level II needed . On 3/19/25 at 1:24 PM, an interview was conducted with the Social Services Manager (Social Worker/SW 'D'). When asked about whether the facility had completed a change in condition and submission to the local community health regarding R61's new diagnosis of schizophrenia since their readmission on 12/27/24, SW 'D' reported they would have to find out. On 3/19/25 at 4:00 PM, SW 'D' provided a 3877 form dated 3/19/25 and reported they just submitted a change in condition 3877 form to OBRA today. When asked why this had not been identified until it was a concern during this survey, SW 'D' reported they were focused on other concerns. Review of the 3877 completed 3/19/25 had an X for Yes and Mental Illness for questions 1-4, and the section to Explain any YES read, New: Dx Schizophrenia-Seroquel Depression-Lexapro. According to the facility's policy titled, Resident Assessment - Coordination with PASARR Program dated 12/2023: .The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority .Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review the facility failed to ensure a Preadmission Screening/Annual Resident Review (PASARR) was submitted and completed by the local community mental health agency after the 30 day exemption period for one (R8) of two residents reviewed for PASARR screenings. Findings include: Review of the clinical record revealed R8 was admitted into the facility on [DATE] with diagnoses that included: schizoaffective disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R8 had intact cognition and had a psychiatric diagnosis of schizophrenia. Review of the initial 3877 form dated 1/3/25 revealed the screening section for questions 1-3 were marked with an X for Yes for mental illness. The section to explain any Yes read, .Patient qualified for exemption. diagnosed with schizophrenia. Patient is prescribed Seroquel. The 3878 form completed at the hospital identified on 1/3/25, R8 had a hospital exempted discharge (which meant the hospital anticipated R8 to be in the nursing facility no more than 30 days), therefore a level II evaluation had not been completed prior to admission into the facility. There was no further documentation in the clinical record that the facility identified and submitted a change in condition to the local community mental health for completion of a level II evaluation as of this review. Further review of the resident's admission social service assessment dated [DATE] documented, . Schizophrenia .PASRR review .Explain: Level 2 issued . (This was inaccurate as no Level 2 was completed.) On 3/19/25 at 2:55 PM, an interview was conducted with the Social Services Manager (Social Worker/SW 'D'). When asked about whether the facility had completed a revision and submission to the local community health regarding R8's diagnosis of schizophrenia and their stay beyond the initial hospital exemption of 30 days, SW 'D' reported they would have to find out. They were unable to explain why their assessment indicated a Level 2 had been issued. On 3/19/25 at 4:00 PM, SW 'D' followed up and reported there was no level II submitted and they just did that today. According to the facility's policy titled, Resident Assessment - Coordination with PASARR Program dated 12/2023: .If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state designated authority for Level II PASARR evaluation and determination. b. The Level II resident review must be completed within 40 calendar days of admission .The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority .

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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** 30675 Based on interview and record review, the facility failed to ensure diagnostic practices met professional standards for one (R61) of two residents reviewed for psychotropic medications when R61 received a new diagnosis of schizophrenia. Findings include: Review of the clinical record revealed R61 was admitted into the facility on [DATE] and readmitted on [DATE] with a new diagnosis of schizophrenia. According to the Minimum Data Set (MDS) assessment dated [DATE], R61 scored a 15/15 on the Brief Interview for Mental Status (BIMS) exam which indicated intact cognition. The schizophrenia diagnoses was not included in section I of the MDS assessment. Documentation also identified the resident had received antipsychotic, antianxiety, and antidepressant medication. Review of R61's physician orders included an order with a start date of 1/31/25 for Seroquel (an antipsychotic medication) oral tablet 50 MG (Milligrams) - give 1 tablet by mouth every 12 hours for schizophrenia. Review of the most recent psych provider consultation included a consult with Psychologist (PhD 'T') dated 1/13/25 which read, .When he arrived here, he had a diagnosis of Parkinson's disease. In June 2024 he went to an outpatient neurologist who stated he did not have Parkinson's disease and diagnosed vascular dementia. He was taken off of Sinemet at that time and it has not been restarted since. Last month, there was an episode where resident became physically aggressive toward staff. He was petitioned out to the hospital and admitted to the general medical unit but not the psych unit. He was seen by psychiatry and neurology at the hospital. No notes from psychiatry were available, but notes from neurology were. Hospital neurology carried over the diagnosis of Parkinson's but also said resident has schizophrenia, which I do not believe he has. Resident returned to this facility 12/29/24 and staff requested follow up today .Today resident was cooperative with encounter. His speech is very difficult to understand and interactions require great care and effort in listening, though his memory does appear decent. Resident indicated being upset about having to go to the hospital and he wants to put it all behind him. Said he is happy now and has no issues as long as he is not sent back to the hospital. Resident likes to sit in common areas and be in charge of others. He often thinks he is directing activities, likes to give advice to others, and tries to tell other residents what to do, though his behaviors appear to be well-meaning rather than aggressive .ASSESSMENT & PLAN .Plan: neurology recently stated that he did not have Parkinson's and that vascular origin was suspected based on history of bizarre behaviors combined with the young age at onset, I suspect possible fronto-temporal origin . Resident is continuing to display fluctuating ataxia with frequent falls as well as rapid fluctuations in speech ability. He likely has Parkinson's dementia or fronto-temporal dementia. I recommend he have another neurology consult to clarify this, as the type of dementia will help explain why he is having the symptoms he is having and help direct interventions. I suspect he is falling due to ataxia related to frontotemporal dementia, and that this diagnosis would also explain his emotional lability, fluctuating speech ability, and poor response to pharmacological interventions . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a neuro consultation dated 2/6/25 did not address or clarify the new diagnosis of schizophrenia and read, Pt (Patient) report no further falls, he feels stable. Stable in cognitive function. Still having Dyskinesia in BLEs (Bilateral Lower Extremities), Reviewed Labs, AST (Aspartate Aminotransferase) level elevated .Diagnosis Mild Dyskinesia, Moderate Cognitive Impairment, Confusion, Mood disturbance . Further review of the clinical record, including social services, attending physician/extender, and psych evaluations revealed there was no further clarification, including clinical rational or DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) criteria documented for the new diagnosis of schizophrenia. There was no further psych evaluation following the above consultation with PhD 'T' on 1/13/25. On 3/19/25 at 1:24 PM, an interview was conducted with the Social Services Manager (Social Worker/SW 'D'). When asked about the resident's new diagnoses of schizophrenia in December 2024, SW 'D' reported they were not aware of that. When asked about the psych consultations and whether there had been any follow-up since the most recent assessment available for review was from PhD 'T' on 1/13/25. SW 'D' reported they were now responsible for scanning those consultations into the medical record and would follow-up. On 3/19/25 at 2:55 PM, SW 'D' provided additional documentation of psych consultations which included the most recent one from PhD 'T' on 1/13/25. Additional consultations were from the Psych Physician Assistant (PA 'U') from 11/20/24 and 1/3/25. The consultation from 1/3/25 did not identify or further clarify the new diagnosis of schizophrenia. On 3/19/25 at 4:02 PM, an interview was conducted with the Director of Nursing (DON). They were informed of the concerns with R61's new diagnoses of schizophrenia and lack of further follow-up or clarification. The DON reported they would look into that further. There was no additional documentation or follow-up provided by the end of the survey. The facility was requested to provide a policy regarding professional standards in regard to practitioner's diagnostic practices. On 3/20/25 at 12:23 PM, the Regional Director of Operations (RDO 'A') acting as the interim Administrator reported they were not able to locate a policy for this concern.

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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** 38271 Based on observation, interview and record review the facility failed to implement effective timely interventions for wounds and complete accurate assessments for one resident (R4) of two residents reviewed for Pressure Ulcers. Findings include: On 3/18/25 at approximately 11:40 a.m., R4 was observed in their room, laying in their bed. R4 was queried if they had any concerns regarding their care and they reported they had a bed sore that hurt. R4 was observed to be laying flat on their back in their bed without any off loading wedges or pillows provided to them. On 3/19/25 at approximately 8:50 a.m., R4 was observed in their room, up in their bed. R4 was queried if any staff had applied any zinc barrier ointment on him the previous day or that morning and they reported they had not and that the staff could not find it. R4 was observed laying on the bed without any off loading devices, pillows or wedges. R4 indicated they still had pain due to their bed sore. On 3/18/25 medical record for R4 was reviewed and revealed the following: R4 was initially admitted to the facility on [DATE], was last readmitted on [DATE] and had diagnoses including Heart failure and Dysphagia. A Braden scale for determining pressure ulcer risk dated 3/4/25 revealed a score of 14 indicating moderate risk for skin breakdown. A weekly skin sweep dated 3/4/25 revealed the following: 1. Please choose the skin condition that was observed: open area Site: 31) Right buttock. Description: open area on buttocks. A wound care evaluation dated 3/5/25 revealed the following: Diaper Dermatitis .Frequency of treatment: BID (twice daily) and PRN (as needed) .Site should be cleaned with N.Saline (0.9 % sodium chloride solution) . Primary dressing: ZN (zinc) oxide product .Secondary dressing Continue to monitor and offload .Additional notes-No open areas noted, bilateral buttock fragile, apply zinc oxide for prevention/protection of moisture related skin breakdown . A progress note dated 3/9/25 revealed the following: Nursing Progress Note-Resident arrived via Stretcher, . resident has small open area with redness on buttocks, paste was applied on buttocks. resident has left side weakness R/T (related to) stroke . A wound care evaluation dated 3/11/25 revealed the following: Diaper Dermatitis .Frequency of treatment: BID (twice daily) and PRN (as needed) .Site should be cleaned with N.Saline (0.9 % sodium chloride solution) .Primary dressing: ZN (zinc) oxide product .Secondary dressing Continue to monitor and offload . Additional Notes-Remains fragile, tender to touch will continue current treatment . A weekly skin sweep dated 3/17/25 (later removed from the electronic medical record) was reviewed and was blank and did not contain any documentation of R4's skin. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at approximately 10:48 a.m., R4's coccyx area was observed by a State Agency-Registered Nurse which revealed the following: R4's coccyx area did not contain any barrier cream or treatments present on the wound. R4 had three separate areas on their coccyx including on the middle of the crack that was reddish-center and had pink border approximately the size of a pinky finger tip as well as two other separate sores on both the right and left side of the center of coccyx that were red and had a center pink color surrounding the skin and was open during the brief change. R4 was noted to be in pain grimacing and saying ouch each time they rubbed the area to clean it. The CNA was observed to have wiped hard and didn't pat dry the wound. R4 then asked for a pressure relieving device due to their coccyx area being painful. On 3/20/25 at approximately 11:20 a.m., R4's wound care orders for their coccyx area were reviewed with Wound Care Nurse C (WCN C) WCN C was shown R4's wound practitioner evaluation dated 3/5/25 in which they had ordered the zinc oxide treatment with normal saline solution BID and PRN treatment for their bilateral buttocks. WCN C reported that the order was never appropriately transcribed to the TAR to be administered. WCN C was queried regarding the open areas noted on 3/4/25 skin sweep evaluation and reported that the Nurse should have contacted the physician for a temporary treatment until the wound care clinician evaluated them. WCN C was queried if R4 should have had offloading devices such as pillows or wedges for their identified coccyx wound and they indicated they should have had something to offload the pressure on the area. WCN C was queried regarding R4's wound observation and the lack of any barrier cream and the wounds presentation and they indicated they should have had a treatment on the coccyx.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to ensure an environment free from accident hazards for two (R28 and R61) of five residents reviewed for accidents. Findings include: R28 On 3/18/25 at 10:00 AM, R28 was observed seated in a wheelchair next to their bed with oxygen actively in use via nasal cannula. The resident reported they were on oxygen continuously for difficulty breathing. At that time, a large container of petroleum jelly was observed on their overbed tray table. On 3/19/25 at 8:36 AM, R28 was observed seated in wheelchair outside room with oxygen actively in use via nasal cannula. The container of petroleum jelly remained on the overbed tray table next to the bed. R61 On 3/18/25 at 9:44 AM, and 3/19/25 at 8:41 AM, observation of R61's room revealed there were multiple bottles stored on top of the window sill, including a bottle of Microban Bathroom Cleaner. On 3/19/25 at 9:32 AM, an interview was conducted with the Regional Director of Operations (RDO 'A') who was acting as the interim Administrator while current Administrator unavailable and the Maintenance Director. When asked about storage of chemicals in resident rooms, RDO 'A' reported if staff were to see that in the resident rooms, they should immediately pull them out from the room. On 3/19/25 at 9:35 AM, RDO 'A' and the Maintenance Director confirmed the storage of the bottle of Microban Bathroom Cleaner. The Maintenance Director reported they hadn't seen that and it was likely brought in by the resident's wife but staff should've seen that. RDO 'A' removed several items, including the bottle of Microban. On 3/19/25 at 9:37 AM, RDO 'A' was asked about the storage of the petroleum jelly for R28 while oxygen was actively in use and they reported that should not have been there. RDO 'A' then informed R28 of the concern that petroleum and oxygen together is flammable and obtained the resident's permission to remove from the room. When asked if multiple staff had been in/out of the rooms why didn't anyone else identify the storage of these items as concerns, RDO 'A' reported that was a concern and should been identified. According to the PubMed https://pumbed.ncbi.nlm.nih.gov: Bauters T, Van Schandevyl G, Laureys G. Safety in the use of vaseline during oxygen therapy: the pharmacist's perspective. Int J Clin Pharm. 2016 Oct;38(5):1032-4. doi: 10.1007/s11096-016-0365-7. Epub 2016 [DATE]. PMID: 27480983: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The justification of the combination of vaseline and oxygen has been subject for discussion in many hospitals. Due to the lack of evidence based data in literature, we have provided recommendations from a pharmacist's perspective. The use of petroleum-based products should be avoided when handling patients under oxygen therapy. Whenever a skin moisturizer is needed for lubrication or rehydration of dry nasal passages, the lips or nose when breathing oxygen, consider the use of oil-in water creams or water-based products . According to the Safety Data Sheet for Microban 24 Bathroom Cleaner dated 4/7/2017: .Hazards Identification Serious Eye Damage/Eye Irritation, Category 2A .This material is classified as hazardous under OSHA regulations .Potential Health Effects (Acute and Chronic) May cause skin irritation. May be harmful if swallowed or inhaled . According to the facility's policy titled, Environmental Services Safety Procedures dated 1/11/2021: .Staff will ensure equipment (e.g .chemicals) is properly stored and not left unattended in areas that are accessible to residents. When not in use, equipment will be stored in a locking closet, cabinet or storage area for safety .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure medically-related social services to address mental health needs and patient advocacy/guardianship for one (R61) of three residents reviewed for social services. Findings include: Review of the clinical record revealed R61 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: unspecified dementia, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, cognitive communication deficit, other impulse disorders, and unspecified mood disorder and a new diagnosis of schizophrenia. According to the profile information in the electronic medical record, R61's spouse had legal guardianship. However, review of the available guardianship documentation revealed that had expired on [DATE]. According to the Minimum Data Set (MDS) assessment dated [DATE], R61 scored a ,d+[DATE] on the Brief Interview for Mental Status (BIMS) exam which indicated intact cognition. Documentation also identified the resident had received antipsychotic, antianxiety, and antidepressant medication. Review of R61's physician orders included an order with a start date of [DATE] for Seroquel (an antipsychotic medication) oral tablet 50 MG (Milligrams) - give 1 tablet by mouth every 12 hours for schizophrenia. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent psych provider consultation included a consult with Psychologist (PhD 'T') dated [DATE] which read, .When he arrived here, he had a diagnosis of Parkinson's disease. In [DATE] he went to an outpatient neurologist who stated he did not have Parkinson's disease and diagnosed vascular dementia. He was taken off of Sinemet at that time and it has not been restarted since. Last month, there was an episode where resident became physically aggressive toward staff. He was petitioned out to the hospital and admitted to the general medical unit but no the psych unit. He was seen by psychiatry and neurology at the hospital. No notes from psychiatry were available, but notes from neurology were. Hospital neurology carried over the diagnosis of Parkinson's but also said resident has schizophrenia, which I do not believe he has. Resident returned to this facility [DATE] and staff requested follow up today .Today resident was cooperative with encounter. His speech is very difficult to understand and interactions require great care and effort in listening, though his memory does appear decent. Resident indicated being upset about having to go to the hospital and he wants to put it all behind him. Said he is happy now and has no issues as long as he is not sent back to the hospital. Resident likes to sit in common areas and be in charge of others. He often thinks he is directing activities, likes to give advice to others, and tries to tell other residents what to do, though his behaviors appear to be well-meaning rather than aggressive .ASSESSMENT & PLAN .Plan: neurology recently stated that he did not have Parkinson's and that vascular origin was suspected based on history of bizarre behaviors combined with the young age at onset, I suspect possible fronto-temporal origin .Resident is continuing to display fluctuating ataxia with frequent falls as well as rapid fluctuations in speech ability. He likely has Parkinson's dementia or fronto-temporal dementia. I recommend he have another neurology consult to clarify this, as the type of dementia will help explain why he is having the symptoms he is having and help direct interventions. I suspect he is falling due to ataxia related to frontotemporal dementia, and that this diagnosis would also explain his emotional lability, fluctuating speech ability, and poor response to pharmacological interventions . Review of a neuro consultation dated [DATE] did not address or clarify the new diagnosis of schizophrenia and read, Pt (Patient) report no further falls, he feels stable. Stable in cognitive function. Still having Dyskinesia in BLEs (Bilateral Lower Extremities), Reviewed Labs, AST (Aspartate Aminotransferase) level elevated .Diagnosis Mild Dyskinesia, Moderate Cognitive Impairment, Confusion, Mood disturbance . Further review of the clinical record, including social services, attending physician/extender, and psych evaluations revealed there was no further clarification, including clinical rational or DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) criteria documented for the new diagnosis of schizophrenia. There was no further psych evaluation following the above consultation with PhD 'T' on [DATE]. On [DATE] at 1:24 PM, an interview was conducted with the Social Services Manager (Social Worker/SW 'D'). They reported they began in their role at the facility in [DATE]. When asked about the resident's new diagnoses of schizophrenia in [DATE], SW 'D' reported they were not aware of that. When asked about the psych consultations and whether there had been any follow-up since the most recent assessment available for review was from PhD 'T' on [DATE], SW 'D' reported they were now responsible for scanning those consultations into the medical record and would follow-up. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked about the resident's current guardianship status, SW 'D' reported the resident's wife makes decisions and she was his guardian. When asked if they could confirm that was correct, and informed the only documentation available in the clinical record was a guardianship letter that had expired on [DATE], SW 'D' reported they were sure that was done and the resident's wife worked long hours and stated they were sure they just didn't have a copy of the current guardianship and would follow-up. On [DATE] at 2:55 PM, SW 'D' provided additional documentation of psych consultations which included the most recent one from PhD 'T' on [DATE]. Additional consultations were from the Psych Physician Assistant (PA 'U') from [DATE] and [DATE]. The consultation from [DATE] did not identify or further clarify the new diagnosis of schizophrenia. R61 had not been seen by psych since [DATE]. When asked why the lack of guardianship had not been identified prior to now, SW 'D' reported there was a lot of other things that needed to be done. On [DATE] at 2:55 PM, SW 'D' provided additional psych consultations but the most recent was from [DATE]. There was no documentation provided that identified R61 had been seen after [DATE], or that there was any additional clarification of the diagnoses of schizophrenia. On [DATE] at 4:00 PM, SW 'D' reported they had spoken to R61's wife regarding need to get guardianship and they had put a note in the chart. Review of the previous social service documentation from [DATE] - [DATE] revealed there was no mention of anyone discussing the need to renew or obtain new guardianship for R61 until concerns were identified during this survey. According to the facility's policy titled, Social Services dated ,d+[DATE]: .The facility, regardless of size, will provide medically-related social services to each resident .The social worker, or social service designee, will pursue the provision of any identified need for medically-related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include .Advocating for residents and assisting them in assertion of their rights within the facility .Assisting with informing and educating residents, their family, and/or representative(s) about health care options and their ramifications .Making referrals and obtaining needed services from outside entities .Providing or arranging for needed mental and psychosocial counseling services .The facility should provide social services or obtain needed services from outside entities during situations that include but not limited to the following .Lack of an effective family or community support system or legal representative .

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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 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** 30675 Based on interview and record review, the facility failed to ensure irregularities identified by the consultant pharmacist were available for review to identify what the irregularity was and the physician response to the irregularities for one (R61) of five residents reviewed for monthly medication regimen reviews. Findings include: Review of the clinical record revealed R61 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: unspecified dementia, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, cognitive communication deficit, other impulse disorders, and unspecified mood disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R61 had intact cognition with a Brief Interveiw for Mental Status (BIMS) score was 15, receives an antipsychotic, antianxiety and antidepressant medication and had not had a gradual dose reduction (GDR-although he did). Review of R61's monthly medication regimen reviews (MRR) from April 2024 to March 2025 revealed the were several irregularities identified for: The MRRs from 5/3/24, 6/6/24, and 12/9/24 read, See report for any noted irregularities. Further review of the clinical record revealed there was no documentation that identified what the specific irregularities were, or if there was any Physician response/follow-up to the irregularities. On 3/19/25 at 4:02 PM, the Director of Nursing (DON) was asked about the facility's MRRs and reported those were kept in the clinical record and if there were any that couldn't be found to let them know so they can provide for review. On 3/20/25 at 9:25 AM, the facility was requested to provide the specific pharmacy recommendation and physician responses from 5/3/24, 6/6/24, and 12/9/24. On 3/20/25 at 1:30 PM, the Regional Director of Operations (RDO 'A') who was acting as the interim Administrator in the absence of the current Administrator was asked about the earlier request for R61's MRRs. RDO 'A' reported they would follow-up. There was no additional documentation provided by the end of the survey. According to the facility's policy titled, Medication Regimen Review dated 1/2025: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The pharmacist shall communicate any irregularities to the facility in the following ways: a. Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. b. Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing. 6. Written communications from the pharmacist shall become a permanent part of the resident's medical record .b. The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review. c. If the pharmacist should identify an irregularity that requires urgent action to protect a resident, the DON or designee is informed verbally .e. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38271 Based on observation, interview and record review, the facility failed to ensure a treatment/medication was secured for two residents (R19 and R37) of two residents reviewed for medication labeling and storage. Findings include: On 3/18/25 at approximately 9:14 a.m., R19 was observed in their room, laying in their bed. a prescribed Dermarite periguard ointment was observed unsecured on a bedside table with R37's name on it along with the pharmacy label. On 3/19/25 at approximately 10:45 a.m., R19 was observed in their room, laying in their bed. R19 was still observed with the Dermarite periguard ointment on the bedside table with R37's name on it along with the pharmacy label. On 3/19/25 at approximately 3:46 p.m., R19 was observed in their room, laying in their bed. R19 was still observed with the Dermarite periguard ointment on the bedside table with R37's name on it along with the pharmacy label. On 3/19/25 at approximately 3:48 p.m., Nurse H was informed of the medication/treatment being unsecured with R37's name on it, in R19's room. Nurse H was observed going into the room and removing the treatment of periguard. Nurse H indicated that she did not put it there,e but that it should have been locked in the treatment cart and that they were going to put it back in the cart. On 3/20/25 at approximately 2:10 p.m., Nurse Manager V (UM V), UM V was queried regarding the observation of R37's periguard ointment on R19's bedside table multiple days in a row and they indicated that it should have locked up and put away. On 3/20/25 a facility document titled Storage of Medications was reviewed and revealed the following: STORAGE OF MEDICATIONS-Policy-Medications and biological's are stored safely, securely, and properly, following manufacturer ' s recommendations or those of the supplier. The medication supply is accessible only to nurses, pharmacists, and pharmacy technicians. Procedures A. [Pharmacy] dispenses medications in containers that meet regulatory requirements and standards set forth by the United States Pharmacopoeia (USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medication to the original container. B. Only nurses, pharmacists, and pharmacy technicians are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access .E. External medications should be kept in a treatment cart or in a separate drawer in the medication cart .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235214	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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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 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** 38271 Based on interview and record review the facility failed to ensure a Physician ordered laboratory (lab) diagnostic was completed for one residents (R58) of two residents reviewed for diagnostics. Findings include: On 3/18/25 the medical record for R58 was reviewed and revealed the following: R58 was initially admitted to the facility on [DATE] and had diagnoses including Subdural Hemorrhage and Dementia. A Physician order dated 3/6/25 revealed the following: CBC (complete blood count) with Diff (differential), CMP (comprehensive metabolic panel), HA1C (blood glucose), PSA (Prostate-specific antigen), Lipid panel, Vitamin D level, Keppra levels, Diagnoses: HTN (Hypertension), BPH (benign prostatic hyperplasia), Seizure, HLD (Hyperlipidemia), Generalize Weakness, History of Falling- Please Draw. Further review of the medical record revealed no results from the labs ordered on 3/6/25. On 3/20/25 at approximately 1:08 p.m., Unit Manger Nurse V (UM V) was queried regarding R58's missing lab results. UM V was observed reviewing R58's record and checking the laboratory portal and indicated that a requisition was never made for the lab to be drawn. UM V indicated that at that time, the medical provider for R58 was switched to a different provider and the Nurses missed processing the lab order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235214	A. Building B. Wing	03/20/2025

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Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review, the facility failed to ensure accurate and updated wound care evaluations/treatments were present in the medical record for one resident (R14) of one residents reviewed for accurate medical records resulting in the potential for misidentification/inappropriate wound care treatments. Findings include: On 3/18/25 at approximately 9:05 a.m., R14 was observed in their room, laying in their bed. R14 was queried if they had any concerns regarding their care in the facility and they reported that they had a sore on their leg that was not healing. On 3/18/25 the medical record for R14 was reviewed and revealed the following: R14 was initially admitted to the facility on [DATE] and had diagnoses including Congestive heart failure and Chronic obstructive pulmonary disease. A wound evaluation completed by Medical Provider W (MP W) dated 2/11/25 revealed the following: Wound Orders .Wound #6 Right, Posterior Thigh .Wound Cleansing-Normal Saline-Or Wound cleanser/pH balanced cleanser. Primary Dressing-Xeroform. Hydrogel - Apply to wound followed by xeroform, apply Xeroform in a triple layer to prevent from sticking to wound Secondary Dressing. Other:-Dry dressing. Dressing Change Frequency-Daily - And as needed to keep dressing in place . A wound evaluation completed by MP W dated 2/21/25 revealed the following: Wound Orders: Wound #6 Right, Posterior Thigh Wound Cleansing-Normal Saline-Or Wound cleanser/pH balanced cleanser. Primary Dressing-Xeroform. Secondary Dressing-Other:-Dry dressing-Dressing Change Frequency-Daily-And as needed to keep dressing in place . A wound evaluation completed by MP W dated 2/25/25 revealed the following: R (right) Gluteal and upper thigh. Frequency of treatment-BID (twice daily) and PRN (as needed) .Primary dressing-Hydrogel plus Xeroform . A wound evaluation completed by MP W dated 3/5/25 revealed the following: R (right) Gluteal and upper thigh. Frequency of treatment-BID (twice daily) and PRN (as needed) .Primary dressing-Hydrogel plus Xeroform . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235214	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at approximately 11:20 a.m., R14's wound care orders for their R gluteal and thigh wound were reviewed with Wound Care Nurse C (WCN C) WCN C Indicated that the wound practitioner had ordered the hydrogel wound treatments with xeroform on 2/11/25 and indicated that they had discontinued it on 2/21/25 because it was making the wound too moist and they changed the treatment order to Xerofoam only. WCN C was shown MP W's consults for 2/25 and 3/5 that indicated the hydrogel should have been continued with the Xeroform dressing. WCN C reported they had spoken with MP W regarding the treatment plans of the continued hydrogel on 2/25 and 3/5 and they indicated that MP W had informed them that the treatment for those dates was inaccurate and the evaluations were not supposed to have the hydrogel on them. On 3/20/25 at approximately 11:30 a.m., MP W was queried regarding R14's R posterior wound orders and they stated that they had made an error on the wound evaluations on 2/25 and 3/5/25 and the hydrogel treatment should not have been included during those evaluations. MP W reported they would have to correct their evaluations and send new copies to WCN C to update in R14's clinical record.