STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235290	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Greenville	828 E Washington St Greenville, MI 48838

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 37872 This Citation refers to Intake Number MI00142152. Based on interview and record review, the facility failed to ensure that 3 residents (R7, R9, R17) out of 6 residents, with the potential to affect 83 residents, received their mail on Saturdays, resulting in residents not being able to exercise their right to receive mail and access communication. Findings include: On 2/5/24 at 1:50 PM, during an interview with R7, he reflected that he was the resident council president, and that protecting his and the other resident's rights was very important to him. R7 further revealed, he usually helps to deliver the mail to his fell ow residents when it comes in, however, lately they have had a problem with not getting mail on the weekends do to staffing cuts. Resident feels, we should not lose our right to weekend mail because the facility has cut staff that use to help me get it and deliver it. On 2/5/24 at 3:19 PM, during an interview R9 stated, We no longer get mail on Saturdays now because no one is here. It used to be an activities job, but they have been let go. On 2/5/24 at 3:38 PM, during the interview R17 stated, we do not get our mail on Saturdays since cuts (staffing) have been made. I pay for the paper 6 days a week. It makes me angry to wait until Monday to get my (Saturday) paper and then I get two. Reading my paper gives me something to do. On 2/6/24 at 2:22 PM, during an interview about mail delivery with Business Manager (BM) P, revealed, We have only been having problems the last month with mail, before that the activities staff would do it on the weekends. BM P stated, Weekdays, I get the mail and (Name of R7) one of our residents will usually help. Otherwise myself, or (Name of Activities Director) would, the activity aides use to do it. We need to get something more concrete than we have in right now. We do not have a set plan in place (for weekend mail delivery.) During an interview with Activities Director (AD) I 2/1/24 at 12:15 PM, she was asked if the resident's received mail on the weekend. AD I stated (Name of R7) the Resident Council President helps with mail; however, her staff use to ensure that the mail was delivered on the weekends prior to them being cut. AD I was not aware of who was responsible to distribute the weekend mail and that she is only one person, and she could not work weekends. (continued on next page)

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

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Resident- Rights- Polic .pdf no date or page information provided, revealed, i. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service including the right to: . The policy did not mention the residents were to receive mail on Saturday. A review of KNOW YOUR RIGHTS-Your Medicaid Care And Coverage In a Nursing Facility, . You have the right to exercise all of your civil and constitutional rights. As a resident of the nursing home, you have a right to send and receive mail the day the nursing home receives it. Nursing home staff must not open your mail without your permission. The home must provide you access to stationery, pencils or pens and postage. You may be charged for these items.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on interview and record review, the facility failed to 1) Notify residents, family and residents representatives in advance of the elimination of the majority of scheduled program of activities; 2) Provide notification and obtain informed consent from the legal guardian of 1 resident (Resident #103) prior to starting a new psychotropic medication (Depakote), out of 9 residents reviewed, resulting in a significant alteration in the plan of care and treatment for all residents living at the facility. Findings: Resident #103 (R103) Review of an Admission Record reflected R103 admitted to the facility with diagnoses that included major depressive disorder, recurrent, severe with psychotic symptoms, unspecified intellectual disabilities, dysthymic disorder (a mild but long-lasting form of depression), generalized anxiety disorder, chronic pain, weakness, high blood pressure, and congestive heart failure (CHF). R103 had a guardian in place to assist with financial and medical decisions. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] reflected R103 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15/15. Section E - Behavior indicated R103 did not have psychosis, would have Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming or cursing at others) 1-3 days during the look back period that did not have an impact on their care or the care of others. R103 did not reject care and did not have wandering behaviors. Section F - Preferences for Customary Routine and Activities reflected R103 reported having family or a close friend involved in discussions about their care, doing things with groups of people, doing favorite activities, getting outside to get fresh air when the weather is good and participating in religious services or practices were all Very important. Review of a quarterly MDS assessment dated [DATE] indicated R103 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15/15. Section D - Mood indicated R103 did not have symptoms of depression and would sometimes experience social isolation. Section E - Behavior indicated R103 did not have psychosis, would have Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming or cursing at others) 1-3 days during the look back period. R103 did not reject care and did not have wandering behaviors. Preferences or Customary Routine and Activities was not assessed during this review. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Comprehensive Care Plan reflected R103 has impaired cognitive function or impaired thought processes related to developmental disability and impaired intellectual functioning and had a guardian in place. An intervention to address the cognitive and intellectual functioning was to Keep my routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion in my day-to-day living (initiated 5/10/2023). R103 was also care planned to address concerning behavioral symptoms that appear sexual in nature. An intervention to address this concern included Redirect (R103) with Activity (initiated on 5/15/2023). The care plan indicated R103 will be invited to participate in the activity program with the goal of participating in independent leisure activities, special events, karaoke, music and fun, and religious groups as well as group activities of interest 2-4 times a week (initiated on 5/1/2023, revised on 7/26/2023). A Social Service Progress Note dated 4/2/2024 at 9:54 a.m. reflected (R103) was demonstrating an increase in behavioral issues including anxiety, pacing, restlessness, agitation and obsessive thoughts about getting married. SW (Social Worker) reached out to (mental health consultant) and provided updated (sic) on patient's behaviors. (Name of mental health consultant) agreeable to starting patient on Depakote (an anti-seizure medication that is also used as a mood stabilizer for the treatment of an acute manic episode or mixed episodes associated with bipolar disorder, with or without psychotic features), 125 mg by mouth two times a day. Review of the April 2024 Medication Administration Record (MAR) reflected R103 was prescribed Depakote Oral Tablet Delayed Release 125 MG (Divalproex Sodium) give 125 mg by mouth two times a day for depression -Start Date- 4/2/2024. Documentation on the MAR showed R103 received the first dose of the medication on the evening of 4/2/2024. Review of a Psychoactive Medication Progress Note dated 4/3/2024 at 10:06 a.m. reflected R103 was started on Depakote 125 mg BID (two times a day) and that Legal Guardian (LG) P was notified and informed of the risks vs. benefits. During a telephone interview on 4/4/2024 at 1:13 p.m., LG P reported that she had been responsible for R103 since before he admitted to the facility and was very familiar with him. LG P said R103's fixation on having a wife and children is not new and inappropriate behaviors were redirectable. LG P said she chose the home for R103 because it is located close to family who visit and knew the activity programming and community atmosphere would benefit R103. LG P was not notified of the significant change in activity programming until after the fact and noticed a serious negative change in R103's mood since then. LG P said she was informed on 4/3/2024 (the day after the intervention and medication had been started) that R103 was exit seeking, now had a wander guard in place and had started on a new medication (Depakote). According to LG P, R103 had been very engaged with the activities at the facility and since the activity staff were let go, R103 was having a much more difficult time. LG P said she was so concerned about R103's mental health that she considered moving the resident to a home that would better suit his need for community and recreation. During an interview on 2/4/2024 at 2:14 p.m., the Nursing Home Administrator (NHA) reported that residents and families or resident representatives were not notified of the elimination of the Activity Budget, Activity Assistants and subsequent loss of a substantial number of meaningful activities within the home. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/4/2024 at 3:15 p.m. Registered Nurse (RN) D said that it is the policy of the facility to obtained informed consent prior to starting a new medication or making a change in the treatment plan. RN D reviewed the electronic health record and confirmed R103 was given a dose of the Depakote in the evening on 4/2/2024, prior to obtaining informed consent from LG P. Review of a policy Behavior Management Program last reviewed 12/2020 reflected The risk/benefit (including black box warnings, appropriate dosing, medication category's drug interactions, medication safety information) assessment will be completed for all psychoactive medications when ordered, when duplicate medications in the same class are prescribed, and when doses are ordered over the recommended limit for the resident's age.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 28101 This Citation pertains to Intake Numbers MI00140761, MI00141234, and MI00142113. Based on observations, interviews and record review the facility failed to meet the shower and hygiene needs for 4 residents (R6, R8, R11 and R12) resulting in frustration and an unkept appearance. R6: Review of R6's face sheet revealed he was an [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: fractured left femur, diabetes mellitus II, Rheumatoid arthritis, muscle weakness, difficulty walking. During an interview with the Director of Nursing (DON) on 2/5/24 at 3:10 PM the DON said she reviewed R6's medical record and could not find any documentation that he received a shower during his stay. The DON said R6's shower day was the day of his admission and he had not been there a week. The DON said residents are scheduled to have one shower a week unless they request additional showers. The DON was asked if residents are asked about shower preferences on admission. The DON was not sure if they asked about preferences. Review of R6's shower task documentation dated 11/17/23 at 12:52 PM revealed R6 was to have a shower every Wednesday evening using a standard shower chair. 11/17/23, the day of his admission, was a Friday and R6 discharged from the facility on 11/22/23 without have a shower during his stay. R8: Review of R8's Resident Dashboard dated 11/27/23 revealed he was admitted to the facility on [DATE] and had diagnoses that included: encounter for surgical after care following surgery on the nervous system, spinal stenosis, convulsions, neuromuscular dysfunction of bladder, muscle weakness and lack of coordination. Review of R8's care plan for Activities of Daily Living (ADL) dated initiated 11/24/23 and canceled 12/18/23 revealed he required the assistance of one staff person for bathing. Review of a concern form for R8 dated 12/6/23 and signed by R8's family member revealed the following concerns, 1) admitted [DATE] and had a shower Saturday 11/25/23. Asked on Wednesday 12/6/23 why he hadn't had another shower, so they took to shower right then. 2) I helped him dress in T-shirt & shorts (over diaper) either Wed (Wednesday) or Thursday, 11/29 or 11/30. I did get his T-shirt off 3 days later, but his diaper was never changed until Monday December 6, and had dried feces in it. During an interview with Registered Nurse (RN) K on 2/6/24 at 8:35 AM, RN K did recall providing R8's family member with a concern form that he turned into management. He recalled the family member was upset and wanted R8 to have a shower. RN K said R8 had moved to his unit from another unit and had missed his shower day. RN K said he made sure R8 got his shower that day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R8's shower documentation revealed R8 had a shower on 11/25/23 at 20:04 (9:04 PM). The document revealed he was to receive a shower every Friday evening (11/25/23 was a Saturday). Review of R8's shower documentation for 12/6/23 at 10:42 AM revealed that R8 had a shower with assistance from 2 people. During an interview with the Director of Nursing (DON) on 2/6/24 at 9:23 AM, she reviewed R8's concern form dated 2/6/24. The DON said she did not follow up on the concern form the Nursing Home Administrator did the follow up on that concern. The DON provided the documentation showing R8 received 2 showers during his 3 weeks stay and confirmed that he should have had a weekly shower. The DON could not recall any details about the missing shower. R11: Review of R11's face sheet dated 2/6/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: acute pancreatitis, adult failure to thrive, anxiety disorder, severe protein-calorie malnutrition, muscle weakness, upper abdominal pain, dysphagia (difficulty swallowing) and brain injury. R11 was her own responsible party. During an observation and interview with R11 on 2/5/24 at 9:00 AM, R11 was sitting on the edge of her bed in her room. Her hair was greasy and not combed. R11 did not know when she was scheduled for a shower and denied staff had assisted her with a shower since admission. Review of R11's ADL care plan dated 1/28/24 revealed that she was scheduled to have a shower every Friday evening and that was initiated on 1/27/24. Interventions included 1 assist with bathing started on 2/5/24, and Supervision with bathing started on 1/29/24. Review of R11's electronic medical record revealed no documentation of a shower being provided since admission on 1/27/24 to 2/6/24. R12: Review of R12's care plan for ADL date initiated on 1/18/24 revealed she was admitted on [DATE] and required one person assistance with showers. During an observation and interview with R12 on 2/5/24 at 9:05 AM, R12 was very upset with her care, her hair was greasy and not combed. She was too emotional to provide details of her care concerns. The DON and Social Worker were informed of R12 distress after this interview to follow up with all concerns. During an interview with the DON on 2/6/24 at 2:30 PM, the DON provided R12's shower documentation and reviewed R12's shower task. Documentation revealed R12 received a shower on 1/18/24 at 13:34 (1:34 PM) and 2/1/24 at 11:04 AM. R12 received a bed bath on 1/25/24 and no reason was provided for why a shower was not provided. The DON confirmed that R12 should have had shower on 1/25/24.

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F 0679 Level of Harm - Actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37872 This Citation refers to Intake Numbers MI00141976, MI00142052, MI00142152, and MI00142213. Based on observations, interviews, and record review, the facility failed to provide an adequate Activities Program for seven residents (R7, R9, R10, R11, R15, R16, R17), resulting in boredom and feelings of anger, frustration, and depression. Findings include: Review of a facility policy Activities last reviewed [DATE] reflected It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group and individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community. R10: During an interview on [DATE] at 11:11 AM, R10 stated the following, I'm upset about activities. We used to have activities from the time we got up until the time we went to bed. It kept me busy. We used to sit up front by the nurses' desk but now that is not allowed. So now we have NO social outlet. We like to sit, gather, and socialize and people watch and now we can't do that. (As resident is talking, she is becoming more agitated, her face is becoming more flushed, cheeks are redder, shoulders are straighter, residents' hands are opening and closing, until she grabs a tissue, eyes continued to glass over as she talks.) The people that were hanging out talking, we would have been in activities, but now we really have nothing. I feel they are taking the companies financial mistakes out on me/us residents. I am still paying the same amount every month and I am getting less. R10 further stated, I feel bored, depressed, angry and it's not fair! I'm missing my family (Family refers to the activities staff and the residents that attend daily) my connection with everyone. Resident is observed sniffing and her tears are becoming more prominent. R10 further stated, we now have nothing to do on the weekends. We always had less on the weekends, but now we have nothing. Nothing is boring, time just drags so slow all we have to look forward to is Monday! During the interview on [DATE] at 11:11 AM, R10 revealed she had serious concerns about her roommate's well-being. Upon seeing her roommate's bed empty and boxes on top of it R10 revealed that her roommate Resident#11 (R11) has been gone for a while. R10 stated the (Name of R11) was a social butterfly. She went to every activity. After the activities stopped (being all day and went down to 2 a day) she got very depressed, she wouldn't get out of bed, at times she would not eat, get dressed or take a shower. She told me a couple of days before that Sunday I am just going to lay here and die.' (R10 states R11 said this to her before She became very distraught on a Sunday, we had that big storm she couldn't go to church, and she could not get the service to watch on her phone. She got so upset she took a pen to her wrists. They sent her out to the hospital that day and she hasn't been back. (continued on next page)

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F 0679 Level of Harm - Actual harm Residents Affected - Some	R10 reflected R11 was a social butterfly, she went to all the activities. She lost all hope and was depressed. She said she had no reason. She went around activities to be around people. R11: During an interview on [DATE] at 12:11 PM, R11 was asked if she would like to talk about how she was doing. R11 revealed the following, I felt down, all alone, like I had no friends, no religion. I did try to hurt myself a few weeks ago. First my family died , then I got Covid and was stuck in my room, and then right after that all my activity's family were all let go. Resident revealed she came here because her doctor felt she needed to come to a nursing home where she would have other people around her. I went to all the activities, I loved the people, how they talked to us. It was a reason we stayed positive. Activities kept me active; it was enjoyable. We lost everything because of budget cuts. R11 stated, I used to go to activities, have a meal, rest for bit, and go again (to activities). When everything changed it felt like it was overbearing. I felt helpless because we had no change in sight. I was just so alone; the changes were overwhelming and not for the better. (R11 was observed crying during this interview and refused to end the interview multiple times, stating she needed to be heard.) R11 further stated, I want, I need more visits and things to fill my time up. I lost my appetite, but I am trying to get better. I am not trying to end my life; I know I have a reason to live for, but at the time I wanted to. During an interview on [DATE] at 12:15 PM, Activities Director (AD) I revealed that activities use to run from approximately 7:30 AM to 8 PM during the week (averaging 9 a day), with a couple of activities on the weekends. AD I revealed her department had recently lost 5 employees due to staffing cuts and she was now the only member left from her team/department. AD I confirmed activities were now down to two a day during the week, with no activities being schedule on the weekend. AD I then clarified that community volunteers were still providing a church service on every other Sunday. AD I further reflected, 1 on 1 activities have ceased for residents confined to their beds because she didn't have the time or staffing to do everything. During the interview AD I was asked about (Name of R11) and her participation. AD I revealed that (Name of R11) was usually one of the first residents down every morning and usually one of the last to leave. She came to practically every activity. Review of the January Activities Calendar prior to cuts reflected a busy calendar with approximately 9 options for residents to attend during the week. Two of the resident's favorite activities Coffee & News and Bingo were occurring 5 days a week. The after-staffing cuts January Calendar reflected 2 activities during the weekday and no weekend activities. Further review of downgraded calendar reflected coffee being listed as a lone activity and bingo being offered now once a week. R7: During an interview on [DATE] at 1:50 PM, R7 stated he has a problem with activities now being held only 2 times a day. Resident revealed he is upset and feels depressed because activities went from being all day to twice a day, and I now have very little to do. It's not fair, they are not treating us like they should. It's like they are taking away our rights to do activities. We used to have bingo everyday but Tuesday and Sunday, I looked forward to it, I miss it. Now we only play bingo on Mondays we went from 20 days a month to 4 days. Resident asked how this was right? I'm depressed and this does not help. They are doing away with things that relate to our well-being. All these changes are about greed the owner is pocketing money and we are left with nothing. (continued on next page)

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F 0679 Level of Harm - Actual harm Residents Affected - Some	R15: During an interview on [DATE] at 2:20 PM, R15 revealed that she was upset with all the changes going on, it makes me feel like I don't matter and that I'm not important. We did bingo 5 days a week now its 4 x a month. It got me out of my room, I went to a lot of activities it was something I looked forward to. It was every day, all day during the week and a few on the weekends. The (activities) staff were really good about encouraging us to get out of our rooms. The activities staff cared about us. They were like our family. They cared and they talked to us like we mattered. We had people that would play games and do things with us at night, now nothing. We have 2 activities a day now and the last one is at 2 or 3 PM. Sometimes we had choices because some activities would be going at the same time. Now we have hardly anything. I love our aides and nurses, but they are busy. You don't understand what you have until its gone. What they did (all the cuts) it feels like we do not matter. We sit, time just drags now. I don't have things to look forward to. R15 further revealed that she feels like our motivation is gone. I feel disgusted, with the lack of staff and the weekends just drag because of nothing to do. I feel like my life is empty now and I'm sad. I just don't feel important, they took away our choices. We didn't do this; they did this to us. Now I sit on my butt so much I'm worried about getting sores. I have never sat this much. During this interview the resident became very teary and went through several tissues. During an interview on [DATE] at 3:04 PM, Registered Nurse (RN) T was asked if he had noticed any changes in the residents. RN T stated since the cuts we have seen an increase in resident behaviors. Residents are upset, devastated, angry and pissed-off. Our residents use to be busy; we would have to hunt for them. They were happier. R9: On [DATE] at 3:19 PM, R9 was observed sitting on her bed the fitted sheet has slid down the mattress and is bunched up behind her. The resident's hair is unbrushed, her clothing is wrinkled. As the resident is talking, she is sighing and frowning. Her hands are mindlessly clenching and unclenching her fists during the entire interview. R9 states she has several concerns including the Internet being down since last week. R9 revealed she is frustrated with the lack of activities. They had bingo this morning and popcorn was the afternoon activity. Handing out popcorn is not an activity! Now we have nothing. I was used to a full schedule and now we don't. I feel depressed, not much to do makes the days very long. Nothing is going on the weekends; they are so boring and long. We no longer get mail on Saturdays because that was done by the activities staff, and they let them all go. I'm in my room today cause I'm in a bad mood. I want to be busy again. I hate being in my room with nothing to do. I miss the activities people. They always said hello and would check on our moods and would push/encourage us to get up and do things. I'm sad. R17: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Actual harm Residents Affected - Some	During an interview on [DATE] at 3:38 PM, R17 stated, I feel like they have taken a lot from us. We no longer get mail on Saturdays since the cuts (staffing) have been made. I pay for the paper 6 days a week. Reading my paper is one of my activities I used to do on the weekends. I am angry because I no longer get my paper on the weekend, and I am forced to wait until Monday for staff to deliver my Saturday and Monday paper. I do not want to read my Saturday paper on Monday. R17 further revealed she was unable to do anything on her tablet (Internet out) which has caused her to be bored since last week. During an interview on [DATE] at 10:45 AM, Certified Nurses Aide (CNA) J was asked if she had noticed any resident changes since staffing cuts occurred, she revealed she had heard a concerning conversation taking place between (Name of R11) and someone on her phone. CNA J stated she heard (Name of R11) yelling and arguing about not going to meeting and not being able to get it on zoom. I reported to the nurse that day that she was not acting her norm. (Name of R11) never got on her zoom meeting, she stated it did not matter, an that nothing mattered. The resident was sent out later that day for trying to self-harm. CNA J revealed (Name of R9) does not want to come out of her room now and she is no longer making her bed. She would always make her bed up in the morning, now she doesn't want to do anything. (Name of R15) now just goes to lunch and that's it. She will not come out of her room. She used to spend maybe a half hour of the morning in her room, now she is in there most of the time. CNA J states (Name of R15) denied herself popcorn yesterday, she had no interest and said [NAME] when it was offered. She loves popcorn. (Name of R10) is snapping at other residents, she is yelling, her behaviors are definitely increasing. She is telling us of her displeasure. CNA J revealed, the residents on the North and South Hall use to live for activities. During a follow-up interview on [DATE] at 2:30 PM, AD I was asked to provide a list of residents in the building that had received 1 on 1 activities from [DATE] to [DATE] and then from [DATE] -[DATE]. After providing both reports to this surveyor the first set activities note revealed the facility had approximately 16 residents were receiving 1:1 activities. The second report AD I provided from ,d+[DATE]-,d+[DATE] revealed there were no 1 on 1 activities during this time-period. When asked what happened, AD I stated, I'm just one person, I can't get it all done. I update resident care plans, attend their care conferences, make calendars, put in management notes, and do two activities a day. I just do not have enough time. R16: Review of R16's care plan reflected the following, I am here for long term, and I am dependent on for all my care needs. I would like to be read books that my wife has brought in for me. I will listen to staff reading to me during 1:1 visits 2 x per week. Date initiated: [DATE]. R16's interventions included, For 1:1 visits, I would enjoy: Harry [NAME] books, Jesus calling and the Bible read to me. These are books my wife brought in for me. Date initiated [DATE]. I am of Baptist religious affiliation and want to participate with religious activities at the facility. Date Initiated [DATE]. Review of R16's activities from [DATE] - [DATE] reflected he received 6 1:1 activities from ,d+[DATE] to ,d+[DATE]. Further review of R16's record reflected all activities ceased for him after [DATE]. During an interview on [DATE] at 2:50 PM, Physical Therapist (PT) S revealed the residents seem to be having a hard time since the cuts have been made in the building. (Name of R7) told me he has no reason to leave his room now. There is no laughter in the hallways. PT S stated, I miss hearing the residents coming down early to the activities room to drink coffee and chat. These guys (residents) are no longer going around joking, they are just sad. (continued on next page)

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F 0679 Level of Harm - Actual harm Residents Affected - Some	During an interview on [DATE] at approximately 3:00 PM, Anonymous Employee (AE) U revealed she has seen an increase in anxiety and sadness among the residents since the activities program has been cut. They are worried about what's going on, what's going to be taken away from them next. We are no longer doing 1 on 1 activities so the residents that are bed bound are just not getting any extra care or attention. They used to be talked to, read to, some would get their nails painted, and they would listen to music together. Now, those residents have nothing. Our residents use to have fun, they had a routine and schedule they liked, they had fun parties. States she is seeing more residents just depressed.

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F 0692 Level of Harm - Minimal harm or potential for 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** 28101 This Citation pertains to Intake Number MI00141234. Based on observations, interviews, and record review, the facility failed to accurately weigh one resident (R13) of 3 residents reviewed for nutrition. This deficient practice resulted in confusion of R13's true weight and medical needs. Findings include: Resident #13 (R13): Review of R13's face sheet dated 2/6/24 revealed she was a [AGE] year-old female, admitted to the facility on [DATE] and had diagnoses that included: traumatic brain injury, abscess of mediastinum (infection in the body between the lungs), pseudocyst of pancreas (collections of leaked pancreatic fluids), acute pancreatitis with uninfected necrosis (inflammation of the pancreas with dead tissue around it), adult failure to thrive, alcohol abuse in remission, anxiety disorder, anemia (lack of healthy red blood cells), severe protein-calorie malnutrition, major depressive disorder, attention-deficit hyperactivity disorder, insomnia, chronic pain, generalized weakness and dysphagia (difficulty swallowing). R13 was her own responsible party. Review of R13's weights revealed that all her weights were taken on a standing scale. R13's weights were listed as: 1/27/24 - 92.8 pounds, 1/28/24 - 90.6 pounds, 2/1/24 - 90.2 pounds, 2/2/24 - 89.8 pounds, 2/5/24 - 80.8 pounds, and 2/6/24 - 82.8 pounds. During and interview with R13 and R13's family advocate on 2/5/24 at 12:33 PM, R13 said she was concerned about her weight. She said she weighted 92 pounds on admission, and no one had weighed her since admission. R13 shared her weight concern with Clinical Care Coordinator (CCC) D and CCC D asked Certified Nurse Aide (CNA) L to get R13's weight. CNA D came to R13's room with a home style scale. CNA D said he had never taken R13's weight before and R13 denied ever seeing a scale like the one CNA D brought into the room. CNA L said the only other scale she could use was in a shower room. R13 was agreeable to go to the shower room for her weight. The scale in the shower room was a large hospital style scale with a base large enough to hold a wheelchair. R13 denied ever being weighed on the shower room scale. R13 stood independently on this scale. R13's weight on the shower room scale was 80.8 pounds. R13 and her family advocate were very disappointed with the weight loss and requested to speak with the physician related to this significant weight loss of 12 lbs. in 9 days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Regional Registered Nurse (RRN) M on 2/5/24 at 2:59 PM, RRN M said she reviewed R13's Medical Record and determined CNA N had obtained all for R13's weights after her day of admission to 2/5/24. RRN M called CNA N for a joint interview with the Surveyor and RRN M CNA N confirmed she had taken R13's weight on a few occasions on second shift using the home style scale. CNA N said R13 is generally confused, she often needs reminders as to where she is, and she usually has to direct her to do things she has done in the past. CNA N said R13's baseline has been confused since admission. CNA N told RRN M they started using the home style scale after the nursing home scale on that unit stopped working. CNA N could not recall the time frame of when the scale broke. RRN M told CNA N to stop using the home style scale and to only use the facility scale. RRN M said she would begin education and get new weights on all affected residents. During an interview with Registered Dietitian (RD) A on 2/6/24, RD A confirmed that the facility informed her yesterday that they had been using a home style scale for some resident's weights for an unknown period. RD A said she would be assisting the facility to get new weights on all residents affected by this practice. RD A stated that the home style scales cannot be calibrated for accuracy and the facility needs to identify which scale residents are being weighed on for accuracy. RD A said she would be contacting R13's Physician Assistant (PA) once she has completed an assessment for R13. Review of R13's Interdisciplinary Team note dated 2/6/24 at 9:44 AM electronically signed by RD A revealed RD A and R13's PA met with her and reviewed her medical and nutritional concerns. R13 verbalized she understood the information they provided and was agreeable to following the nutritional/medical plan they presented.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This Citation pertains to Intake Number MI00141234. Based on observations, interviews and record review the facility failed to adequately assess and monitor the tube feeding placement and intake for one resident (R13) resulting in confusion of the amount of tube feeding received and the need for further intervention. Findings include: Resident #13 (R13): Review of R13's face sheet dated 2/6/24 revealed she was a [AGE] year-old female, admitted to the facility on [DATE] and had diagnoses that included: traumatic brain injury, abscess of mediastinum (infection in the body between the lungs), pseudocyst of pancreas (collections of leaked pancreatic fluids), acute pancreatitis with uninfected necrosis (inflammation of the pancreas with dead tissue around it), adult failure to thrive, alcohol abuse in remission, anxiety disorder, anemia (lack of healthy red blood cells), severe protein-calorie malnutrition, major depressive disorder, attention-deficit hyperactivity disorder, insomnia, chronic pain, generalized weakness and dysphagia (difficulty swallowing). R13 was her own responsible party. During an observation and interview with R13 on 2/5/24 at 9:00 AM, R13's feeding tube was disconnected. R13 said she had been requesting and new tube feeding ([NAME]) and device that holds the tube in place that reduces the risk of tube pullouts. The [NAME] secures the placement of the feeding to ensure proper placement. R13 said she went to the emergency room last week because the feeding tube was not in place and the emergency room was not able to replace the [NAME]. During an interview with Clinical Care Coordinator (CCC) D on 2/5/24, CCC D confirmed that R13 had requested a new feed tube [NAME] and R13 was sent to the emergency room last week with a concern about the tube feeding placement. Once the feeding tube placement was confirmed R13 returned to the facility. CCC D explained that the service providing R13 tube feeding care was not local and a tube feeding [NAME] need to be placed by a physician. CCC D said she would confirm appoints but believed R13 was schedule to receive follow up care with the tube feeding provider in the next few weeks. All documents related to R13's tube feeding [NAME], tube feeding placement, care, intake, tube feeding orders and policy was requested. During an observation with R13 on 2/5/24 at 12:33 PM, R13 had her feed tube disconnected. During an interview and observation on 2/5/24 at 12:55 PM CNA L took R13 to the facility shower room to get her weight on a facility scale. R13 weighted 80.8 pounds. R13 was surprised at the amount of weight she lost since admission, reporting she weighted 92 pounds when she entered the facility. Review of R13's weights revealed that all her weights were taken on a standing scale. R13's weights were listed as: 1/27/24 - 92.8 pounds, 1/28/24 - 90.6 pounds, 2/1/24 - 90.2 pounds, 2/2/24 - 89.8 pounds, 2/5/24 - 80.8 pounds, and 2/6/24 - 82.8 pounds. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R13's electronic medical record revealed R13's tube feeding intake was not being monitored. Review of R13's electronic medical record revealed no documentation of a measurement or way to assess tube feeding placements. All tube feeding documentation was requested on 2/5/24 and no documentation of tube feeding placement/assessment were located. No tube feeding intake documentation was located. During an interview with RD A on 2/6/24 at 1:55 PM, RD A confirmed that the facility had not been documenting R13's tube feeding intake and did not measure the tube feeding for placement. RD A reported R13's physician just ordered an x-ray to ensure proper placement and they will measure the feed once they confirmed placement. RD A confirmed they educated R13 today to keep the tube feeding running and they implemented documentation of tube feeding intake every shift. Review of R13's progress note dated 2/6/24 at 2:23 PM revealed R13's Physician assistant measured feeding tube, ordered a [NAME] and planned to place the [NAME] when it arrives.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview, and record review, the facility failed to implement behavioral interventions before the initiation and administration of psychotropic drugs and ensure PRN (as needed) psychotropic drugs are limited to 14 days for 1 resident (Resident #103) out of 9 residents reviewed, resulting in ongoing expressions and/or indication of distress and unnecessary medications. Findings: Resident #103 (R103) Review of an Admission Record reflected R103 admitted to the facility with diagnoses that included major depressive disorder, recurrent, severe with psychotic symptoms, unspecified intellectual disabilities, dysthymic disorder (a mild but long-lasting form of depression), generalized anxiety disorder, chronic pain, weakness, high blood pressure, and congestive heart failure (CHF). R103 had a guardian in place to assist with financial and medical decisions. Review of the Comprehensive Care Plan reflected R103 has impaired cognitive function or impaired thought processes related to developmental disability and impaired intellectual functioning and had a guardian in place. An intervention to address the cognitive and intellectual functioning was to Keep my routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion in my day-to-day living (initiated 5/10/2023). R103 was also care planned to address concerning behavioral symptoms that appear sexual in nature. An intervention to address this concern included Redirect (R103) with Activity (initiated on 5/15/2023). The care plan indicated R103 will be invited to participate in the activity program with the goal of participating in independent leisure activities, special events, karaoke, music and fun, and religious groups as well as group activities of interest 2-4 times a week (initiated on 5/1/2023, revised on 7/26/2023). Further review of the Comprehensive Care Plan reflected new Focus areas were added and indicated R103 sexually harassed and developed an obsession with a female staff member who can no longer work in the area R103 lives (initiated 3/20/2024). On 4/2/2024 R103 was identified as being At risk for elopement related to change in condition, independent with mobility and exit seeking. A wander guard (a sensor that activates an alarm in proximity to an exit) was placed on their left ankle. R103 demonstrated behavioral symptoms that included intruding into other rooms, delusions, expressions of confusion, fear, wanders, short attention span, excessive motor activity . (R103) makes statements regarding wish to leave, go home, or actions such as packing their belongings. The interventions put in place to mitigate the risk for elopement included completing a risk assessment and putting information into the elopement book. The interventions did not include diversions or activities to redirect R103's attention. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a behavioral consultation note dated 3/15/2024 reflected R103 had episodes of verbal behaviors such as fixating on a female staff member, berating her verbally, loudly cursing and swearing, fixated on needing dentures, swearing at staff, yelling at staff and storming away after returning from a leave of absence (LOA). Social service reports the resident having emotional disturbances and fixating on getting dentures. Social service reports PRN (as needed) Ativan (antianxiety medication) was started yesterday by PCP (Primary Care Physician). Review of a Risk vs Benefit/GDR (Gradual Dose Reduction) Form dated 3/15/24 reflected R103 had been started on Lorazepam (anti-anxiety) medication. Non-pharmacological interventions attempted prior to initiation: quiet atmosphere. The form indicated staff were to document non-pharmacological interventions attempted prior to the administration of the medication. Review of the March and April 2024 MAR reflected an order for Lorazepam Tablet 0.5 MG Give 1 tablet by mouth every 12 hours as needed for GAD (generalized anxiety disorder)/agitation -Start Date- 3/14/2024 at 11:12 a.m. No end date was noted. R103 was given the medication on 3/20/2024 at 11:46 a.m., 4/2/2024 at 5:20 a.m., and 4/2/2024 at 12:18 p.m. Review of Behavior Notes dated 3/19/2024 at 9:37 p.m. indicated the Director of Nursing (DON) was contacted by a Certified Nurse Aide (CNA) who was crying as she reported R103 was following her and making statements about a ring and marriage which made her very uncomfortable and unable to work on the unit due to inappropriate statements and continued sexual advancements. Non-pharmacological interventions attempted to address R103's behavior was to inform him the CNA will no longer work on that unit and the resident should not be seeking CNA out. If he is observed to be doing so, these behaviors will be addressed. The note did not indicate how the behaviors would be addressed. Review of a Case management note dated 3/20/2024 at 11:37 a.m. indicated that Registered Nurse (RN) D spoke to R103 about the behaviors toward staff. RN D documented R103 was remorseful he made the CNA cry but was angry he couldn't get married. Res (R103) at this time of this note is receiving his Ativan (Brand name of Lorazepam, anti-anxiety drug) from the nurse under encouragement to reduce his anger. He is agreeable to not call his family until he calms down as to not upset them. The note does not indicate any non-pharmacological interventions were attempted. Review of a Social Service Progress Note dated 4/2/2024 at 3:24 a.m. reflected R103 was talking to staff about plans to marry an unknown friend's daughter. When staff attempted to redirect the conversation R103 became agitated. Staff then exited the area to de-escalate the situation, 5 minutes later R103 was resting in bed. Review of an Alert Note dated 4/2/2024 at 5:37 a.m. revealed Resident restless/anxiety noted resident pacing around facility. Talking non-stop about getting married today. Resident stopped at each exit looking out for someone. Resident needs wander guard for safety, unable to locate strap will pass on to day shift. The progress note did not indicate an attempt was made to engage R103 in diversional activities to address R103's distress. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Social Service Progress Note dated 4/2/2024 at 9:54 a.m. reflected (R103) was demonstrating an increase in behavioral issues including anxiety, pacing, restlessness, agitation and obsessive thoughts about getting married. SW (Social Worker) reached out to (mental health consultant) and provided updated (sic) on patient's behaviors. (Name of mental health consultant) agreeable to starting patient on Depakote (an anti-seizure medication that is also used as a mood stabilizer for the treatment of an acute manic episode or mixed episodes associated with bipolar disorder, with or without psychotic features), 125 mg by mouth two times a day. The progress note did not document any non-pharmacological interventions that had been attempted prior to the initiation of the psychotropic medication. Review of the April 2024 Medication Administration Record (MAR) reflected R103 was prescribed Depakote Oral Tablet Delayed Release 125 MG (Divalproex Sodium) give 125 mg by mouth two times a day for depression -Start Date- 4/2/2024. Documentation on the MAR showed R103 received the first dose of the medication on the evening of 4/2/2024. Review of a Psychoactive Medication Progress Note dated 4/3/2024 at 10:06 a.m. reflected R103 was started on Depakote 125 mg BID (two times a day) and that Legal Guardian (LG) P was notified and informed of the risks vs. benefits. During an observation and interview on 4/4/2024 at 10:48 a.m., R103 was dressed and sitting on the edge of his bed, certificates of baptism hung on the wall next to his bed. When asked about activities at the facility R103 stated I'm bored, they used to have more to do. I'm lonesome, I don't like the food, it's the same thing day in and day out. I used to enjoy myself. It's just dull here. I would like a girlfriend and to get married, someone I can talk to. I don't want to live here; I want to get out of here. R103 said he loved to sing and go to church and enjoyed going on outings with his brother on Tuesdays. On 4/4/2024 at 11:32 a.m., R103 was discovered in a Resident Lounge, seated at a table. No staff or other residents were in the room. R103 was listening to Elvis [NAME] music on a tablet. R103 said he wasn't going to eat lunch in the dining room and exclaimed See, I told you I don't have any friends! I don't like it here, I just want to leave, I don't have no fun here, I like to sing, I like to go to church. During an interview on 4/4/2024 at 3:15 p.m. Registered Nurse (RN) D reviewed the March and April 2024 MAR and noted the order for Lorazapam did not specify an end date. Further review of the clinical record did not reveal the prescribing provider documented a rational for extending the PRN order beyond 14 days. RN D said it is the policy of the facility to obtain informed consent prior to starting a new medication or making changes to the treatment plan. RN D reviewed the electronic medical record and confirmed R103 was given a dose of Depakote in the evening on 4/2/2024, prior to obtaining informed consent for LG P. (continued on next page)

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	235290	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Greenville	828 E Washington St Greenville, MI 48838

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy Behavior Management Program last reviewed 12/2020 reflected, PRN orders for psychotropic medications are limited to 14 days. If the prescribing practitioner believes it is appropriate for the order to be extended beyond 14 days, then he/she should document their rational in the medical record and indicate the duration for the order. Further review of the Behavior Management Program revealed Additional Behavioral Intervention Tips and listed symptoms: Wandering, Yelling, Verbal or Physical Threats, Incontinence, Stealing, Disrobing and Repetitive Questions. Possible causes associated with the behavioral symptoms were listed for each. Anxiety/Boredom were identified as causative triggers for wandering, yelling and repetitive questions. Possible Interventions to relieve the behavioral symptoms included Recreational Activities. During an interview on 4/4/2024 at 2:14 p.m., the Nursing Home Administrator (NHA) reported that at the beginning of January, 2024 the budget for the Recreational Activity Department had been eliminated. The NHA said residents and families or resident representatives were not notified of the elimination of the Activity Budget, Activity Assistants and subsequent loss of a substantial number of meaningful activities within the home prior to the significant change in services.

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 29073 Based on interview and record review, the facility failed to follow its Facility Assessment and review and revise the facility assessment with input from relevant department heads and resident groups before substantial modifications to the community were planned and implemented, resulting in diminished quality of life for all residents who lived at the facility. Findings: Review of a facility policy Facility Assessment last reviewed 12/2020 reflected The facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its resident competently during both day-to-day operation and emergencies. The policy indicated that The facility assessment will include but not limited to the following: . ii. The care required by the resident population considering the types of diseases, condition, physical and cognitive disabilities, overall acuity and other pertinent facts that are present within that population; iii. Staff competencies that are necessary to provide the level and types of care needed for the resident population; . v. Any ethic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to activities and food and nutrition services. The facility assessment is to reflect the resources including iv. All personnel, including manager, staff (both employees and those who provide services under contract) and volunteers, as well as their education and/or training and any competencies related to resident care. 4. The facility assessment will be reviewed and updated whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment or at a minimum annually. Review of the Facility Assessment reflected that the QAA (Quality Assessment and Assurance) Committee on 2/21/23 and approved by the Nursing Home Administrator (NHA) and the Regional Director of Operations (RDO) on 3/3/2023. The Revision History Page reflected the assessment had been updated on 3/3/2023 to reflect the new NHA. Responsibility to Complete Assessment indicated the assessment was completed at the facility level to serve as a record for staff and management to understand the reasoning for decision made regarding staffing and other resources and included the involvement of Department heads (as needed) . Activity Director . Resident/family councils, residents, resident representatives or families (not required but encouraged). The Administrator was designated as the leader for the facility assessment process. The Administrator is responsible for ensuring the completion of the facility assessment and maintaining all documents that pertain to the assessment. Further review of the facility assessment reflected Information About our Staff and showed the Activities Department included the Activity Director (Recreation Director) (RD) H with 1-2 Activities Staff per day and Volunteers who report to the Activity Department. The assessment indicated We offer 1:1 and group activities that are catered toward the resident population and needs. They are reviewed by our resident council and in QAPI on a monthly and as needed basis to determine the appropriateness for the population, and adjustments are made as needed. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of the assessment reflected Residents have access to religious services based upon their preferences and request. We currently offer rosary weekly, a nondenominational church service every Sunday, a full Catholic mass offered every other week, and streaming religious services upon demand. This meets the current resident population needs and preferences. However, other services and faiths are able to be accommodated upon request. Preferences are reviewed upon admission, quarterly, and as needed. During an interview on 2/4/2024 at 2:14 p.m., the Nursing Home Administrator (NHA) reported that residents and families or resident representatives were not notified in advance of the elimination of the Activity Budget, Activity Assistants and subsequent loss of a substantial number of meaningful activities within the home. The NHA also reported the Facility Assessment had not been reviewed and updated to reflect the significant changes that had been implemented since January 2024. Review of a document Resident Council Emergency Meeting dated 1/4/2024 reflected Residents are very concerned that all the activity staff were let go as of today. (NHA) explained that it was not his decision and that he fought to keep the staff. He tried his best but cannot change it. He will answer questions. (NHA) explained that the maintenance position, the social work advocate's position, and the infection control position were also eliminated. Review of an Employee Roster provided to the surveyor on 4/3/24, that included contact information and credentials/position and department reflected only one employee working in the Recreation Department, Recreation Director (RD) H.