

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Cedar Springs		STREET ADDRESS, CITY, STATE, ZIP CODE  400 Jeffrey Cedar Springs, MI 49319	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>36221</p> <p>Based on observation, interview, and record review, the facility failed to ensure timely care and services to promote dignity and ensure a dignified environment during meal times in 3 of 3 residents (Resident #14, #17, &amp; #60) reviewed for dignity/respect, resulting in long call light wait times and the potential for feelings of diminished self-worth, sadness, and frustration.</p> <p>Findings include:</p> <p>In an observation on 12/9/24 at 12:11 PM, lunch service was in progress in the main dining room. Noted a total of five tables in the main dining room. Observed 4 of 6 residents were served at the first table (near the television), with two still waiting to be served their lunch meal. Observed 2 of 5 residents were served at the center table, with three still waiting to be served their lunch meal. Observed 2 of 7 residents were served at the far table (near the window), with five still waiting to be served their lunch. Observed Resident #14 and Resident #17 in the main dining room, at the far table near the window. Noted Resident #14 had not yet been served her lunch meal.</p> <p>In an observation on 12/9/24 at 12:14 PM, the two remaining residents at the first table (near the television) were served their lunch meals. Observed one resident served a lunch meal at the center table (now 3 of 5 residents served), and one resident served at the far table near the window (now 3 of 7 residents served). Noted staff were not serving all residents at a table their lunch meal before moving on to the next table. No apparent pattern for meal service noted in the main dining room.</p> <p>In an observation on 12/9/24 at 12:15 PM, two residents were served lunch at the far table near the window (now 5 of 7 residents served). Noted Resident #14 had not yet been served.</p> <p>In an observation on 12/9/24 at 12:18 PM, one resident (Resident #14) was served lunch at the far table near the window (now 6 of 7 residents served), and one resident was served at the center table (now 4 of 5 residents served).</p> <p>In an observation on 12/9/24 at 12:22 PM, the remaining resident at the center table was served a lunch meal.</p> <p>In an observation on 12/9/24 at 12:24 PM, the remaining resident at the far table near the window was served a lunch meal. Observed a female resident at the center table finish her meal and exit the main dining room.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/9/24 at 12:34 PM, Certified Nursing Assistant (CNA) QQ reported the order residents are served in the main dining room depends on order the trays are sent out from the kitchen.</p> <p>Resident #14</p> <p>Review of an Admission Record revealed Resident #14 was a female, with pertinent diagnoses which included Alzheimer's disease, anemia, depression, and anxiety.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #14, with a reference date of 9/24/24, revealed a Brief Interview for Mental Status (BIMS) score of 8, out of a total possible score of 15, which indicated moderate cognitive impairment.</p> <p>In an interview on 12/10/24 at 10:02 AM, Resident #14 reported there is generally no specific pattern/order for meal service in the main dining room. Resident #14 reported staff often do not finish serving one table in the main dining room before moving onto the next. Resident #14 reported she would prefer meals to be served one table at a time, so everyone gets to eat together.</p> <p>Resident #17</p> <p>Review of an Admission Record revealed Resident #17 was a female, with pertinent diagnoses which included depression.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #17, with a reference date of 10/17/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.</p> <p>In an interview on 12/10/24 at 10:07 AM, Resident #17 stated in regard to meal service in the main dining room .you could be the first one in there but the last to be served . Resident #17 reported it bothers her when everyone else at a table is served and a couple people have to wait, and stated .you see the whole table got theirs and you're just waiting. They (other residents at the table) are pretty much done by the time you get your plate . Resident #17 reported she would prefer meals to be served one table at a time, so everyone gets to eat together.</p> <p>In an interview on 12/10/24 at 1:49 PM, Unit Manager GG reported staff are supposed to serve one table at a time in the main dining room before moving on to the next.</p> <p>41982</p> <p>Resident #60</p> <p>Review of an Admission Record revealed Resident #60 was a female, with pertinent diagnoses which included: muscle weakness, generalized.</p> <p>In an interview on 12/8/24 at 10:01 AM, Resident #60 reported when she turned on her call light, sometimes it takes a while for staff to respond. Resident #60 reported it could sometimes take up to an hour before staff answered.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47955</p> <p>This citation pertains to intake #MI00148287</p> <p>Based on interview and record review, the facility failed to protect the residents right to be free from resident to resident sexual abuse in 1 of 1 residents (Resident #30) by Resident #58</p> <p>Findings include:</p> <p>Review of Incident Report dated 11/3/24 revealed Reported resident (Resident #30) was outside the south cafe door when another male resident (Resident #58) was seen with his hand in her pants. It is reported by witness resident (Former Resident (FR) VV) that resident (Resident #30) tried to roll away and male resident (Resident #58) grabbed her (Resident #30) hair and pulled her back.</p> <p>Resident #30</p> <p>Review of an Admission Record revealed Resident #30 had pertinent diagnoses which included: dementia and anxiety.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #30, with a reference date of 11/19/24 revealed a Brief Interview for Mental Status (BIMS) score of 2/15 which indicated Resident #30 was severely cognitively impaired.</p> <p>Review of Care Plan for Resident #30 revealed Focus, Goals, and Interventions: I have severe impaired cognitive function r/t (related to) dementia; I have difficulty understanding situations: please encourage me to stay on East/West unit. I have communication problem r/t sometimes not understanding verbal communication r/t advance dementia. I will attempt to sit away from male residents at meal times and group activities, I do propel myself around the room. monitor behavior symptoms that include wandering. No noted care plan related to trauma informed care.</p> <p>Review of Kardex (a document that instructs workers how to care for the resident) for Resident #30 dated 12/10/24 revealed safety - wandering; please remove me from stressful situations.</p> <p>Resident #58</p> <p>Review of an Admission Record revealed Resident #58 had pertinent diagnoses which included: dementia and anxiety.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #58, with a reference date of 10/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #58 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Care Plan for Resident #58 revealed Focus, goal and interventions: I have the potential to exhibit behaviors that sound or appear sexual in nature. I have a hx (history) of requesting others give me oral pleasure (10/8/2024) I also have a history of touching myself and others inappropriately: I will not engage in behaviors that sound or appear sexual in nature in a public place. I make statements or ask staff/other residents to join me in sexual acts. Interventions: two staff with all personal care, I may make sexual statements or ask staff/other residents to join me in sexual acts. Please inform me this in inappropriate: initiated 9/13/2024</p> <p>Review of Progress Note for Resident #58 dated 9/12/24 revealed was reported to this nurse that resident exposed himself and started to masturbate in front of a minor staff who was delivering dinner trays .</p> <p>Review of Progress Note for Resident #58 dated 9/14/24 revealed .cna went in to help resident and he said, 'would \$20 make you get freaky with me?</p> <p>Review of Progress Note for Resident #58 dated 9/29/24 revealed resident asked CNA 2 times if she would take \$200 in exchange for sexual favors with resident.</p> <p>Review of Progress Note for Resident #58 dated 10/8/24 revealed A resident .was passing out crafts to other resident. When she entered this resident's room, he asked her to suck my cock for \$5 .</p> <p>Review of Progress Note for Resident #58 dated 10/16/24 revealed .resident's sexual behaviors are not stopping even after medication adjustments .</p> <p>Review of Progress Note for Resident #58 dated 11/3/24 revealed resident was witnessed by another resident putting his hands in a female residents pants.</p> <p>In an interview on 12/9/24 at 5:32 PM., Resident #58 stated I did an inappropriate to her and they called the police on me. Resident #58 stated she made me feel good, and a guy saw us and told on us. This surveyor asked Resident #58 how she (Resident #30) made him feel good and Resident #58 stated She let me touch her and that made me feel good. Resident #58 stated I did not rape her, I just touched her.</p> <p>In an attempted interview on 12/8/24 at 9:41 AM., Resident #30 was in bed in her room, eating breakfast, and did not engage in any meaningful conversation with this surveyor.</p> <p>In a telephone interview on 12/9/24 at 12:07 PM., Former Resident (FR) VV reported he observed Resident #58 blocking Resident #30 in the hallway near the cafe on the south unit and Resident #58 had his hand down Resident #30's pants. FR VV reported he pulled Resident #58 away from Resident #30 and Resident #58 went right back to Resident #30 and put his hand up her shorts along her leg, grabbed her hair, and was pulling her in her wheelchair to him. FR VV reported he then yelled for help. FR VV reported Resident #30's face was grim, she was crying, and she appeared to be completely helpless.</p> <p>In an interview on 12/8/24 at 11:52 AM., Certified Nurse Assistant (CNA) D reported Resident #58 was alert and oriented and aware of what he was doing. CNA D reported Resident #58 did grab Resident #30, pull her to him, and put his hand down her pants. CNA D reported she heard Resident #58 state he was giving her (Resident #30) what she was asking for. CNA D reported Resident #30 was mostly non-verbal, did not speak much, if at all, was confused and unaware of what was going on around her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/8/24 at 2:56 PM., Unit Manager (UM) C reported Resident #58 has had many behaviors during his stay, he had a resident-to-resident incident, and he had asked staff for oral sex in exchange for money. UM C reported Resident #58 had been observed by staff exposing his genitalia and masturbating in the open doorway of his room. UM C reported when the incident on 11/3/2024 between Resident #30 and Resident #58 occurred Resident #58 was touching Resident #30 inappropriately (Resident #58 had his hand in Resident #30's pants), Resident #30 tried to escape, and Resident #58 grabbed Resident #30 by the hair and pulled her back to him.</p> <p>In an interview on 12/9/24 at 9:11 AM., CNA QQ reported Resident #30 did wander around the facility while sitting in her wheelchair and she was very confused. CNA QQ reported Resident #58 had offered her (CNA QQ) 200 dollars cash to get freaky with him while she was assisting him with personal care.</p> <p>In an interview on 12/9/24 at 9:25 AM CNA QQ reported staffing on the south unit during meals was one CNA and one nurse. The second assigned CNA to the unit was required to assist with the dining room.</p> <p>In an interview on 12/9/24 at 12:22 PM., Licensed Practical Nurse (LPN) DD reported Resident #58 had escalating behaviors prior to the incident with Resident #30 and Resident #58 continues to display inappropriate behaviors including exposing himself to others. LPN DD reported on 11/3/24 FR VV yelled out for her and when she rounded the corner near the cafe on the south unit, she saw Resident #58 aggressively trying to get ahold of Resident #30. LPN DD reported she made herself a barrier between the two residents as Resident #58 aggressively continued to grab Resident #30. LPN DD reported she separated Resident #30 and Resident #58. LPN DD reported Resident #58 was taken to his room and Resident #30 was taken to her room.</p> <p>In an interview on 12/9/24 at 12:35 PM., LPN DD reported staffing on the south unit during meals was one CNA and one nurse. The second assigned CNA to the unit was required to assist with the dining room. LPN DD reported the incident that occurred on 11/3/24 between Resident #30 and Resident #58 occurred during breakfast and staffing was only one nurse and one CNA, who was assisting a resident in a room, on the unit at that time.</p> <p>In an interview on 12/9/24 at 1:29 PM., Scheduler (S) T reported Resident #30 would wander around the facility in her wheelchair. S T reported Resident #58 would fixate on sex and his behavior would escalate. S T stated we are doing our best to keep the environment safe. S T reported staffing on the south unit during meals was one CNA and one nurse. The second assigned CNA to the unit was required to assist with the dining room.</p> <p>During an interview on 12/9/2024 at 2:34 PM., Director of Nursing (DON) B reported her expectations were that one of the two CNAs scheduled on the South unit assisted with the main dining room during meals. DON B reported the staffing on south unit during meals was one CNA and one nurse.</p> <p>In an interview on 12/9/24 at 2:48 PM., Physician Assistant (PA) XX reported she recognized when Resident #58 admitted that something was off with him, he would talk to himself, he would hallucinate, and it progressed to behaviors sexual in nature. PA XX reported medications have been adjusted for Resident #58 and the sexual behaviors have lessened but were not eliminated.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/10/24 at 10:26 AM., Social Services Manager (SSM) X reported Resident #58 was observed by another resident with his hand down Resident #30's pants. SSM X reported Resident #30 did not verbalized anything during follow up sessions with her. SSM 'X reported Resident #58 did not recall the incident on the first of three follow up sessions, but did recall the incident on the second and third follow up session. SSM X reported Resident #58 appeared unphased by the incident. SSM X reported Resident #58 was aware of his actions.</p> <p>In an interview on 12/10/24 at 12:56 PM., CNA Z reported Resident #30 was touched inappropriately by Resident #58, and that incident was the second time Resident #30 had been touched inappropriately by a male resident. CNA Z reported Resident #58 had put his hand in Resident #30's pants and when it happened Resident #30 was crying. CNA Z reported staffing on the south unit during meals was one CNA and one nurse. The second assigned CNA to the unit was required to assist with the dining room.</p> <p>Using the reasonable person concept, though Resident #30 had decreased ability to verbally express her own thoughts due to mental diagnosis, witness accounts of Resident #30 crying during the incident with Resident #58 on 11/3/24 clearly indicated she was upset. This emotional response has the potential to continue well past the date of the incident based on the reasonable person concept. During a telephone conversation on 12/9/24 at 4:45 PM., Family Member (FM) WW (a family member of Resident #30) reported Resident #30 would have been upset, angry, and would have tried to slap Resident #58 during the altercation.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>47955</p> <p>Based on interview and record review the facility failed to update a care plan following a new diagnosis in 1 (Resident #58) of 17 residents reviewed for care plans, resulting in an incomplete depiction of a resident's status and the potential for unmet care needs.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #58 had pertinent diagnoses which included: dementia and anxiety.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #58, with a reference date of 10/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #58 was cognitively intact.</p> <p>Review of Care Plan for Resident #58 revealed no noted documentation regarding Resident #58's diagnosis of dementia.</p> <p>In an interview on 12/10/24 at 12:42 PM., Unit Manager (UM) C reported Resident #58 had received a diagnosis of dementia on 10/8/24. UM C reviewed Resident #58's care plan and confirmed there was no mention of dementia in Resident #58's care plan. UM C reported she should have updated the care plan to include Resident #58's diagnosis of dementia.</p> <p>On 12/10/24 at 12:45 PM., UM C was noted to add a dementia diagnosis to Resident #58's care plan.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</b></p> <p>Based on observation, interview and record review the facility failed consistently apply a positioning device (a brace) for 1 resident (R#55) of 2 residents reviewed for limited range of motion (ROM), resulting in the potential for decreased range of motion, contractures (hardening of the muscles, tendons, and other tissues), and pain.</p> <p>Findings include:</p> <p>Resident #55 (R55):</p> <p>Review of an Admission Record for R55 revealed she was admitted to the facility on [DATE] with pertinent diagnoses of stroke, paralysis of right dominant side, lack of coordination, muscle weakness, cognitive communication deficit ((progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language), dysphagia (damage to the brain responsible for production and comprehension of speech), and aphasia (loss of the ability to understand or express speech caused by brain damage, like with a stroke).</p> <p>Review of a Care Plan with the focus initiated on 10/17/24, revealed, .I have an ADL (Activities of daily living) Self Care Performance Deficit r/t (related to) disease process, cerebral infarction (stroke)with limited mobility . with the intervention .PROM (passive range of motion) to right hand &amp; wrist prior to applying right resting hand splint. On in AM and off around lunch as tolerated .</p> <p>Review of Orders dated 11/5/24, revealed, .Monitor right hand/wrist for skin breakdown under brace. Notify provider with any abnormal findings .Every shift .</p> <p>During an observation on 12/08/24 at 10:32 AM, R55 was observed seated in her wheelchair, there was a tray for the right side of the wheelchair. R55 was observed without her right resting hand splint. It was observed on top of the night stand next to her bed.</p> <p>During an observation on 12/09/24 at 09:15 AM, R55 was observed in her room with her tray on her wheelchair and she did have the right resting hand splint but her hand was not placed correctly.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 12/09/24 at 09:17 AM, Rehab Director YY was observed entering the room and placed a photo in the resident's closet. Rehab Director YY reported she brought in a new picture of how R55's brace was supposed to be applied. Rehab Director YY was attempting to readjust R55's fingers and hand in the brace for her right hand. Rehab Director YY reported the CNA was unable to place the brace and her fingers were not placed in the brace appropriately and she had come in to help fix it up. Rehab Director YY' reported the brace was to be placed each day by the CNAs. Rehab Director YY began to perform range of motion with R55's fingers and she reported she was completing the ROM to help loosen her fingers up a little. Rehab Director YY reported this was to be completed each day before the brace was placed as it helps to loosen up her fingers and makes the brace fit better too. Rehab Director YY reported she might have to pick R55 back up for therapy as she was having some contracture of her fingers. Rehab Director YY reported if the resident was refusing her brace, staff would notify her, and she had not received any notification of R55 refusing to wear her brace or that she was not tolerating it as long. Rehab Director YY reported the brace was to put on in the morning and removed around lunch time every day.</p> <p>During an observation 12/10/24 at 09:50 AM, R55 was observed seated in her room and she had her tray on her wheelchair, but her brace was lying on her night stand.</p> <p>Review of policy, Restorative Nursing Program revised on 6/23, revealed, .It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level .e. Assisting residents in adjustment to their disabilities and use of any assistive devices .f. Assisting residents with range of motion exercises, performing passive range of motion for residents unable to actively participate .4. All residents will receive maintenance restorative nursing services as described above, as needed, by certified nursing assistants .</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36221</p> <p>Based on interview, and record review, the facility failed to provide palatable food products in 5 of 7 residents (Resident #8, #9, #4, #12, &amp; #22) reviewed for food palatability, resulting in dissatisfaction with meals and the potential for nutritional decline.</p> <p>Findings include:</p> <p>Review of the Resident Council Minutes, dated 11/25/24, revealed concerns regarding cold food and a lack of flavor.</p> <p>Review of the Resident Council Minutes, dated 12/4/24, revealed concerns regarding cold food.</p> <p>Resident #8</p> <p>Review of an Admission Record revealed Resident #8 was a female, with pertinent diagnoses which included stroke, protein-calorie malnutrition, and diabetes.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #8, with a reference date of 12/3/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.</p> <p>In an interview on 12/8/24 at 12:03 PM, Resident #8 reported the food served at the facility is often cold when it gets to her room. Resident #8 reported the cart used to transport the meal trays is not insulated. Resident #8 reported the coffee at the facility is .terrible . and tastes like .road sludge . Resident #8 reported a lot of the foods served are dry, and gave examples which included the fried chicken, and the waffles served for breakfast recently which were .rock hard .</p> <p>In an interview on 12/9/24 at 11:15 AM, Resident #8 reported she tried to drink a cup of coffee this morning and wasn't able to finish it. Resident #8 stated .the taste of it was horrible . Resident #8 reported the oatmeal served for breakfast was watery/runny.</p> <p>Resident #9</p> <p>Review of an Admission Record revealed Resident #9 was a female, with pertinent diagnoses which included stroke, dysphagia (difficulty swallowing), diabetes, depression, and anemia.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #9, with a reference date of 9/10/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.</p> <p>In an interview on 12/8/24 at 11:20 AM, Resident #9 reported the food served at the facility is .kind of iffy . Resident #9 reported the quality of the food varies depending on who is cooking in the kitchen. Resident #9 reported she usually eats her meals in her room, and stated .some days the food is cold . Resident #9 reported she has talked to staff about her concerns with the food, but nothing has changed.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/10/24 at 1:55 PM, Resident #9 reported the potatoes served for dinner the previous night were hard and cold.</p> <p>41424</p> <p>Resident #4: (R4)</p> <p>Review of a Admission Record for R4 revealed she admitted to the facility on [DATE] with pertinent diagnoses of cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language), dementia, heart disease, dysphagia (damage to the brain responsible for production and comprehension of speech), hydrocephalus (build up of fluid on the brain).</p> <p>Review of Orders dated 9/13/24, revealed, .NAS (No added salt) diet 6-soft and bite sized texture, Thin consistency, 2L (liters) fluid restriction 12 oz with meals and 920 cc by nursing daily. For breads ok . Note: Level 6 diet was small, soft, tender, and moist pieces of food. Required moderate chewing before swallowing.</p> <p>In an interview on 12/08/24 at 03:12 PM, R4 reported she does not like her food, it does not look very good or taste very good. R4 reported when she looked at it, she feels like throwing up. R4 reported they only give them salt and pepper for seasoning and that does nothing to make it taste better. R4 reported her food was also cold all the time. She reported if it was warmer if might taste a little better but she was unsure of that.</p> <p>Resident #12: (R12)</p> <p>Review of a Admission Record for R12 revealed she admitted to the facility on [DATE] with pertinent diagnoses of parkinson's disease, malnutrition, GERD, and dysphagia (damage to the brain responsible for production and comprehension of speech).</p> <p>Review of Orders dated 1/19/24, revealed, .NAS (No Added Salt) diet 5-Minced and moist texture, Mildly thick/Nectar consistency, FR 2L Fluid distribution plan: 8 oz with breakfast and 12 oz with lunch/dinner from dietary; 1040 cc from nursing daily . Note: level 5 diet is a texture modified diet for people who have difficulty swallowing or chewing .consists of soft, moist foods that are easy to mash or break into pieces and are coated with a thick sauce or gravy.</p> <p>Review of Care Plan with the focus, initiated on 7/26/22, revealed, .I have the potential for a nutritional/hydration problem r/t (related to) parkinson's disease, fall risk, R (right) hip pain, HTN (high blood pressure) .dysphagia .other voice/resonance disorder . with the intervention .Per SLP (Speech language pathologist) and NP (Nurse Practitioner) resident diagnosis will have further declines in ability to swallow. Family and resident have been educated .</p> <p>In an interview on 12/08/24 at 11:28 AM, Family Member ZZ reported there were many complaints about the food that were not corrected before. The food doesn't taste very good, it was cold, and there were not enough options for the softer foods. Family Member ZZ reported the facility grinded her foods up and she won't eat it at all.</p> <p>41982</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #22</p> <p>Review of an Admission Record revealed Resident #22 was a male, with pertinent diagnoses which included: Type 2 Diabetes Mellitus, without complications (a condition where the body is not able to properly use sugar from the blood).</p> <p>Review of a Brief Interview for Mental Status (BIMS) assessment for Resident #22, with a reference date of 9/18/24 revealed a score of 15, out of a total possible score of 15, which indicated Resident #22 was cognitively intact.</p> <p>In an interview on 12/8/24 at 10:11 AM, Resident #22 reported their biggest complaint at the facility was that the food served was not consistently hot enough (not served at a palatable temperature) and the meat was tough. Resident #22 reported they ate in their room stated it was hard to get a hot meal here. Resident #22 reported everybody complained about the food temperature.</p> <p>In a follow-up interview on 12/9/24 at 2:53 PM, Resident #22 reported the lunch meal that day was actually warm but not hot. Resident #22 stated at least it was not cold this time. Resident #22 reported unpalatable food temperatures had been an ongoing problem.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</b></p> <p>Based on observation, interview, and record review the facility failed to ensure appropriate personal protective equipment (PPE) was utilized as required when providing care for 2 (Resident #40 and #17) of 6 residents reviewed for infection control practices resulting in the potential for the spread of disease and infection.</p> <p>Findings include:</p> <p>During an observation on 12/08/24 at 09:20 AM, this surveyor was informed surgical masks were required in the building due to a COVID-19 outbreak. This writer observed multiple staff members who did not have surgical masks on with only Certified Nursing Assistant (CNA) V who did have on a surgical mask.</p> <p>Resident #40 (R40)</p> <p>Review of an Admission Record for Resident #40 (R40) revealed he admitted to the facility on [DATE] with pertinent diagnoses of dementia, contracture of muscle, muscle weakness, age-related physical debility, and COVID-19.</p> <p>Review of Nursing Progress Notes dated 11/29/24 at 11:40 AM, revealed, .tested for covid. Positive results .</p> <p>Review of Droplet/Contact Precautions signage revealed, .Everyone must follow the following infection control guidelines: Clean hands before entering room/applying PPE, Gown, N95 Mask, Eye Protection (Face shield), and Gloves .</p> <p>During an observation on 12/08/24 at 09:34 AM, Registered Nurse (RN) S reported R40 was the only resident with COVID, and he would be removed tomorrow from precautions. Certified Nursing Assistant (CNA) N observed donning (putting on) personal protective equipment (PPE) and placed the N95 over the surgical mask. CNA N was observed to not don goggles or other eye protection when she entered the room.</p> <p>During an observation on 12/08/24 at 09:38 AM, CNA N was removing the PPE and kept the surgical mask on upon exit, which was under the N95 when in the room with R40 and headed down the hallway.</p> <p>During an observation on 12/08/24 at 09:40 AM, CNA Y was observed doffing her PPE and she had an N95 over her surgical mask. She removed the N95 and left the surgical mask on.</p> <p>During an observation on 12/08/24 at 03:08 PM, Licensed Practical Nurse (LPN) CC was observed at the medication cart and she had on a black N95 with the mask not covering her nose.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 12/09/24 at 01:02 PM, Registered Dietician (RD) RR was carrying the lunch tray for R40 and she entered the room without donning PPE. The sign on the door indicated .Droplet Precautions . observation/isolation period ends: 12/9/24 at 23:59 . RD AAA reported the staff were to still use PPE until later as R40 did not come off precautions until midnight tonight. She reported the Director of Nursing (DON) B had told them they still needed to use personal protective equipment (PPE) until then even though staff were not required to wear a mask any longer.</p> <p>In an interview on 12/09/24 at 01:19 PM, CNA Z reported the staff were still required to wear PPE when entering R40's room.</p> <p>In an interview on 12/09/24 at 01:02 PM, Director of Nursing (DON) B reported the staff were not required to wear a mask any longer today as the facility had completed a third outbreak testing with no new COVID positive. DON B reported the facility had gone to surgical masks and last Friday, 12/6/24 as there were no new positive resident after a second outbreak testing. DON B reported the facility used a messaging system in which all staff were notified of any changes, such as the switch to surgical masks, and they were expected to review the messages. DON B reported R40 would not come off isolation precautions until 11:59 PM this evening as indicated by the sign on the door as well.</p> <p>36221</p> <p>Resident #17</p> <p>Review of an Admission Record revealed Resident #17 was a female, with pertinent diagnoses which included hemiplegia (paralysis on one side of the body), muscle weakness, and a stage two sacral (area near the bottom of the spin and the tailbone) pressure ulcer.</p> <p>Review of an Order Summary Report for Resident #17 revealed the active physician order .Enhanced Barrier Precautions while performing high contact care activities .every shift for Infection control . with a start date of 12/6/24.</p> <p>Review of a current Care Plan for Resident #17 revealed the focus .I am at risk for impaired skin integrity r/t (related to) risk for moisture d/t (due to) incontinence, risk for immobility, risk for shear &amp; friction, require assistance with my ADLs (Activities of Daily Living) .I have a pressure injury to coccyx acquired in house on 12/4/24 . with interventions which included .Enhanced barrier precautions . initiated 12/6/24.</p> <p>In an observation on 12/10/24 at 11:02 AM, Licensed Practical Nurse (LPN) P and Certified Nursing Assistant (CNA) Z provided care to Resident #17 in her room. Noted a sign on Resident #17's door which indicated Enhanced Barrier Precautions (EBP) were in place. Observed LPN P and CNA Z assist Resident #17 with incontinence care and a brief change. LPN P noted Resident #17's sacral dressing was no longer adhered to the skin and would need to be changed. Observed LPN P perform a wound dressing change with the assistance of CNA Z. Noted LPN P and CNA Z did not don gowns prior to providing direct care to Resident #17.</p> <p>In an interview on 12/10/24 at 12:33 PM, LPN P reported for a resident on EBP, gowns and gloves are required for direct care. LPN P reported they were not aware that Resident #17 was on EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/10/24 at 12:47 PM, CNA Z reported they were not aware of any additional precautions currently in place for Resident #17. CNA Z stated .I guess yesterday was the last day for that .</p> <p>In an interview on 12/10/24 at 12:55 PM, CNA KK reported for a resident on EBP, gowns and gloves are required for direct care. CNA KK reported EBP are usually put in place for residents with catheters or open wounds.</p> <p>In an interview on 12/10/24 at 1:49 PM, Unit Manager GG reported they put EBP in place if a resident develops a new wound. Unit Manager GG reported EBP were initiated for Resident #17 due to a new sacral pressure ulcer. Unit Manager GG reported when EBP are initiated, a physician order is obtained, the care plan is updated, and a sign is placed on the resident's door.</p> <p>Review of the policy/procedure Enhanced Barrier Precautions, dated 3/2024, revealed .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .Enhanced barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .High-contact resident care activities include .Changing briefs or assisting with toileting .Wound care: any skin opening requiring a dressing .</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</b></p> <p>Based on observation, interview and record review the facility failed to maintain a functioning call light for 1 of 2 residents (Resident #39) reviewed for call lights which could potentially result in delayed response and negative resident outcomes.</p> <p>Findings include:</p> <p>According to website:</p> <p><a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7148550/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7148550/</a>, dated March 27, 2020, .In conclusion, the call light system is critical for interactions between the nursing home staff and residents. Research conducted in other health care settings has demonstrated that the call light system not only significantly improves the communication between staff and patients together but also helps ensure the safety of patients .In this study, it has been observed that the call light system is perceived to be an important factor affecting the outcomes of the care process and the satisfaction of both residents and staff as well in addition to the staffs' performance .</p> <p>Resident #39 (R39):</p> <p>Review of an Admission Record for R39 revealed she admitted to the facility on [DATE] with pertinent diagnoses of history of fracture of right femur, unsteadiness of feet, chronic pain, muscle weakness, osteoporosis (bones were weak and brittle), hard of hearing, history of falling, kyphosis (abnormally curved spine), and limitation of activities due to disability.</p> <p>During an observation on 12/08/24 at 10:41 AM, R39 was observed lying in bed, offset from right side, contracted upper body, still in a gown, eyes closed, and she had a lanyard around her neck with a round disc on the end. R39's call light was not in reach.</p> <p>In an interview on 12/08/24 at 02:39 PM, R39 reported she had concerns with staff not answering her call light and she had to wait for a long time for anyone to respond to her. R39 reported she can't hear, and staff have to write questions down for her and she never gets out of bed. This writer had R39 press the button on the disc around her neck and was able to hear a doorbell ding in the hallway, it only had one ding before becoming silent. The activation of the disc did not illuminate the light above the door to the room. The dinging could be confused with the doorbell for the front door. R39 did not have her room call light near here, it was lying on the night stand out of reach.</p> <p>In an interview on 12/08/24 at 02:47 PM, Registered Nurse (RN) BBB reported the disc system only dings once. This writer had RN BBB press the disc and confirmed if no one was in the hallway they wouldn't hear it unless R39 pressed the button again.</p> <p>In an interview on 12/09/24 at 12:38 PM, Unit Manager (UM) GG reported the doorbell disc was plugged into the wall in the hallway. UM GG reported the facility believed there was a short in the call light system. They could not get the call light fixed, and it would turn on and would work and then it wouldn't work. UM GG reported the facility gave the disc doorbell pendant to the resident to use to alert staff to her needs.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/09/24 at 12:31 PM Certified Nursing Assistant (CNA) HH reported she had the disc doorbell alarm due to her call light not working. During an observation on 12/09/24 at 12:32 PM, This writer and CNA HH entered R39's room, the call light cords split off from the plug in at the wall and went to each resident in the room. We tested the call light system, and the call light did illuminate and indicated in the hallway above the resident's door. Observed the call light was not in reach at the time and CNA HH provided the call light to R39.</p> <p>In an interview on 12/09/24 at 12:52 PM, Environmental Services Manager (ESM) H reported the call light for R39 had not been working since at least last week&gt; ESM H reported he just started back a few weeks ago and he had received a request to have it fixed and he had not gotten around to fixing it yet. ESM H reported the facility does have the plug for the wall to replace if need be.</p> <p>In an interview on 12/10/24 at 09:52 AM, Licensed Practical Nurse (LPN) K reported R39 still had doorbell disc around her neck. R39's doorbell alert button was plugged into the wall in the hallway. LPN K reported R39 lied only on her left side, facing the window.</p> <p>During an observation on 12/10/24 at 10:05 AM, R39 was calling for help and NHA in Training E went to her room to assist her. NHA in Training E reported she didn't have her call light and it did not work, but now it works (as she pressed the call light and it illuminated in the hallway). NHA in Training E reported the facility had to plug the call light in and unplug it multiple times, they changed out the cords multiple times. NHA in Training E reported the facility thinks it was in the wall that keeps shorting the call light out.</p> <p>During an observation on 12/10/24 at 3:00 PM, this writer heard the doorbell alert system for R39 alert and LPN K heard the alert and went to the front of the hallway to observe the front door to determine if it was the front door or for R39. LPN K reported she checked the door first before determining whether it was the front door or R39 calling for assistance.</p> <p>Review of Work Order #56 dated 11/25/24, revealed, Light not working, Room #, Notes: Keep replacing the call light I believe the issue is the electrical within the wall .Priority: Medium .Due Date: Dec. 6, 2024 .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>38905</p> <p>Based on observation, interview, and record review the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents 1 of 66 residents as well as staff, and the public. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living, affecting all residents.</p> <p>Findings Include:</p> <p>During a tour of central supply storage, at 2:53 PM on 12/9/24, with Environmental Services Manager (ESM) H, found that raw wood shelving was being used for storage of clean and sanitary supplies. Raw wood was observed with numerous stains, chipping, and pitting in areas. Items observed stored on these shelves were: gauze, oxygen supplies, personal hygiene products.</p> <p>During a tour of the outside storage barn, at 3:00 PM on 12/9/24, it was observed that numerous outer openings were found near the entrance door and front garage door. Large rusted areas around the bottom perimeter were found that would allow the entrance of pests into the pole barn. Currently the pole barn is heated and some equipment and emergency supplies are stored in the barn.</p> <p>During a tour of the outside storage shed, at 3:04 PM on 12/9/24, found a portion of the roof, on the back left of the shed, was deteriorating and dropping wet building debris onto wheelchairs and walkers stored for later use.</p> <p>During a tour of the facility, at 9:54 AM on 12/10/24, with ESM H, observation of the main hall soiled utility room found brown water discharged from the hot an old water lines for the hopper fixture. When asked if this is an area that gets flushed, ESM H stated he had only been here a week and was not sure.</p> <p>During a tour of the west hall spa room, at 10:01 AM on 12/10/24, it was observed that two privacy curtains covering the commode and sink areas were found with four golf ball to baseball size brown stains on the inside of the curtain. When asked how often privacy curtains were cleaned, ESM H stated that they should get cleaned every three months or as needed.</p> <p>During a tour of the East Hall spa room, at 10:05 AM on 12/10/24, observation of the spa room found a shower chair with brown and tan crusty debris around the seams and crevice's of the chair. Bolts on the back of the chair were found with black and brown debris over the screws that hold the back support on.</p> <p>During a tour of the cafe, at 10:10 AM on 12/10/24, observation of the inside of the microwave found areas of pitting and scuffing on the inside ceiling.</p> <p>During a tour of the South hall spa room, at 10:16 AM on 12/10/24, it was observed that a large shower chair was found with a disposable wipe on the back. The wipe was smeared with black, brown, and red, and was stuck to the back bar of the chair.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Cedar Springs		STREET ADDRESS, CITY, STATE, ZIP CODE  400 Jeffrey Cedar Springs, MI 49319	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a tour of the South Hall soiled utility room, at 10:19 AM on 12/10/24, it was observed that a small amount of brown tinged water came out of the hopper faucet when the cold and hot water taps were turned on.</p> <p>41982</p> <p>Resident #22</p> <p>Review of an Admission Record revealed Resident #22 was a male, with pertinent diagnoses which included: chronic obstructive pulmonary disease, unspecified (a lung disease that results in difficulty breathing).</p> <p>Review of a Brief Interview for Mental Status (BIMS) assessment for Resident #22, with a reference date of 9/18/24 revealed a score of 15, out of a total possible score of 15, which indicated Resident #22 was cognitively intact.</p> <p>During an observation and interview on 12/8/24 at 10:11 AM, it was noted that the personal fan in Resident #22's room was caked with a moderate amount of dust and debris on the grates and blades of the fan. Resident #22 reported the facility usually got around to cleaning it once a month or so but that it needed to be cleaned. The privacy curtain in Resident #22's room was soiled with multiple specks of dirt and debris as well as two stains of a dried brown substance toward the top of the curtain. Resident #22 reported the curtain had been hanging in the room for a while and had not been washed or changed. The windowsill in the room was overall dusty and had a small collection of dust in the corners.</p> <p>During an observation on 12/9/24 at 12:29 PM in Resident #22's room, noted the fan remained dusty, the curtain remained soiled, and the windowsill remained dusty.</p> <p>In an interview on 12/9/24 at 1:08 PM, Housekeeper (Hsk) L reported resident rooms were cleaned daily. Hsk L reported room cleaning involved cleaning the bathrooms; wiping down all the surface areas, remote controls, bedside tables, and windowsills; sweeping the room; taking out the trash, and mopping the entire room and the bathroom. Hsk L reported housekeepers were also supposed to inspect privacy curtains for tears and stains and remove and replace them when needed. Hsk L reported during room cleaning, housekeepers were also supposed to wipe down fans and if the inside of the fan was dusty, it should be removed and cleaned.</p> <p>During an observation and interview on 12/9/24 at 1:13 PM, Hsk G reported she had cleaned Resident #22's room earlier that morning. Resident #22 granted permission for this surveyor to enter the room with Hsk G at which time this surveyor showed Hsk G the privacy curtain. Hsk G reported the privacy curtain should have been removed and replaced. This surveyor, along with Hsk G then observed the buildup of dust and debris on the grates and blade of the fan. Hsk G reported the fan should have been cleaned. This surveyor, along with Hsk G then observed the windowsill. Hsk G reported the windowsill should have been dusted.</p> <p>A review of the facilities Room Clean / Deep Clean / Discharge Check Off Sheet, not dated, found that staff should, 4. Clean and dust ceilings, vents, light fixtures, light pull cords, sprinkler pipe. and 5. Clean windows, windowsills, and blinds. Replace room curtains if necessary.</p>		

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NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Cedar Springs		STREET ADDRESS, CITY, STATE, ZIP CODE  400 Jeffrey Cedar Springs, MI 49319	

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>47955</p> <p>Based on interview and record review the facility failed to ensure that an effective training program for abuse prevention for all staff was maintained and monitored for completion, resulting in the potential for decreased resident safety.</p> <p>Findings include:</p> <p>In an interview on 12/9/24 at 2:30 PM., Director of Nursing (DON) B reported the facility does not have a staff development role. DON B reported she was responsible for monitoring completion of assigned online trainings. DON B reported the facility no longer had an employee in the role of human resources present in the facility. DON B reported employee training records were maintained by human resource at the corporate level.</p> <p>In a telephone interview on 12/9/24 at 4:45 PM., Former Nursing Home Administrator (FNHA) UU reported abuse education was completed online annually, and the facility had completed the topic of abuse sometime during the summer.</p> <p>Review of Course Completion History for Module - Abuse, Neglect, and Exploitation provided by the facility on 12/9/24 and dated 12/9/24 revealed Abuse, Neglect, and Exploitation course was due on 7/31/2024. 66 total employees from all departments were listed, and 11 had not yet started the module. Also, Unit Manager (UM) C and DON B status for assigned module, Abuse, Neglect, and Exploitation with a due date of 7/31/24 was noted to be listed as in progress.</p> <p>The facility did not provide documentation for the completion of abuse training by all employees by the time of exit.</p>