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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235355	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Physical Rehab Ctr of Lamont	13030 Commercial St Lamont, MI 49430

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake # MI00145786 Based on observation, interview, and record review, the facility failed to effectively implement interventions for effective communication for one resident (R2) of four reviewed for care plans, resulting in the miscommunication of care needs. Findings include: Review of a Face Sheet for R2 revealed she originally admitted to the facility on [DATE] with pertinent diagnosis of hemiplegia and hemiparesis (one sided weakness), aphasia (may be unable to comprehend or unable to formulate language because of damage to specific brain regions), and cognitive communication deficit. In an interview on 7/24/24 at 8:28 AM, the Designated Power of Attorney (DPOA)/husband of R2 reported that R2 cannot speak or say words like that because she has expressive aphasia. He works with her every day using word cards and a computer program to encourage her to speak in the mornings. He said the facility staff does not know how to communicate with her like he does. In an interview on 7/24/24 at 12:37 PM, R2 had no communication board in her room or any other modes for R2 to communicate verbally, nonverbally, or any means to reinforce words she was trying to express. Review of the Electronic Medical Records for R2 revealed no communication board or communication devices were available and no baseline communication/cognitive status established. In an interview on 7/29/24 at 9:15 AM, the Director of Nursing (DON) reported R2's husband usually comes to visit 2-3 times a day and will work with her doing therapy in the gym, help work on her speech, and some gardening. The NHA (Nursing Home Administrator) and DON were not aware of any baseline communication or communication devices for R2. (continued on next page)

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/29/24 at 11:00 AM, Speech Therapist (ST) S reported he is not at the facility often and is not given the autonomy to screen the residents himself but does get referrals. He reported he has made several attempts to see R2, but she was either sleeping and difficult to arouse, or another time he tried, and she backed herself up in a corner. There was a time ST S thought R2 may have been sick when he attempted to see her approximately in May/June 2024 and was asked to not attempt to try at this time. When asked about R2 saying si (si, C, or see) when she communicated, ST S reported it could have been an utterance without any value to it. Like a pattern of talking and may not have communication value. Nonverbal communication may be more effective when she is nodding her head. ST S reported that knowing the communication pattern would be valuable. Based on her record review, ST S could not figure out what her baseline communication was. He would have to assess more for her ability to identify pictures from verbal commands, yes or no questions, or even a communication board. Review of a Secure Conversation note for R2 dated 4/12/24 revealed: husband/guardian is requesting a letter be written stating that (name of R2) is cognitively intact and can make decisions but has difficulty communicating due to aphasia. Will one or both of you please evaluate her cognition? Her BIMS has been a 14 or 15 since I started using a picture board so she can point to her answers (with the exception of the November assessment when she was not interacting with staff). Review of a Social Service Progress Note dated 5/20/24 for R2 revealed, During the resident's quarterly PHQ-9 assessment, the resident expressed she has thoughts of suicidal ideation/self-harm almost daily. A Columbia Suicide Screening assessment was completed. Social worker and administrator do not feel the resident is an immediate threat to herself. Will attempt communication device as resident is frustrated that she is not able to communicate after her stroke. Review of a Practitioner Progress note dated 5/23/24 for R2 revealed: Cognitive communication deficit, continue supportive care and monitoring. Could be contributing to anxiety and depression. Review of a Practitioner Progress note for R2 dated 6/10/24, 6/13/24, 6/20/24, and 7/2/24 revealed: Cognitive communication deficit, continue supportive care and monitoring. Could be contributing to anxiety and depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for R2 revealed: I will be able to communicate needs daily by Yes/No answers, initiated 5/17/22. Monitor/document communication skills. Document baseline. If resident is presenting problems with cognitive function and communication, obtain an order for Speech Therapy consult to evaluate and treat, initiated 5/17/22. Monitor/document mobility status. If resident is presenting with problems or paralysis, obtain order for Physical therapy and Occupational therapy to evaluate and treat, initiated 5/17/22. Reinforce any cognitive programs put in place by therapy services, initiated 5/17/2022. Discuss with me/Guardian concerns or feelings regarding communication difficulty, initiated 5/27/22. Encourage me to continue stating my thoughts even if I am having difficulty making sense. Focus on a word or phrase that makes sense and help me elaborate from that word/thought. Allow me time to try to formulate my thoughts without feeling rushed to do so, initiated 5/27/22. Help me to develop a communication tool that I can utilize to communicate my needs, initiated 5/27/22. Monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. Monitor/document frustration level. Allow me time before providing me with words. Review factors affecting underlying cause of communication deficit, recent onset, chronic or recurrent conditions, success of attempted remedial actions, ability to compensate with nonverbal strategies, understanding in particular situations etc. Validate my spoken message by repeating aloud, initiated 5/27/24. Record/report to MD for [signs and symptoms] of UTI: pain, burning, no output, increased pulse, increased temp, urinary frequency, fever, chills, altered mental status, change in behavior, change in eating patterns. Social worker will collaborate with therapy to develop a communication board to help ease my frustration with not being able to communicate, initiated 5/20/24. Review of the Care Plan for R2 revealed: I have the potential for impaired cognitive function [related to] history of cerebral infarction with residual deficits/communication problems initiated 11/30/22 and no revision date. Goal: Will maintain current level of cognitive function through the review date, initiated 11/30/22 and no revision date. Interventions: -Ask me yes/no questions in order to determine my needs. Date Initiated: 11/30/2022 -Report to Social Services and Nurse any changes in cognitive function, specifically changes in: decision making ability, memory, recall, or confusion. Date Initiated: 11/30/2022

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake # MI00145786 Based on observation, interview, and record review, the facility failed to effectively manage care for one resident (R2) of four reviewed for quality of care, resulting in unmet care needs. Findings include: Review of a Face Sheet for R2 revealed she originally admitted to the facility on [DATE] with pertinent diagnosis of hemiplegia and hemiparesis (one sided weakness), aphasia (may be unable to comprehend or unable to formulate language because of damage to specific brain regions), and cognitive communication deficit. In an interview on 7/24/24 at 8:28 AM, the Designated Power of Attorney (DPOA)/husband of R2 reported he saw her Friday morning on 7/19/24 and she was timid and didn't want to communicate which was abnormal for her, because she is usually cheery. He left and came back in the afternoon and R2 was having some pain in her abdominal/vaginal area. He had the nurse assess R2 and did not see any concerns. The next morning on 7/20/24, the DPOA came to visit, and his wife still had pain in her vaginal area. He asked the nurse to do a urinalysis because she was having symptoms similar to a urinary tract infection as she had in the past. The nurse told him they would do it for R2. When he came back to the facility at 1:30 PM, the nurse told him the strip indicated there was bacteria in the urine and the doctor ordered the urine sample to be sent out to the lab. In an interview on 7/23/24 at 3:34 PM, the Nursing Home Administrator (NHA) said they are waiting for labs to be done. A urinalysis (U/A) was collected on Saturday but was not picked up or sent out and needed to be redone. She began to refuse medications which was not normal for her. She had recently been sent to the hospital for behaviors and was diagnosed with a UTI. During multiple observations on 7/23/24 at 1:43 PM, 2:56 PM, and 4:22 PM, R2 was in bed with the lights out and would not engage or acknowledge this surveyor, visitors, and had limited staff interaction. She would open her eyes briefly and quickly close them. Review of a Behavior Notes dated 7/19/24 at 1:04 PM for R2 revealed: Resident spent the entirety of this shift in bed. When asked if she wanted to get up, she refused. Resident very quiet and appears to be sad. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Behavior Notes dated 7/19/24 at 9:40 PM for R2 revealed Registered Nurse (RN) D documented: At the start of this shift, resident's husband approached this staff and he said that his wife was in pain, and she was pointing at her genital area. Went to this resident's room and checked. This staff observed this resident was crying and she was pointing at her genital area. This staff assessed the area and her bottom. She did not have any skin condition. Her skin in the genital area and bottom was intact. Asked this resident if she wanted her pain medication. She nodded. This staff gave her (as needed) Tylenol and milk of magnesia for she was on the BM (bowel movement) list. After a few minutes, she was seen in bed and asleep. In an interview on 7/24/24 at 3:37 PM, RN D reported he was working second shift on Friday 7/19/24 when R2's husband approached him about 2:10 PM with concerns about his wife having complaints of pain in the general area of her lower abdomen and vaginal area. The day shift nurse thought her pain was from constipation, but the husband told them she had a bowel movement the previous day. R2 was observed laying flat on her back and visibly crying. RN D asked R2 if it hurt down there, and she said si and pointed to her vagina. RN D was thinking she may have a yeast infection. RN D assessed the resident's vaginal area and noticed a discharge similar to a yeast infection and thought that may be the problem. He pressed on her suprapubic area, and she grimaced. R2 could not communicate well so he asked her pertinent questions. RN D then said he did not have any assessment concerns and convinced R2 to take a Tylenol and she then went to sleep. R2 was fine the rest of the night. When asked if he documented the assessment, RN D reported he did not. When asked if he notified the physician, he reported he did not. In an interview on 7/24/24 at 11:42 AM, Licensed Practical Nurse (LPN) H reported R2s husband approached her in the morning of 7/20/24 with concerns his wife having complaints of burning in her genitals. LPN H asked the resident if it burns when she is dribbling urine and said yes or si. LPN H asked if she had a urinary tract infection (UTI) in the past and if it felt the same and she said yes. LPN H collected a urine sample after R2s husband left that morning via straight catheter collection method and noticed the edge of the outer vagina (labia majora) looked raw and the resident hurt when she moved positions. LPN H did not notice any concerns inside the labia (labia minora) when she straight cathed the resident. LPN H reported she did not document her assessment findings. LPN H did a urine dipstick that resulted in the resident having 70+ bacteria in her urine and called the physician who ordered a urinalysis with a culture. LPN H reported she is new and did not know how to send out a urinalysis (UA), so she put the urine on ice and talked to oncoming RN I who did not know how to send it out either but was going to find out and take care of it. LPN H reported she later found out it was not sent out. LPN H reported there was nothing abnormal about R2 this day and her behavior was normal, she was just in pain and uncomfortable. A thorough pain assessment was not completed or documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/24/24 at 7:00 PM, CNA M reported she was familiar with R2 and reported she could communicate her needs but not verbalize them. Staff could usually guess or figure out what R2 wanted or needed. On Saturday 7/20/24 R2 was checked to see if she needed incontinence care after dinner and R2 said no. CNA M reported she checked her brief anyway and it was dry. About 45 minutes later R2 put on her call light to be changed and her brief was wet. When CNA M put the head of the bed down, she was making noises like she was aggravated. CNA M reported she was told in report R2 was being checked for a UTI. R2 was breathing heavy and CNA M asked her if she hurt when she pees and R2 said no. When CNA M removed her brief R2 inhaled like it hurt and asked her if it hurt. She thought the brief grazed over the sore area. R2 replied no but si. CNA M noticed a bright red lump on her inner right labia similar to an abscess and a milky white fluid coming from her vagina. She folded R2s brief back up and got RN I. RN I came in and got some Nystatin cream and applied it to R2. In an interview on 7/24/24 at 3:20 PM, RN I reported she worked the second shift on 7/20/24 and started around 2:00 PM. She was told in report from the day shift nurse (LPN H) that R2 was having some abdominal pain and burning in her genital area. LPN H told her that she obtained a urine sample for a urinalysis to be sent out but did not know which lab to send it out to. RN I told LPN H she would take care of it. RN I reported she texted the DON (Director of Nursing) to find out which lab to send the urinalysis to and was instructed to find out when the urine was collected because it was at room temperature with no date or time of the collection marked on the sample. CNA M (Certified Nursing Assistant) approached RN I to tell her that R2 was having pain in her genital area and CNA M saw bruising. RN I said she assessed R2 and saw some redness and an abrasion inside her labia that was not real red and some discharge but did not document any assessment. RN I reported it could have been from her brief. RN I asked RN L to assess R2 because she thought there were abrasions, and she was the only nurse on duty from 2-6 PM and wanted a second opinion. In an interview on 7/25/24 at 1:33 PM, RN L reported she started her shift on 7/20/24 at 6:30 PM. When she arrived, RN I was the only nurse at the time and was passing medications to other residents. She was informed by CNA M about a rape allegation involving R2 and her husband. RN I then gave report that they were concerned earlier about R2 having a UTI, RN L did an assessment of R2's vaginal area and saw some bruising and redness. A circular abrasion was on her left inner labia and a small area was on her right. It was similar to a rug burn or an irritation with some inflammation that looked like it would have been from the last couple of hours. She did have some discharge and it could have been a yeast infection. R2 could scratch her genitals if she had any itching. R2 was incontinent. Review of a Practitioner Progress note dated 7/20/24 at 9:32 PM for R2 revealed: Nurse called [8:16 PM]. Pt had been complaining of pain around genitalia. I gave verbal order to transfer her immediately to ED (emergency department). Review of a Nurse Practitioner Note dated 7/22/24 for R2 revealed .ROS reveals concerns for potential UTI, reviewed with patient, she denied firmly to have straight cath (catheter) for eval of UTI. She denies any other concerns at this time. In an interview on 7/24/24 at approximately12:15 PM, LPN/Unit Manager J reported there has been some ups and downs with labs recently and named several labs the facility uses. She was not clear at first which labs and forms the facility is to use for a urinalysis then named a couple options. UM J reported she communicates with staff by cheat sheets in a binder that has snap shots of how to put in orders based on the lab. UM J said there is one lab that provides a urinalysis collection kit with instructions the staff could use. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/24/24 at 12:30 PM, LPN H reported she did not use the UA collection kit that the UM J reported was available. In an interview on 1/24/24 at 1:00 PM LPN C reported she was informed that week on where to send a urinalysis. In an interview on 7/29/24 at 9:15 AM the Director of Nursing (DON), reported they were able to collect another urine sample on 7/23/24 and sent to the lab. The urinalysis resulted on 7/26/24 and R2 was positive for a UTI.