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	10/23/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on observation, interview, and record review, the facility failed to position a urinary catheter collection bag to facilitate drainage for 1 resident (Resident #20) of 2 residents reviewed for urinary catheter care. Findings include: Review of an Admission Record revealed Resident #20 (R20) admitted to the facility on [DATE] with pertinent diagnoses which included flaccid neuropathic bladder and retention of urine. Review of a Minimum Data Set (MDS) assessment for R20, with a reference date of 10/11/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R20 was cognitively intact. Review of a current urinary catheter Care Plan intervention for R20, initiated 4/16/2024, directed staff to position her urinary catheter bag below the level of the bladder. In an observation and interview on 10/21/2024 at 3:28 PM in R20's room, R20 was sitting in her wheelchair with her urinary catheter collection bag hanging from the back of her wheelchair level with her middle and upper back and above the level of her bladder. R20 reported her urologist instructed her at an appointment that same day that she needed to store the bag below the level of her bladder. In an observation on 10/22/2024 at 8:15 AM in the dining room, R20 was in her wheelchair with her urinary drainage tube going over the back of her wheelchair and the urinary catheter collection bag hanging from the back of her wheelchair level with her middle and upper back and above the level of her bladder. Urine was visible backed up in the drainage tube and unable to empty into the urinary catheter collection bag. In an interview on 10/22/2024 at 10:16 AM, Certified Nursing Assistant (CNA) P reported staff had been storing R20's urinary catheter collection bag on the back of her wheelchair for months because this was R20's preference. In an interview on 10/22/2024 at 10:20 AM, CNA T reported staff had been storing R20's urinary catheter collection bag on the back of her wheelchair for months because it was being pulled on when it was stored under the wheelchair. (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/22/2024 at 10:26 AM, Registered Nurse (RN) E reported R20's urinary catheter collection bag was being stored on the back of her wheelchair because it was leaking when under her chair. RN E reported the bag should be placed under the wheelchair to prevent urine from going back into the bladder and causing possible infection. In an interview on 10/22/2024 at 10:41 AM, the Director of Nursing (DON) reported R20's urinary catheter collection bag was being stored on the back of her wheelchair because it was getting caught up under the wheelchair and leaking. The DON reported keeping the bag above the level of the bladder could cause urine to reflux back into the bladder. In an interview on 10/22/2024 at 4:05 PM, R20's community Urologist M reported he noticed R20's urinary catheter collection bag was on the back of her wheelchair and above the level of her bladder at her appointment with him the previous day. Urologist M reported he educated R20 that the bag and tubing must be below the level of the bladder to allow the bladder to empty and prevent reflux of urine back into the bladder. Urologist M reported the bladder remaining full of urine and urine reflux can cause urinary tract infections.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on observation, interview, and record review, the facility failed to date and discard an outdated-for-use biological medication and failed to discard two insulin pens kept in active storage past the manufacturer's recommended expiration date and after the medication had been discontinued. Findings: On [DATE] at 7:55 AM a review was conducted of the facility medication room with Licensed Practical Nurse (LPN) J. Review of the medication refrigerator revealed an opened and entered multidose vial of purified protein derivative (PPD) solution. It was observed that the vial was not dated when it had been placed in service. LPN J noted that the box in which the undated vial was contained was dated [DATE] but that the vial itself was not dated. LPN J indicated she did not know the date the vial had been placed into service and reported that the vial expiration date would be the manufacturer's expiration date on the vial. On [DATE] at 8:10 AM the North unit medication cart was reviewed with Registered Nurse (RN) E. Review of the top drawer revealed a [NAME] insulin pen dated as placed in service [DATE] and an Admelog insulin pen dated as placed in service [DATE] for Resident #15 (R15). RN E reported that all nurses are responsible for maintaining an orderly medication cart. RN E reviewed the electronic medical record for R15 and reported no current Doctor's Orders were in place for the insulin pens and that both should have been discarded. The policy provided by the facility titled Medication Storage in the Facility last revised [DATE] was reviewed. The document reflected, Policy. Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier . The policy reflected Procedures ., H. Outdated, contaminated or deteriorated medications .are immediately removed from inventory . And Expiration Dating, C .1).b. Drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medication is: 1. In a multidose injectable vial. 2. An item for which the manufacturer has specified a usable life after opening. And D. When the original seal of a manufacturer's vial is initially broken, the vial will be dated. 1) The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial will be 30 days unless the manufacturer recommends another date . G. All expired medication will be removed from the active supply .regardless of the amount remaining. Review of the Manufacturer's instructions for the Admelog insulin pen reflected Only use your pen for up to 28 days after its first use. Throw away .after 28 days even if it still has insulin in it. Review of the Manufacturer's package insert for the Lantus insulin pen reflected the device was to be discarded 28 days after it was placed in service. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Manufacturer's package insert for the PPD solution reflected Storage . A vial of (PPD solution) which has been entered and in use for 30 days should be discarded. On [DATE] at 11:01 AM an interview was conducted with the Director of Nursing (DON) in her office. The DON acknowledged the PPD solution should have been discarded. The DON also reported that the insulin pens discovered in the North medication cart that were outdated and without a current order should have been tossed a long time ago.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on observation, interview, and record review, the facility failed to ensure proper use of Personal Protective Equipment (PPE) for residents in Enhanced Barrier Precautions (EBP) for 1 resident (Resident #22) of 12 residents reviewed for infection control. Findings include: Review of an Admission Record revealed Resident #22 (R22) admitted to the facility on [DATE] with pertinent diagnoses which included pressure ulcers. Review of R22's Physician's Orders, active 10/23/2024 at 9:00 AM, revealed he required multiple daily dressing changes. Further review revealed no order for EBP's. In an observation and interview on 10/23/2024 at 9:30 AM in R22's room, Registered Nurse (RN) E performed several dressing changes without donning a gown. There was no signage on the door indicating the need for PPE. RN E reported R22 should have EBP's in place because of his wounds. In an interview on 10/23/2024 at 10:04 AM, the Director of Nursing (DON) reported R22 should have had EBP's in place since admitting to the facility because of his wounds that required dressing changes. Review of facility policy/procedure Enhanced Barrier Precautions, reviewed 3/2024, revealed .EBP refer 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 . An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers) . High-contact resident care activities include . Wound care: any skin opening requiring a dressing .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation and interview, the facility failed to maintain cleanliness and general repair of equipment, plumbing, the onsite waste water system, and other aspects of the physical environment. This deficient practice has the potential to affect all residents in the facility. Findings Include: During a tour of the dry storage room, at 10:22 AM on 10/21/24, it was found that an odor resembling sewer gas was present upon entering the room. When asked if they knew what the odor was, Dietary Manager R and Regional Dietitian U were unsure. Upon further evaluation of the room, it was found that a slowly leaking sewer pipe was observed in the back left corner with totes underneath it to catch the leak. The sewer pipes were observed covered in duct and electrical tape in some spots, with no adequate fix to the line. No food storage was under this area. During a tour of the facility, at 1:40 PM on 10/21/24, observation of the Ice Machine room with Regional Dietitian U, found a black rubber insulated seal was dangling down on the backside of the white plastic shield that hangs over the bottom bin portion of the ice machine. Further observation of the unit found increased amounts of black debris accumulation on the side wall of the unit, between the plastic shield and the wall. Observation of the room found an accumulation of brown crusted debris on the underside of the ice machine with a dozen plastic lids that had fallen behind the unit onto the floor. The unit was observed draining water from three different water lines into the stainless steel preparation sink next to the ice machine. When asked if that is the sink where hydration pass is filled, Regional Dietitian U stated she believes so. The sink was found with heavy rust staining on the inside compartment and walls. Two of the three discharge lines, hanging over the sink, were from a water-cooled compressor, the third line was from the ice that melts in the bottom bin, drains to a condensate pump (where it stays stagnant in an enclosed container that doesn't get cleaned) until the pump fills to the level to be discharged into the sink (where residents receive hydration pass). During a tour of the east hall spa room, at 1:50 PM on 10/21/24, it was observed that one of the two light ballasts in the room was not working and left the shower area dim and hard to see. Observation of the central supply room, at 2:23 PM on 10/21/24, found a leaking sewer line in the back left corner of the room that was falling onto old files and records the facility had in storage. The files and records were observed with black spotted mold looking accumulation with numerous water lines and marks from consistent leaking and drying in this area. During an interview with Environmental Services Manager (ESM) G, at 2:40 PM on 10/21/24, it was found that he has been at this facility less than a month and has been trying to play catch up on some of the repairs that the facility needs. When asked about the sewer line in dry storage. ESM G stated that they have reached out to a vendor to fix the issues and are just waiting on them to come and complete the project. When asked about the leaking sewer line in central supply ESM G stated he was not aware about that leak. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the laundry room, at 3:30 PM on 10/21/24, it was found that one of two washers and one of two dryers were not operational. When asked if there was progress on getting repairs or new equipment, ESM G stated it has been going through the purchase order process, but he's not sure where it's at currently. When asked if staff can keep up with demand, ESM G stated that they have been, but it's harder on staff as they work longer hours in order to make it happen. ESM G wasn't sure how long the machines have been down, but mentioned staff told him its been this way for a while. Last annual survey, in December of 2023, these pieces of equipment were down and not operational. In an interview with ESM G, at 3:05 PM on 10/21/24, the surveyor questioned the operation of the facilities' onsite wastewater treatment plant and found that they have been having issues staying in compliance with the Michigan Department of Environment Great Lakes and Energy ([NAME]) regarding the wastewater treatment plant. ESM G stated that since coming on board the last few weeks he has started to take over ensuring their vendor wastewater operator is fulfilling the obligations of his position. Previously the reports and samples were not received by the facility and would just go to the vendor. ESM G stated that [NAME] was out last week and had discharge concerns with numerous violations.