

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/16/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Flint		STREET ADDRESS, CITY, STATE, ZIP CODE  G 3201 Beecher Rd Flint, MI 48532	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38471</p> <p>This citation pertains to Intake Number MI00148880</p> <p>Based on interview and record review the facility failed to contrive a plan to maintain the safety of one resident ((Resident #704) of one resident reviewed for wandering, after his Wanderguard was removed resulting in him eloping from the facility six days later.</p> <p>Findings Include:</p> <p>Resident #704:</p> <p>On 12/12/2024 at 11:15 AM, Resident #704 was observed sleeping peacefully in bed, his Wanderguard was affixed to his right ankle.</p> <p>On 12/12/2024 at approximately 12:00 PM, record review was completed of Resident #704's chart and it revealed he admitted to the facility on [DATE] with diagnoses that included, Vascular Dementia, Diabetes, Hypertension, Mood Disorder and Diabetes. Further review was completed of Resident #704's records and it yielded the following:</p> <p>Physician Orders:</p> <p>Wanderguard order was initiated in July 22, 2024</p> <p>Care Plan:</p> <p>I am at risk for elopement r/t (related to): Resident makes statements regarding wish to leave, go home, or actions such as packing their belongings and walking to the front door unsupervised. Wanderguard placed on left ankle. Expiration 12/2026. initiated on 7/22/2022.</p> <p>Progress Notes:</p> <p>11/30/2024 19:56: Confirm Wanderguard placement on right ankle. HE7ETG Exp:10/27</p> <p>every day and night shift for confirm Wanderguard placement</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Confirm wanderguard placement on right ankle. HE7ETG Exp:10/27</p> <p>every day and night shift for confirm wander guard placement. Removed temporarily for swelling and patient complaint of pain.</p> <p>12/1/2024 10:49: Confirm Wanderguard placement on right ankle. HE7ETG Exp:10/27</p> <p>every day and night shift for confirm Wanderguard placement</p> <p>No, Removed by 7PM-7A nurse due to due to swelling of lower extremities.</p> <p>12/3/2024 at 16:25: Confirm Wanderguard placement on right ankle. HE7ETG Exp:10/27</p> <p>every day and night shift for confirm Wanderguard placement</p> <p>resident refusing to wear.</p> <p>12/3/2024 20:06: Check function of Wanderguard every night shift every night shift for Wanderguard in place resident refused placement of device.</p> <p>12/4/2024 10:02: Confirm Wanderguard placement on right ankle. HE7ETG Exp:10/27</p> <p>every day and night shift for confirm Wanderguard placement</p> <p>Attempt made to replaceWanderguard . Resident ref, yelling, NO. Nurse informed by hospice nurse, resident has ref other attempts @ replacing Wanderguard .</p> <p>12/4/2024 23:42: Confirm Wanderguard placement on right ankle. HE7ETG Exp:10/27 every day and night shift for confirm wanderguard placement NOT ON RESIDENT.</p> <p>12/6/2024 at 4:14: Administrator and DON clarified that resident went outside on the front porch without staff accompanying him. Resident is returned to building/assigned floor and safe. Assessments process in place. All parties notified.</p> <p>Elopement Risk Scores:</p> <p>7/12/2024: At risk for elopement</p> <p>7/22/2024: At risk for elopement</p> <p>9/10/2024: At risk for elopement</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/12/2024 at 1:40 PM, an interview was conducted with Housekeeper J regarding Resident #704's elopement. She was not expecting anyone to be downstairs around 6:00 AM but saw Resident #704 prying open the first set of double doors. She attempted to redirect him but was unsuccessful and given his stature, she made the decision to quickly go upstairs to alert his nurse. Upon alerting his floor staff his CNA (Certified Nursing CNA) came right down to intercept him. Housekeeper J was asked if there was a receptionist that morning or if the alarms sounded and she responded, No, to both questions.</p> <p>On 12/12/2024 at 2:15 PM, Unit Manager B was interviewed regarding her involvement with Resident #704's elopement. Manager B stated she assisted after the incident occurred in putting interventions in place. Manager B reported some days prior his Wanderguard was removed as his ankle was swollen and when he eloped from the facility, he did not have his Wanderguard in place. Their intervention after the fact was replacing his Wanderguard for continued safety due to his wandering. Manager 'B explained Resident #704 had unsteady gait and while he utilized a wheelchair he would walk away from it. So, placing the mechanism on his wheelchair was not the best option for him. Review was completed of Resident #704's records and it was documented his Wanderguard was cut off on 11/30/2024 due to swelling and some attempts were made to put it back on, but were unsuccessful. Manager B stated it does not appear that any additional safety interventions were put in place for Resident #704 to monitor his safety.</p> <p>On 12/12/2024 at 2:40 PM, Transportation Aide L shared while backing in her vehicle she observed Resident #704 sitting in his wheelchair outside by the therapy gym. She initially thought it was another resident but when she yelled for the resident to put on a coat and they did not respond she decided to get out her vehicle. She then saw it was Resident #704 and told him lets go in and get your coat and he swung at her, but Aide L was still able to get him inside of the building. When taking him back into the facility, the Wanderguard alarm did not sound. Upon reaching the elevator his CNA was getting off to come and get him. Aide L explained when she initially arrived to work and clocked-in, there was no one in the lobby and it was about five-seven minutes for her to clock- in and then go to her vehicle. She reported she does not believe that he was outside for an extended amount of time.</p> <p>Review was completed of the FRI (Facility Reported Incident) investigation completed by the facility into Resident #704's elopement:</p> <p>Timeline for December 6, 2024:</p> <p>06:37 am- a resident is observed leaving his room and then heads to the elevator alongside another resident</p> <p>06:38 am- residents get on to the elevator.</p> <p>06:38am- residents are in the lobby . resident (#704) heads towards the front door.</p> <p>06:39 am- a resident is seen going out the front door. The housekeeper (J) is standing in the service hall door watching him as he goes out the door.</p> <p>06:39 am- resident is outside sitting in his wheelchair by the brown, brick wall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>06:41 am the driver of the facility van (L) was parking her vehicle sees him and yells go back in and get your coat. She stated that she thought it was another resident . With her eyes on him, she walked over to him and realized it was a different resident and hurriedly escorted him back into the building and to his floor.</p> <p>06:41 am- CNA (D) met the resident (#704) and staff person (L) at the elevator.</p> <p>06:43 am- resident in the day room with the nurse for an assessment and placed a wander guard device on his right leg. The resident was stable, and no issues or concerns noted or observed. 06:50 am- resident in the day room and then rolls himself back into the hallway.</p> <p>Analysis:</p> <p>From a systems perspective, before the incident, the nursing staff removed the wander guard device at the resident's request, who reported that the device was overly constrictive and observed swelling in that area, with the intention of loosening the band and replacing it promptly. The residents' physical aggression and unmanagability prevented the staff from intervening at that moment. Following the recent incident, the facility has replaced the wander guard device at a manageable level to guarantee sufficient security and continuous supervision for the resident.</p> <p>CNA D Statement 12/6/2024:</p> <p>I was in another room at the time and was told that the resident was downstairs. She didn't say that he had gotten out but that he was combative as she was trying to keep him from getting out. She told me that he was downstairs, and I just went downstairs and saw him with (Transportation Aide L) and brought him back up to the floor. I was told by the nurse that he was fighting and did not have a wander guard on. When residents get close to the elevator and alarm goes off and realized he did not have his device on. Me and the nurse put it back on. While taking care I kept my eye on him.</p> <p>Nurse M Statement 12/6/2024:</p> <p>I spoke with laundry lady who stated that the resident was downstairs in the front lobby and going out the front door. I asked the CENA to go and get him while I stayed on the floor to watch the floor. As soon as he got back to the floor, I assessed him and placed the wander guard on his right ankle. He was kicking and closing his hand fist to lifted his hands towards me. He then stayed in the day room for a bit.</p> <p>Housekeeper J Statement 12/6/2024:</p> <p>I saw (Resident #704) in the front lobby and wondered what he was doing down there. I tried to get him back upstairs; he motioned his arm as if to make me move out of his way. I stepped back and he would not go back upstairs. I ran up the elevator to get help and told the nurse and CNA that he was downstairs. They went to go and get him back upstairs. I then spoke to the administrator and told her what happened.</p> <p>Transportation Aide L Statement 12/6/2024:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>I came into the building at 6:36 am to clock in and then exited the building to go and get the facility Van ready for 6:45 am dialysis residents. As I was getting into my vehicle, I noticed a resident sitting outside on the front porch area by the therapy window sitting in his wheelchair. I yelled out, go and put on a coat as I thought it was one of the residents who go out to smoke. I then got the van and pulled up to him and said lets go in and get a coat for right now. He was hitting, swinging at me and I said to him we need to get your coat and he then mumbled something and allowed me to take him in.</p> <p>On 12/16/2024 at 10:00 AM, Nurse Practitioner K was queried regarding Resident #704's elopement. She reported given his Wanderguard was not currently in place at the time of the incident, he could have been placed on frequent checks to ensure safety until the Wanderguard was able to be replaced.</p> <p>On 12/16/2024 at 1:46 PM, an interview was conducted with the Administrator regarding Resident #704's elopement. The Administrator shared his Wanderguard was removed by nursing staff at the end of November due to swelling and attempts were made to replace it, but the resident would not allow staff to do so. She stated they found through their investigation that management staff was never made aware of this fact and the nursing staff communicated amongst themselves regarding replacement of the Wanderguard . The Administrator agreed that while it was not problematic the Wanderguard was removed due to swelling, a plan could have been enacted for enhanced monitoring when out of his room given it was not able to be replaced timely.</p> <p>Review was completed of the facility policy entitled, Elopements and Wandering Residents, revised 5/24. The policy stated, .This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk . Adequate supervision will be provided to help prevent accidents or elopements. Staff will monitor the implementation of interventions, response to interventions, and document accordingly .</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39059</p> <p>This citation pertains to Intake Number MI00148300.</p> <p>Based on observation, interview and record review, the facility failed to document a urinary catheter change and follow up on a positive urinalysis for one resident (Resident #706) of three residents reviewed for urinary catheters, resulting in a positive urinalysis, bluish purple tinged Foley catheter tubing and urinary drainage bag.</p> <p>Findings include:</p> <p>Resident #706:</p> <p>On 12/12/24, at 12:03 PM, Resident #706 was resting in their bed. There was a strong smell of urine in the room. Their urinary catheter tubing was bluish purple in color. The urinary collection bag was hooked to the bed with white clips. The bag manufacture name of Medline was on the bag. Nurse E entered the room. Nurse E removed the dignity cover to reveal the entire bag to be bluish purple in color. The area where the urine drained into the collection bag was a deeper blue color. Nurse E was asked how they assess the color of the urine and Nurse E stated, you can't see the urine until you dump it.</p> <p>On 12/12/24, at 3:31 PM, an observation of Resident # 706's catheter bag with Infection Control Nurse (IC) F was conducted. IC Nurse F was asked why the tubing and collection bag was discolored bluish purple and IC Nurse F was unsure but thought that they were supplied by the residents insurance company and came that way. IC Nurse F was asked to provide the company name and contact number for the catheter supplies.</p> <p>On 12/16/24, at 8:30 AM, a record review of Resident #706 's electronic medical record revealed an admission on 02/15/2018 with diagnoses that included Multiple Sclerosis, Paraplegia and Neuromuscular Dysfunction of Bladder. Resident #706 required extensive assistance with all Activities of Daily Living and had intact cognition.</p> <p>A review of the URINARY CATHETER care plan revealed . I will be free of catheter related complications . Interventions . Monitor for potential complications of indwelling catheter use such as redness, irritation, signs/symptoms of infection, obstruction, urethral erosion, bladder spasms, hematuria, or leakage around the catheter and ensure the bag is upright and not laying flat. Date Initiated: 07/23/2019 . Observe/document/report to MD PRN for s/sx of UTI, Frequency, urgency, malaise, foul smelling urine, dysuria, fever, N/V, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, behavioral changes Date Initiated: 09/09/2019 . Super Pubic catheter 18F 10 cc balloon. Change for leakage and blockage. Document in progress note once completed. One time a day, every month/PRN Date Initiated: 09/09/2019 .</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the MEDICATION ADMINISTRATION RECORD 12/1/2024 - 12/31/2024 revealed Super Pubic catheter 18F 10 cc balloon to be changed ever 30 days and PRN every day shift every 30 day(s) -Start Date- 03/11/2024 Fri 6 was check marked that the catheter had been changed. There was no correlating progress note documenting the catheter change or assessment of the catheter.</p> <p>A review of the urinalysis results from 11/7/24 revealed numerous bacteria were detected.</p> <p>A review of the progress notes revealed 11/7/2024 20:11 Nursing Progress Note . Provider notified about results regarding patient urine dip. Results are as follows: Leukocytes 500+, Nitrates +, proteins is +, PH of 6, blood is -, SG 1.005, Ketones 5+, Bilirubin 1(17+), Glucose -, Writer is waiting on return call with further instructions regarding urine specimen. A review of the progress notes from 11/7/2024 to survey date revealed no additional notes from nursing, the Physician nor Nurse Practitioner (NP) K of any follow up regarding the positive urinalysis result.</p> <p>On 12/16/24, at 9:48 AM, NP K entered the conference room and offered that the blue tinge tubing was normal. NP K offered, they ordered a blood test for Resident #706 just to be sure as the resident had not met McGreers criteria for a Urinary tract infection. A record review along with NP K of Resident #706's electronic medical record revealed a positive urinalysis result collected on 11/7/2024. NP K offered that it was most likely a contamination or a colonization of the bacteria. A review of the progress notes revealed no follow up assessment by the Physician or NP K. NP K was asked why and NP K stated, that they must have missed that. NP K logged into the laboratory portal, downloaded the final urinalysis culture and uploaded into Resident #706's electronic medical record.</p> <p>On 12/16/24, at 10:20 AM, an observation of the facility urinary catheter supplies in the medication room with IC Nurse F was conducted. The supplies were clear plastic and had Medline manufacturer name on them. IC Nurse F offered Resident #706's supplies come from Dynarex and that they come blue tinged. IC Nurse F offered that they called American Medical Technologies for information but hadn't heard back from the company. IC Nurse F further offered Resident #706 had a urinalysis done on 12/13/2024.</p> <p>On 12/16/24, at 10:30 AM, an observation of Resident #706's urinary catheter tubing and collection bag was conducted with IC Nurse F. The collection bag had the Medline manufacturer name on it and appeared to be the same size and shape of the Medline bag in the supply closet which was clear plastic.</p> <p>On 12/16/24, at 11:00 AM, a record review of the Urinalysis Collection Date: 12/13/2024 revealed . clarity Result turbid . Leukocytes Result Large . Nitrite . Positive .</p> <p>On 12/16/24, at 11:05 AM, a phone interview with Lab Staff N was conducted. Lab Staff N was asked if the result for the urinalysis was positive and Lab Staff N offered, yes and that the urine was sent to North [NAME] on 12/16/24 for a final culture to be done.</p> <p>A review of Medline.com revealed the drainage bags were all clear plastic, and no urinary catheter supplies come blue or purple.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to National Library of Medicine . Purple urine bag syndrome is a rare clinical presentation of urinary tract infection, which results in purple discoloration of urine bag and tube. It mostly indicates ongoing urinary tract infection, where certain bacteria produce enzymes that metabolize tryptophan into indigo (blue) .</p> <p>According to Wikipedia.com, Purple urine bag syndrome is a medical syndrome where purple discoloration of urine collection bag occurs in people with urinary catheters and co existent urinary tract infections .</p>		