

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 05/29/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>Based on observation, interview and record review, the facility failed to ensure Residents dignity was maintained for Resident #'s (5, 16, 49, 58, 59, 62, 71, 72, 102,104 and R#223) and a group of Residents that attended a Resident group meeting, of a sample of 25, resulting in thread bare gowns, long call light wait times, Residents not provided a snack when the meal was late, unaware of an appointment, lack of snacks available, frustration, positioned in bed with the head of the bed lower than feet with no bed controller, call light in reach, and the potential for unmet care needs, hunger and embarrassment.</p> <p>Findings include:</p> <p>Resident Group Meeting</p> <p>On 5/21/24 at 10:02 AM, a group meeting was held with 10 Confidential Residents. The group was asked about care provided with dignity. The group indicated that personal phone use was an issue with staff watching a movie on their phone while giving medication. Two Residents indicated that staff use ear buds in their ears and talk to someone, one Resident said she was answering the staff and were told that they were not talking to them and had stated, They said 'No, I am talking on the phone'. It was a group consensus that staff on their phone was an issue with staff on their phone at the Nurses station, in the dining room and when in the hallway.</p> <p>The group was asked about call light response times and the majority rarely use the call light due to being able to take care of themselves. One Resident had an issue and reported when he does not get a response with his call light on, he will go out into the hallway and find staff to take care of his needs. A couple of Residents indicated that they hear other Residents yelling for help over and over and they are not attended to timely. Two Residents reported that call lights will go off over a Residents' doorway and not answered timely with one Resident that stated, I see the lights beeping a lot, takes a while to answer.</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 - Some</p>	<p>The group was asked about nighttime snacks being available. The Residents expressed that snacks were not consistently brought up and that other Residents would raid the snacks leaving nothing left for others. A couple of the Residents voiced that they were diabetics, and a substantial snack was not always available before they went to bed due to other Residents raiding the snacks and taking out an armful from the refrigerator. A couple Residents expressed that on the weekends sometimes the snacks would not be brought up. The Residents expressed that there was a long period between the evening meal and breakfast the next morning with 15 hours between meals and stated, That's too long, you get hungry, the diabetics need something, and they are not getting what is needed, and some take 5 or 6 snacks at a time and shoot out of there. The Residents expressed frustration with not having available substantial nighttime snacks. A Resident stated there were vending machines but they take your money without getting the snack and they cost too much from the vending machine.</p> <p>Another concern the group brought up was the lack of linen available at night and the poor condition of the linen. Three Residents complained of linen that was very thin, threadbare. It was the consensus of the group that there was not enough linen brought up at night. When asked what linen was not available, they indicated bottom and top sheets, blankets, and towels. One Resident stated, You have to wait until somethings come up, from the laundry and that it may not come up until the morning and one Resident stated, You have to deal with what you have, and indicated you can not get clean linen until it comes from laundry or some one goes to get it for you.</p> <p>On 5/22/24 at 12:46 PM, an interview was conducted with Nurse Unit Manager I regarding snacks provided at HS (nighttime). A review of the concern that Residents were taking multiple snacks at a time and then not enough snacks were provided to other residents including Residents with a diagnosis of diabetes. The Unit Manager indicated that they have had to replace the lock on the fridge because the lock had been broken off. An observation was made of the refrigerator located in the common area on the 3rd floor of the snack bin in the refrigerator that had multiple packages of crackers and a couple cookies and some condiments. The sheet that indicated the snacks had been sent up and signed for was reviewed. The last weekend had a signature that the snacks had been sent but there was no signature that they had been received. The Unit Manager indicated the nurse must forgot to sign.</p> <p>Resident #5</p> <p>A review of Resident #5's medical record revealed an admission into the facility on [DATE] with diagnoses that included diabetes, dysphagia, paranoid schizophrenia, anxiety disorder, depression, dementia, delusional disorders and malnutrition. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 7/15 that indicated severely impaired cognition and was independent with eating and rolling from side to side, required supervision or touching assistance with oral hygiene and was dependent on staff for toileting hygiene, bathing, dressing and personal hygiene.</p> <p>On 5/19/24 at 11:56 AM, an observation was made of Resident #5 lying in bed. The Resident was interviewed but did not answer most questions appropriately. The Resident had a gown draped over her body that was very thin and thread bare. The Resident had a sheet that was on her lower legs and feet. An observation was made of the Resident's call light under the head of the bed and not in reach for the Resident.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/20/24 at 9:12 AM, an observation was made of Resident #5 lying in bed with the head of the bed down in a Trendelenburg position with the feet higher than the head. The Resident had a perimeter mattress on the bed. The Resident did not have a bed controller in reach to position herself and the call light was not in reach for the resident. Nurse F came into the room, was asked about the Resident in Trendelenburg position, indicated the head of the bed should be up, was unable to find a bed controller for the Resident, finds controls on the footboard of the bed and raises the head of the bed and the Resident acknowledges comfort. CNA G comes in and when asked about the Resident's position, the CNA indicated the Resident likes it that way and will put it down, but the Resident does not have a controller to adjust the bed. The CNA was alerted of the call light not in reach and places the call light in reach for the Resident. The call light does not have a clip on the cord to keep it in reach.</p> <p>On 5/22/24 at 11:55 AM, an observation was made of Resident #5's lying in bed with the Resident positioned in a Trendelenburg position. The Resident did not have a controller in reach to adjust the bed and the call light was positioned on a chair about a foot away from the bed with briefs piled on top. The call light was not in reach for the Resident.</p> <p>On 5/22/24 at 12:55 PM, an interview was conducted with CNA H regarding Resident #5's position. When queried about the Trendelenburg positioning of the Resident, the CNA reported the Resident liked it that was. When asked if the Resident had a bed controller to position the bed the way she wants, the CNA stated, No, there is no controller for her, I looked the other day. An observation was made with the CNA of Resident #5 lying in bed adjusting her gown and sheet that covered her. The CNA indicated that the controls for bed mobility were on the foot board of the bed. When asked if the Resident could reach it, the CNA stated, No. The CNA raises the bed and goes too high and the Resident winces, the CNA lowers the bed with the head of the bed approximately 30 degrees and the Resident motions that she was comfortable. When asked about the call light that remained on the chair and covered with briefs, the CNA reported the Resident will throw the call light over there. The CNA places the call light in reach and the Resident throws it to the corner top of the bed, the CNA assisted the Resident and wrapped the call light around the top corner of the bed. The Resident puts her hands down then reaches up for the call light and pats it when she felt it there. The call light did not have a clip on it to keep it in place.</p> <p>On 5/29/24 at 10:45 AM, Resident #5 was observed to be lying in bed. A CNA was observed to leave the room prior to the surveyor going into the room. The Resident was lying with the bed flat. The call light was observed to be on the floor. The call light did not have a clip on it.</p> <p>On 5/29/24 at 11:11 AM, an interview was conducted with Nurse Unit Manager, I regarding Resident #5's positioning. When asked about the multiple observations of the Resident in Trendelenburg position and the CNAs were using the positioning as a restraint, the Unit Manager indicated the Resident should not be in Trendelenburg position. The multiple observations of the call light not within reach for the Resident was reviewed with the Unit Manager. The Unit Manager indicated she would look into getting a clip for the call light and will make sure her position is appropriate. The concern of staff personal phone use was reviewed with the Unit Manager. When queried regarding facility policy, the Unit Manager stated, They are not supposed to be on their cell phone. Will monitor for that.</p> <p>Resident #16</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #16's medical record revealed an admission into the facility on [DATE] with diagnoses that included paranoid schizophrenia, dysphagia, dementia, diabetes, depression and malnutrition. A review of the Resident's MDS assessment revealed a BIMS score of 5/15 that indicated severely impaired cognition and the Resident needed substantial/maximal assistance with toileting hygiene, dressing, personal hygiene, bed mobility and transferring.</p> <p>On 5/19/24 at 11:48 AM, an observation was made of Resident #16 lying in bed with a sheet covering the Resident that was very thin and see through. The Resident had a shirt on. The Resident was interviewed but answers were not reliable. An observation was made of the Resident with a call light touch pad for a call light that was positioned on the floor under the head of the bed and not within reach for the Resident.</p> <p>On 5/19/24 at 12:11 PM, an observation was made of Resident #16 eating lunch. The meal was on the tray that was on the overbed table. An observation was made of Resident #12's call light touch pad that remained on the floor.</p> <p>Resident #49</p> <p>A review of Resident #49's medical record revealed an admission into the facility on [DATE] and re-admission on 3/20/24 with diagnoses that included acute respiratory failure, diabetes, altered mental status, fracture of the left humerus, difficulty in walking, dementia, falls and weakness. A review of the Resident's MDS assessment revealed a BIMS score of 14/15 that indicated intact cognition and the Resident needed setup assistance with eating, supervision or touching assistance with oral hygiene was dependent on bathing, toileting hygiene and dressing.</p> <p>On 5/20/24 at 9:48 AM, an observation was made of Resident #49 in their room, dressed and in a wheelchair. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about care provided by staff with dignity. The Resident responded that they observed staff on their personal phone and stated, I see it happening every day. Talking on the phone in the hallway, not communicating with the residents.</p> <p>Resident #62</p> <p>A review of Resident #62's medical record revealed an admission into the facility on [DATE] and readmission on 5/2/24 with diagnoses that included Parkinson's disease, acute respiratory failure, tracheostomy status, diabetes, muscle weakness and gastrostomy. A review of the Resident's Minimum Data Set assessment revealed a BIMS score of 14/15 that indicated intact cognition and was dependent for self-care that included bathing, dressing, and using the toilet.</p> <p>On 5/19/24 at 11:30 AM, an observation was made of Resident #62 lying in bed, awake. The Resident had a tracheostomy but was able to answer questions during interview. An observation was made of the Resident in a hospital gown. He lifted the gown around his chest area and shakes his head back and forth. The gown was so thin and was see through. An observation was made of the Resident's call light clipped to his pillow. When asked about response time when he used the call light, the Resident stated, depends. When asked if he had to wait more than a half an hour, the Resident stated, Yes, when asked if he had to wait more than an hour the Resident nodded and stated, Uh-huh.</p> <p>Resident #104</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #104's medical record revealed an admission into the facility on [DATE] with diagnoses that included heart disease, chronic obstructive pulmonary disease, diabetes, bipolar disorder, and need for assistance with personal care. A review of Resident #104's MDS revealed a BIMS score of 12/15 that indicated moderately impaired cognition and the Resident needed maximal assistance with toileting hygiene, mobility and transfers.</p> <p>On 5/19/24 at 12:19 PM, an observation was made of Resident #104 in their room in bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident had his call light positioned inside a bedside table drawer. When asked if he could reach it, the Resident indicated it was in reach for him. The Resident was asked if he used his call light, the Resident indicated that he does use it when he needs something. The Resident was asked about call light response times when he used the call light. The Resident stated, It all depends, if you call at three in the morning, you will be waiting a while. When asked if he had to wait more than 30 minutes, the Resident stated, Oh yeah. When asked if he has had to wait an hour, the Resident stated, Yes, queried if had to wait for call light response up to two hours, the Resident stated, Yes it has been that long.</p> <p>A review of facility policy received regarding Cell Phone use, revealed, Cell Phones & Text Messaging: Cell phones have become a valuable tool in managing our professional and personal lives. However, cell phones raise a number of issues involving safety, security, and privacy. Employees should confine personal cell phone calls and text messaging o lunch breaks or other rest period breaks. Excessive use of a cell phone at work for texting and other purely social purposes is not permitted .</p> <p>A review of facility policy titled, Promoting/Maintaining Resident Dignity, reviewed 2/2024, revealed, Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as were as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights . 5. When interacting with a resident, pay attention to the resident as an individual. 6. Respond to requests for assistance in a timely manner . 8. Conversation should be resident focused, and resident centered . 12. Maintain resident privacy .</p> <p>A review of facility policy titled, Call Lights System, reviewed/revised 12/20, revealed, Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response . 1. Staff will have knowledge of the resident call system, including how the system works and ensuring resident access to the call light . 5. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed .</p> <p>22348</p> <p>Resident #58 (R58)</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/22/24 at 12:15 PM, R58 was observed in his room on the ground with his face on the floor, torso on the floor mat, and his hips and bilateral post-amputated legs positioned on top of the bed. R58 was wearing a shirt with only an incontinence pad and no pants. The privacy curtain was not drawn, and R58 was exposed as you entered his room. He was incontinent with bowel and bladder and was soiled upon the date and time of the observation.</p> <p>On 5/22/24 at 1:30 PM, a review of the record for R58 revealed he was not interviewable with a Brief Interview Mental Status (BIMS) Score of 01 on 2/01/2024. A BIMS score of zero to seven points suggests severe cognitive impairment. R58 was admitted to the facility with a primary diagnosis of Type 2 Diabetes with Hyperglycemia, Paraplegia, Hepatitis C, and Polyneuropathy in addition to other diagnoses. R58's Minimum Data Set, dated dated dated [DATE] assessment revealed that R58 was always incontinent with both bowel and bladder elimination patterns, always dependent on lower body dressing, showers, and personal hygiene. The care plan was reviewed and did not indicate R58's preferences of wearing just the incontinence pad.</p> <p>The assigned CNA R, was interviewed on 5/22/24 at 12:19 PM. CNA R indicated that he went to lunch at 11:40 PM and recalled that the last time he cared for R58 was before 11:00 AM. R58 was lying on his bed. CNA R revealed he did not have another staff member assigned to take his place when he was gone on his lunch break. When queried about how R58 was found in his incontinence pad only and with no pants, CNA R did not say why he left R58 wearing an incontinence pad only.</p> <p>The incident report (I/A) was reviewed on 5/27/24 at 12:00 PM. The I/A noted that on 05/22/2024 at 12:00 PM. Staff informed resident was On the floor, in his room. Upon entering his room, the nurse observed the resident lying on his stomach on his bed with his head resting on the floor mat next to the bed. Resident awake & alert, moving all extremities without S/S of pain. PROM without S/S of pain or discomfort. Resident lifted to bed via Hoyer lift, & several staff members.</p> <p>Resident room [ROOM NUMBER] (R223)</p> <p>R223, during the initial tour observation on 05/19/24 at 10:33 AM, she was found in her room, finishing breakfast, and noticed that she was wearing a shirt top and incontinence pad only without pants, a blanket to cover her legs while sitting in her wheelchair.</p> <p>During R223's interview on 5/19/24 at 10:35 AM, the surveyor asked if it was her choice to wear only her incontinence pad. She stated, No. Then, the surveyor asked if she wished to wear pants over her incontinence pad. She nodded, indicating, Yes. R223 further stated that she had pants in her closet and was unsure why the staff had not put them on her this morning. R223 appeared sad and indicated that she felt embarrassed. R223 pointed out where her closet was and allowed the surveyor to examine if clean pants were available. It was confirmed that at least two clean pants were found in the first drawer.</p> <p>(continued on next page)</p>		

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<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on interview and record review, the facility failed to ensure Code Status was assessed, documented and accessible in the medical record for 2 residents (#'s 35 and 55) of 3 reviewed for Advance Directives, resulting in the potential for the resident's lack of informed knowledge related to options for code status and miscommunication of code status which could lead to a lack of appropriate interventions for care.</p> <p>Findings Include:</p> <p>Resident #35</p> <p>Advance Directives</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #35 was admitted to the facility on [DATE] with diagnoses: Diabetes, COPD, anxiety, depression, hypertension and cataracts. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 14/15 and the resident was independent with most care, needing some assistance with showers, and supervision mobility.</p> <p>A review of the Medical Treatment Decision Form, for Resident #35 identified Full Code but it was not signed by the resident and was dated 6/16/23.</p> <p>On 5/20/2024 at 11:58 AM, Resident #35 was interviewed about his Code status preferences and he said he did not agree with Full Code. He said he would not want to be a vegetable. Resident #35 said he did not sign the code status form because he did not recall anyone talking to him about it.</p> <p>On 5/22/24 at 11:03 AM, Social Worker M was interviewed about Resident #35's code status preferences and his Medical Treatment Decision Form, was dated but not signed for Full Code. The Social Worker stated, I wasn't here then and I don't know why that is like that. He is due to be updated.</p> <p>Resident #55</p> <p>Advance Directives</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Multiple sclerosis, severe protein-calorie malnutrition, chronic osteomyelitis (bone infection), Stage 2 and Stage 4 pressure ulcers, unstageable pressure ulcer, sepsis infection, contracture unspecified joint, and underweight. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 13/15 and the resident needed assistance with eating and was dependent with all other care.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the Medical Treatment Decision Form for Resident #55 indicated it was signed by the resident on 10/4/22. It designated the resident chose DNR/Do Not Resuscitate. The Face sheet in the electronic medical record said Full Code.</p> <p>A review of the physician orders for Resident #55 revealed an order for: Full Code, dated 5/3/2024.</p> <p>A review of the Care Plans for Resident #55 identified I choose DNR . dated 10/4/22.</p> <p>On 5/22/24 at 10:55 AM, Director of Social Work M was interviewed about the Code Status for Resident #55, as there was conflicting information in the medical record. The Social Worker stated, He has been a DNR since he came here. He went to the hospital April 24th, 2024 and when he came back they made him a Full Code by default. The nurse should have assessed on readmission. They did not put the right code status in. I usually check to see if anything changed for him and it didn't. I will have to check on that.</p> <p>On 5/22/2024 at 3:30 PM, Social Worker M provided a copy of a Medical Treatment Decision Form, dated 5/22/2024. Resident #55 signed he chose Full Code. The Social Worker said the Care Plan would be updated with his preference.</p> <p>A review of the facility policy titled, Residents' Rights Regarding Treatment and Advance Directives, date implemented 5/17/2006 and reviewed/revised 3/23 provided, It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive . On admission , the facility will determine if the resident has executed an advance directive, which can designate a DPOAH and/or future healthcare treatment preferences, and if not, determine whether the resident would like to formulate an advance directive . Any decision making regarding the resident's choices will be documented in the resident's comprehensive care plans .</p>		

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 05/29/2024
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	

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>This Citation pertains to Intake Number MI00144249.</p> <p>Based on observation, interview, and record review the facility failed to provide a clean, comfortable and home like environment to ensure that hallways, resident rooms, floors and other facility areas were clean, uncluttered, and in good repair for one Resident #33 and four resident rooms (401, 410, 413, 421), resulting in an unclean physical environment, resident dissatisfaction and complaints regarding the lack of cleanliness.</p> <p>Findings Include:</p> <p>FACILITY</p> <p>Environment</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #31 indicated admission to the facility on [DATE] with diagnoses: Diabetes, kidney disease, left ankle pressure ulcer Stage 3, spine disorder, depression, history of seizures, prostate enlargement, right leg amputation below the knee, hypertension, and anemia. The MDS assessment dated [DATE] revealed the resident had moderate cognitive decline with a Brief Interview for Mental Status (BIMS) score of 9/15 and needed some assistance with eating and hygiene and dependence with all other care.</p> <p>On 5/19/2024 at 10:14 AM, during a tour of the facility room [ROOM NUMBER]-1 was observed to be very cluttered with garbage on the floor and the under bed. There were items piled in chairs in boxes and around the room. Resident #31 said nobody had time to help him put it away. The room had 2 closet areas and they had space to store some items in each.</p> <p>On 5/19/2024 at 10:47 AM , during a tour of the facility, room [ROOM NUMBER] was listed as empty. The bed was made, but there were partially empty drink containers sitting on the floor, Gatorade on the bedside table, and a coffee cup on the floor.</p> <p>On 5/19/2024 at 11:20 AM, during a tour of the facility, room [ROOM NUMBER]-2 was observed to have an unmade bed with a mattress with a large brown stain, and rips and tears.</p> <p>On 5/28/24 at 9:05 AM, room [ROOM NUMBER] was observed to have silverware, papers and debris on the floor; it appeared very dirty, with smeared sticky dirt on the floor.</p> <p>A review of the facility policy titled, Resident Rights, date implemented 11/10/07 and reviewed/ revised 2/24 provided, . The resident has a right to a dignified existence . The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences .</p> <p>49944</p> <p>Resident #33 (R33):</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #33 is [AGE] years old and was admitted to the facility on [DATE] with diagnoses that include asthma, obstructive sleep apnea, chronic obstructive pulmonary disease and hypertension. R33 has a Brief Interview for Mental Status (BIMS) score of 14 indicating they are cognitively intact.</p> <p>On 05/19/24 at 11:45 AM, observation revealed R33's room had a strong odor of urine, the garbage can was full of old briefs and trash and the floor was sticky. Observation of the bathroom revealed the garbage can was full with trash and wipes with bowel movement on them. It was observed that R33's bed was unmade, there were no sheets or blankets present. R33 was observed sitting by the window in a rolling walker. R33 was asked about the cleanliness of her room and if her bed is usually not made at this point in the day. R33 stated that the facility often runs out of garbage bags so they let the garbage can get full before they empty it. R33 stated that her bed is often not made and they have to lay on the bare mattress when they want to rest.</p> <p>On 05/21/24 at 08:48 AM, observation revealed that R33's bed was unmade and there was a strong odor of urine. R33 was observed sitting by the entry door to the room. R33 was asked about the lack of linens on the bed. R33 stated they had just taken the linen off of the bed and were waiting for the staff to make the bed.</p> <p>On 05/21/24 at 01:55 PM, observation revealed that R33's bed was still not made. R33 was observed sleeping on the mattress with no linen.</p> <p>On 05/22/24 at 08:41 AM, observation revealed that R33's bed was not made.</p> <p>On 05/22/24 at 09:05 AM an interview was conducted with Certified Nursing Assistant 'B', CNA 'B' was asked when they would make a residents bed or change out the linen. CNA 'B' responded that they change the linens when the residents get up for a shower or if their bed is visibly dirty and needs to be changed. CNA 'B' was asked why R33 still had an unmade bed after being out of it most of the morning. CNA 'B' stated they were not the aide responsible for R33 but that they would look into why the bed was not made.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review, the facility failed to protect a resident's right to be free from neglect for one resident (Resident #46), of one resident reviewed for neglect, resulting in Resident #46 having necessary medications, including narcotics, withheld without his knowledge or his physician's approval, which lead to pain, suffering, distress, and the potential for narcotic diversion.</p> <p>Findings Include:</p> <p>Resident #46:</p> <p>A review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #46 indicated the resident was readmitted to the facility on [DATE] and again on 8/16/2023 with diagnoses: history of a stroke, dysphagia, irritable bowel syndrome, epilepsy, dementia, depression, hypertension diabetes, atrial fibrillation, bipolar disorder, COPD, gastrostomy tube, asthma, chronic pain, acquired absence of left leg below knee, GERD and heart disease. The MDS assessment dated [DATE] indicated the resident had moderate cognitive loss with a Brief Interview for Mental Status (BIMS) score of 11/15 and the resident needed assistance with all care.</p> <p>During a tour of the facility on 5/19/24 at 11:39 AM, Resident #46 was observed rubbing his legs, especially his left upper leg. The resident was asked if he was having pain and he stated, My knee and hip are killing me and have been for the last week, but especially today. The resident was asked if he normally received pain medication and he said he usually received pain medication. When asked if he received it that morning, he said he didn't know.</p> <p>On 5/19/2024 at 11:40 AM, Nurse K was observed outside the door of Resident #46 with her medication cart. The nurse was asked if the resident received pain medication and she said Resident #46 was scheduled to receive a Norco/oxycodone-acetaminophen at 12:00 noon. Nurse K said she would give it to him soon. Discussed with Nurse K that the resident appeared very uncomfortable and was repeatedly rubbing his legs. The Nurse said Resident #46 was to receive the Norco every 4 hours via a feeding tube/peg tube.</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>During the interview with Nurse K on 5/19/2024 at 11:40 AM, the surveyor asked Nurse K to review the narcotics log for Resident #46's Norco pain medication. The narcotics log showed the Norco was signed out on 5/19/2024 at 8:00 AM and 11:00 AM. The nurse was asked if she already gave Resident #46 the pain medication and she said she was going to give it. Nurse K was asked if she signed the narcotic pain medication Norco for Resident #46 out at 11:00 AM (40 minutes prior) and she then scribbled out the 11:00 AM and changed the time to 12:00 PM. Nurse K was asked how she could change the time to 12:00 PM when she had already taken the narcotic out at 11:00 AM. The nurse did not have a response. The surveyor asked Nurse K to see the narcotic cassette that contained the Norco for Resident #46; it was in a locked drawer inside the medication cart. The nurse unlocked the drawer and lifted the medication cassette out. Nurse K showed the cassette for the Norco for Resident #46 and it showed 14 pills remained in the cassette. The narcotics log was reviewed for the resident's Norco and it also showed 14 pills were documented as remaining in the cassette after Nurse K signed that she took one out at 11:00 AM. Nurse K was asked where the Norco pill was if she already took it out of the cassette but did not give it to the resident. The nurse did not respond and then pointed at the top drawer of the medication cart. It was unclear what she was pointing at. She then removed a small medication cup from the back of the drawer and the medication cup read 16-2. The nurse said the resident was in room [ROOM NUMBER]-2. There were approximately 10 pills in the cup. Nurse K was asked if it contained the Norco and she said it did. The Norco pills in the medication cassette were compared to the pills in the medication cup and it was confirmed there were 2 Norco in the cup, plus a variety of other medications. The resident had not received his morning medications, including the Norco.</p> <p>On 5/19/2024 at 11:50 AM, Nurse K took the resident's medications including the 2 Norco, crushed them and administered them to Resident #46 via the feeding tube/peg tube.</p> <p>On 5/19/2024 at 12:20 PM, the Director of Nursing/DON was interviewed related to Nurse K removing Resident #46's medications including narcotic pain medication and not providing them to the resident. He said he was not aware of that. He said Nurse K was a Nurse Manager and had picked up an extra shift 5/19/2024 (Sunday). Reviewed with the DON that Nurse K had signed Resident #46's narcotics out of the double-locked medication drawer, placed them into a single-locked drawer and chose not to give them to the resident, until she was repeatedly asked where the medication was. He said that was not acceptable and he would look into it. The DON was asked for a copy of the Medication Administration Record with times administered for Resident #46 on 5/19/2024.</p> <p>The Medication Admin Audit Report for Resident #46 was received on 5/22/2024. The report identified what time the resident's medications were to be administered/Schedule Date and Time; Administration Time and what time they were documented as given to the resident/Doc'd Time.</p> <p>Further review of the Medication Admin Audit Report for Resident #46 revealed the resident was to receive the following medications at 7:00 AM:</p> <p>Omeprazole 20 g capsule for GERD; Sertraline 50 mg tablet for Depression; Lactobacillus Capsule for nutritional supplement; Aripiprazole 5 mg tablet for Bipolar disorder; Aspirin 81 mg for his heart; Metoprolol 100 mg for hypertension; Multaq 400 mg tablet for a heart dysrhythmia; Docusate 100 mg capsule for constipation.</p> <p>The Resident was supposed to receive one medication: Hydrocodone-Acetaminophen (Norco) 5-325 mg tablet at 8:00 AM.</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>Resident #46 was to receive one medication at 12:00 PM: Hydrocodone-Acetaminophen (Norco) 5-325 mg tablet.</p> <p>The 7:00 AM medications were all documented on the Medication Admin Audit Report as given at 9:30 AM, but they were still in the medication cup in the top drawer of the medication cart at 11:40 AM, as confirmed with Nurse K.</p> <p>The 8:00 AM Norco was documented as given at 9:24 AM, but it was also in the medication cup.</p> <p>The 12:00 PM Norco was documented as given at 11:47 AM. This was the time Nurse K was observed giving all of the morning and noon medications.</p> <p>A review of the nurses' notes on 5/19/2024 and on 5/22/2024 indicated the nurse had not notified the physician that she had withheld two doses of Resident #46's narcotic pain medication and did not provide the resident with his medications as ordered.</p> <p>On 5/29/2024 at 8:45 AM, the Administrator was interviewed about Nurse K intentionally not providing Resident #46 with his medications, including his narcotic pain medication. The Administrator said Nurse K walked out of the facility and quit on 5/22/2024 in the middle of her shift.</p> <p>A review of the facility policy titled, Abuse, Neglect and Exploitation, dated reviewed/ revised 6/23 provided, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of property . Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .</p> <p>A review of the facility policy titled, Resident Rights, dated reviewed/ revised 2/24 provided, The facility will inform the resident both orally and in writing, in a language that the resident understands of his or her rights . All residents will be treated equally . The facility will ensure that all direct care and indirect care staff members, including contractor and volunteers, are education on the rights of the residents and the responsibility of the facility to properly care for its residents . The right to receive the services and/or items included in the plan of care .</p> <p>A review of the facility policy titled, Administration Procedures for All Medications, effective date 09-2018 and revision date 08-2020 provided, Medication will be administered in a safe and effective manner .</p> <p>A review of the facility policy titled, Medication Storage in the Facility, dated June 2019 provided, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, and record keeping in the facility in accordance with federal, state and other applicable laws and regulations . Schedule II-IV controlled substances and other medications subject to abuse or diversion are stored in a permanently affixed, double-locked compartment separate from all other medications .</p>

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944</p> <p>Based on interview and record review the facility failed to complete and transmit a discharge minimum data set (MDS) assessment timely for one resident (#60) of one resident reviewed for MDS assessments, resulting in the late completion and transmission of an MDS discharge assessment. Findings include:</p> <p>Record review revealed that R60 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, acute respiratory failure, depression and hypoxemia. R60 discharged from the facility on 12/04/23.</p> <p>On 05/21/24 at 11:30 AM, record review revealed a discharge MDS assessment was completed late on 04/30/24 and not transmitted to the Centers for Medicare and Medicaid Services (CMS) for R60. R60 discharged from the facility on 12/04/23.</p> <p>On 05/21/24 at 11:54 AM, and interview was conducted with MDS Coordinator 'D'. MDS Coordinator 'D' was asked why the discharge MDS assessment was completed late and not transmitted for R60. MDS Coordinator 'D' stated that they just started this role in the facility at the beginning of May 2024 and they were unsure why it wasn't completed or transmitted timely. MDS Coordinator 'D' stated it appears as if the MDS assessment was not added to a batch for submission somehow and therefore not submitted. The MDS Coordinator 'D' and corporate MDS Coordinator 'E' stated they would get the discharge MDS assessment transmitted as soon as possible.</p> <p>On 05/21/24 at 12:00 PM record review revealed that the MDS assessment was submitted on 05/21/24 and has been accepted by CMS.</p> <p>Record review of the CMS Resident Assessment Instrument (RAI) Version 3.0 Manual reveals that discharge assessments are to be completed no later than 14 days after the discharge date and transmitted no later than 14 days after the completion of the MDS assessment.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>Based on interview and record review, the facility failed to complete yearly PASARR (Pre-Admission Screening/Annual Resident Review) Level II Screening and/or exemption criteria certification for one Resident #6 of two reviewed for PASARR documentation, resulting in the lack of yearly follow-up PASARR and the possibility for the Resident to forgo specialized behavior/mental health services.</p> <p>Findings include:</p> <p>A review of Resident #6's medical record revealed an admission into the facility on [DATE] and readmission on 6/6/23 with diagnoses that included schizophrenia, major depressive disorder and unspecified dementia, severe, with other behavioral disturbance.</p> <p>A review of Resident #6 medical record revealed a PASARR dated 6/26/22, Form DCH-3877 that revealed Section II-Screening Criteria that marked Yes for The person has a current diagnoses of Mental Illness and Dementia and Yes for The person has received treatment for Mental Illness and Dementia with instruction to Explain any Yes DX (diagnosis): Dementia, Schizophrenia. The bottom of the form instructed, Distribution: If any answer to items 1-6 in Section II is Yes, send one copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.</p> <p>A review of Resident #6 medical record revealed a PASARR dated 2/9/23, Form DCH-3877 that revealed Section II-Screening Criteria that marked Yes for The person has a current diagnoses of Mental Illness and Dementia , Yes for The person has received treatment for Mental Illness and Dementia, Yes The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days and Yes There is presenting evidence of mental illness or dementia, including significant disturbances in thought conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. Instruction to Explain any Yes DX (diagnosis): Dementia, Schizophrenia. Meds: Seroquel. The bottom of the form instructed, Distribution: If any answer to items 1-6 in Section II is Yes, send one copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #6 medical record revealed a PASARR dated 2/7/24, Form DCH-3877 that revealed Section II-Screening Criteria that marked Yes for The person has a current diagnoses of Mental Illness and Dementia , Yes for The person has received treatment for Mental Illness and Dementia, Yes The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days and Yes There is presenting evidence of mental illness or dementia, including significant disturbances in thought conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. Instruction to Explain any Yes DX (diagnosis): Dementia, MDD (major depressive disorder), Schizophrenia. Meds: Risperdal, Trazodone. The bottom of the form instructed, Distribution: If any answer to items 1-6 in Section II is Yes, send one copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.</p> <p>Further review of the medical record revealed no DCH-3878 exemption form or a Level II Evaluation for the years 2022, 2023 and 2024.</p> <p>On 5/21/24 at 1:34 PM, an interview was conducted with the Social Worker (SW) M regarding Resident #6's PASARR documentation and lack of yearly Form DCH-3878 or Level II Evaluation by the local community mental health services. The SW reviewed the DCH-3877 forms and reported that the Residents 2024 form was waiting to be signed. When asked if that was for February 2024, the SW stated, Yes I can see it, but it has not been signed yet, and indicated the doctor was to sign and stated, I don't do the (Form) 78. It's the doctor that needs to sign them. When asked if the Resident needed a Level II Evaluation or exemption criteria (Form-3878), the SW stated, I know my Level II people, he is not one of them. When asked that the Resident should have the Form-3878 completed, the SW indicated Yes. When asked if it had been done for the last couple years, the SW did not answer.</p> <p>On 5/21/24 at 2:01 PM, an interview was conducted with the Director of Nursing (DON). The lack of multiple years of the PASARR Form-3878 not completed for Resident #6 was reviewed with the DON. The DON indicated they would look into it.</p> <p>On 5/22/24, the facility provided the Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification, Level II Screening for Resident #6, dated 5/21/24 and signed by the Nurse Practitioner. Instructions of the form revealed, The patient being screened shall require a comprehensive Level II evaluation unless any of the exemption criteria below is met and certified by a physician's assistant, nurse practitioner or physician.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944</p> <p>Based on observation, interview and record review the facility failed to ensure comprehensive care plans were developed and implemented for two residents (#41,#62) of 23 residents reviewed for comprehensive care plans resulting in incomplete care plans, dignity concerns and potential for unmet care needs. Findings include:</p> <p>Resident #41</p> <p>On 05/20/24 at 11:24 AM, observation revealed a catheter bag uncovered and full of urine.</p> <p>On 05/20/24 at 04:09 PM, record review revealed there was no care plan in place for the catheter.</p> <p>On 05/21/24 at 09:50 AM, observation revealed the catheter bag was uncovered with urine present in it.</p> <p>On 05/21/24 at 09:56 AM, an interview was conducted with the Licensed Practical Nurse (LPN) 'L' providing care for R41. LPN 'L' was asked about the indwelling catheter that R41 has in place. LPN 'L' was asked if there was a diagnosis, order or a care plan for the catheter. LPN 'L' stated they believe the resident had some issues with urinary retention but could not locate an order, diagnosis or care plan. LPN 'L' was asked if the resident should have an order and care plan in place for the indwelling catheter. LPN 'L' stated yes and that they would enter an order and create a care plan. LPN 'L' was asked how the Certified Nursing Assistants (CNA's) know to provide catheter care for residents. LPN 'L' stated CNA's would see the task on their point of care charting after the care plan is created.</p> <p>On 05/21/24 at 11:33 AM, record review revealed an order for the catheter size and care dated 5/21/24. No care plan is present. The entry minimum data assessment (MDS) dated [DATE] does not indicate the presence of an indwelling catheter.</p> <p>Record review of the policy titled Care Planning, revised 06/23, revealed:</p> <p>4.If the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes shall be incorporated into an updated summary provided to the resident and his or her representative, if applicable.</p> <p>5. The comprehensive care plan is developed from the RAI scheduled and is reviewed and revised by the IDT as necessary.</p> <p>37771</p> <p>Resident #62</p> <p>(continued on next page)</p>		

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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	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #62's medical record revealed an admission into the facility on [DATE] and readmission on 5/2/24 with diagnoses that included Parkinson's disease, acute respiratory failure, tracheostomy status, diabetes, muscle weakness and gastrostomy. A review of the Resident's Minimum Data Set assessment revealed a BIMS score of 14/15 that indicated intact cognition and was dependent for self-care that included bathing, dressing, and using the toilet. The Resident had a tracheostomy tube (a curved tube placed through a surgical opening through the neck into the trachea (windpipe)) and PEG tube (Percutaneous Endoscopic Gastrostomy tube-a tube surgically placed through the abdominal wall and into the stomach to administer enteral nutrition, fluids and/or medication).</p> <p>On 5/19/24 at 11:12 AM, an observation was made of Resident #62 lying in bed, awake. The Resident had a tracheostomy but was able to answer questions during interview. An observation was made of humidification connected to and Easy Air machine with a tracheostomy oxygen collar connected to it but was not on the Resident. There was suction equipment on the cart that held tracheostomy supplies that had been used and placed back into the suction catheter wrapper. A yanker was observed to be opened and was not dated with an open date. The Resident had tube feeding tubing on a controller that was not connected to the PEG tube. Syringe and canister were open and not dated, stored on the cart for supplies. There was no emergency tracheostomy equipment that was visible on the cart of supplies.</p> <p>A review of Resident #62's care plan revealed a Focus for altered respiratory status difficulty breathing r/t (related to) s/p (status post) acute respiratory failure with tracheostomy placement, revision date 5/9/24. The interventions included Change/Clean Nebulizer Equipment tubing, filters and mouthpiece per facility protocol, Change/Clean O2 equipment tubing, filters, bags, nasal cannulas and masks per facility protocol and as ordered, Monitor for s/sx (signs/symptoms) of respiratory distress and report to MD (doctor) PRN (as needed) ., and O2 sats per facility protocol and as ordered. The Care Plan lacked interventions specific to care of Resident #62's tracheostomy and maintaining the wellbeing of the tracheostomy itself.</p> <p>Further review of Resident #62's care plan revealed no comprehensive care plan developed for the care of the PEG tube.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review, the facility failed to review and revise care plans with resident changes, to ensure interventions necessary for care and services were provided for seven residents (#12, #30, #31, #46, #55, #62,#70) of 29 residents reviewed for care plans, resulting in the potential for unmet care needs.</p> <p>Findings Include:</p> <p>Resident #31</p> <p>Position, Mobility</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #31 indicated admission to the facility on [DATE] with diagnoses: Diabetes, kidney disease, left ankle pressure ulcer Stage 3, spine disorder, depression, history of seizures, prostate enlargement, right leg amputation below the knee, hypertension, and anemia. The MDS assessment dated [DATE] revealed the resident had moderate cognitive decline with a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] and needed some assistance with eating and hygiene and dependence with all other care.</p> <p>On [DATE] at 10:17 AM, Resident #31 was observed lying in bed watching TV. He showed his left hand; his fingers were curled under. He said he could partially uncurl them. He grabbed his left-hand fingers with his right hand and slowly opened the left-hand fingers. When he released the fingers, they closed towards the palm of his left hand. When asked if he had a brace or splint, or some type of device to aid in preventing the fingers from contracting, he said he did not. The resident was asked if he received any type of exercise program for his left hand and he said he did not, but he would like some.</p> <p>A review of the Care Plans for Resident #31 revealed the following:</p> <p>I have an ADL (activities of daily living) Self Care Performance deficit related to: Metabolic encephalopathy, weakness, history of acute respiratory failure, GERD, hypertension, date initiated [DATE] and revised [DATE] with Interventions including: BUE/BLE PROM/AROM as tolerated during self-care tasks, FMP: ,d+[DATE]x week for 12 weeks, date initiated [DATE]. This intervention was expired. There was no mention of the resident's impaired function of his left hand and no interventions mentioning it.</p> <p>Pressure Ulcer/Injury</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 10:09 AM, Resident #31 was observed lying in bed watching TV. He was lying on his back and his feet were up against the foot board of the bed. He was wearing heel boots that covered his foot and left the toes open. Certified Nurse's Aide S entered the room and assisted to remove the resident's left sock. Resident #31's left foot great toe had a dark purple mushy area at the tip of the toe: above the toenail. The dark purple area was about 1.5 cm in length x 0.25 cm width. The resident was also noted to have an area above the left ankle; it was a dark purple/red oval area with dry skin around it and bright red skin on the outside. There was no dressing or treatment present on the ankle or toe areas.</p> <p>On [DATE] at 9:45 AM, the resident was observed lying in bed with his left foot up against the foot board of the bed. The heel boot was on. He said no one had looked at his left great toe dark purple area.</p> <p>On [DATE] at 8:45 AM, during an interview with Wound Physician T and Wound nurse K about Resident #31, the physician said the resident's ankle wounds were resolved. Physician T was asked about the dark purple area on Resident #31's left great toe and Physician T said he did not know about that, That's new. I will look at it.</p> <p>A physician wound note dated [DATE] identified the following:</p> <p>Wound Care Consultation: . there is area of concern appreciated to the patient's right (it was the left) distal hallux (toe) . right BKA (below the knee amputation) . Wound base shows a partially attached thin dark brown eschar which was easily removed without discomfort to the patient. The wound base shows a beefy red granulation tissue without odor or exudate. Surrounding tissue is clear . Dimensions: 0.7 cm x 0.5 cm x0.0 cm . Please apply betadine soaked to wound surface and cover with Kerlix gauze dressing or border foam dressing. Change Monday, Wednesday and Friday (and as needed) . Please apply foam wedge or pillows to off-load pressure, reposition frequently. Nutritional support and hydration .</p> <p>A review of the Care Plans for Resident #31 revealed the following:</p> <p>I am at risk for Impaired skin integrity related to : incontinence, immobility, date initiated [DATE] and revised [DATE] with Interventions including: Inspect skin daily with care-Report any concerns to nurse, date initiated [DATE].</p> <p>I have a Pressure Injury, Stage 3 developed in facility, date initiated [DATE] and revised [DATE]. There was no mention of the left ankle wounds or the left great toe. The Care Plan was not specific to the resident's concerns.</p> <p>Resident #46</p> <p>Activities of Daily Living</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #46 indicated the resident was readmitted to the facility on [DATE] and again on [DATE] with diagnoses: history of a stroke, dysphagia, irritable bowel syndrome, epilepsy, dementia, depression, hypertension diabetes, atrial fibrillation, bipolar disorder, COPD, gastrostomy tube/feeding tube, asthma, chronic pain, acquired absence of left leg below knee, GERD and heart disease. The MDS assessment dated [DATE] indicated the resident had moderate cognitive loss with a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] and the resident needed assistance with all care.</p> <p>During a tour of the facility on [DATE] at 11:34 AM, Resident #46 was observed lying in bed. The resident appeared unkempt. His hair appeared as if it hadn't been washed. The resident was asked if he received assistance with his care and he stated, I haven't had a shower. I never had a mustache and beard and now I do. I would like to get shaved. I would like my hair washed.</p> <p>On [DATE] at 09:30 AM, there was a strong smell of urine noted in the hallway near the Resident #46's room. The smell worsened upon entering the resident's room; there was a strong smell of urine near the resident. When asked if his bed was wet, he said he did not think so. The resident showed his brief, it was very wet. The Nurse aides were with a different resident. The Housekeeper was in the hall and she was asked if she could identify where the smell was coming from, she pointed toward Resident #46's room.</p> <p>A review of the Care Plans for Resident #46 identified the following:</p> <p>(Resident #46) has an ADL (activities of daily living) self-care performance deficit related to: Type II diabetes, muscle wasting, cerebral infarction, seizures, date initiated and revised [DATE] with Interventions including: Bathing/showering: Dependent x 1 staff; shower's 2 times weekly and as necessary, date initiated [DATE] and revised [DATE]. There was no mention of assisting the resident with shaving.</p> <p>Resident #55</p> <p>Urinary Catheter or UTI</p> <p>On [DATE] at 12:04 , Resident #55 was observed lying in bed, awake. The resident said he was waiting for lunch. The resident was observed to have no water at the bedside, when asked about it he stated, Why don't they bring me water anymore. He had an empty clear cup on the bedside table. The resident said he had a catheter. A urinary catheter (foley) was observed foley lying flat on its side in a basin on the floor. The urine was dark orange to red in the catheter bag and tubing; the urine was not flowing freely.</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Multiple sclerosis, severe protein-calorie malnutrition, chronic osteomyelitis (bone infection), Stage 2 and Stage 4 pressure ulcers, unstageable pressure ulcer, sepsis infection, contracture unspecified joint, and underweight. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] and the resident needed assistance with eating and was dependent with all other care.</p> <p>A review of the Care Plans for Resident #55 identified the following:</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>I have an indwelling catheter related to aggressive wound care management to my buttocks and hip area, date initiated [DATE] and revised [DATE], with Interventions including: Position catheter bag and tubing below the level of the bladder and covered for dignity, date initiated [DATE]; Check catheter tubing for kinks throughout the shift, date initiated[DATE]. There was no mention of not laying the catheter flat on it's side or monitoring for discoloration of the urine in the tubing or bag.</p> <p>22348</p> <p>Resident #12</p> <p>Accidents</p> <p>On [DATE] at 12:30 PM, R12's Electronic Medical Record (EMR) revealed that he was admitted on [DATE] with a diagnosis of Aphasia secondary to Cerebral Infarction, Hemiparesis, and Hemiplegia affecting the dominant left side and Dementia in addition to other diagnoses. The Brief Interview for Mental Status (BIMS) Score dated [DATE] assessment was four. A score of zero to seven indicates the person is severely impaired. R12's Determination of Decision-Making Ability, signed on [DATE] by the attending physician and psychologist, determined that R12 was NOT able to make decisions to participate in medical treatment decisions and handle his own financial affairs.</p> <p>Smoking Assessment according to review of records on [DATE] at 12:30, R12's Smoking Assessment was last performed dated [DATE]. No recent assessment was done after [DATE].</p> <p>A review of R12's Care Plan date created on[DATE] revised dated [DATE] revealed:</p> <p>.Focus: I am a supervised smoker.</p> <p>Interventions:</p> <ol style="list-style-type: none"> 1. I wear a smoking apron. 2. Instruct (Resident's name) about smoking risks and hazards and about smoking cessation aids that are available. 3. Smoking assessment per facility policy. 4. The resident requires SUPERVISION while smoking . <p>There are no updates, revisions on R12's smoking interventions since [DATE].</p> <p>Resident #30</p> <p>Nutrition</p> <p>During the record review conducted on [DATE] at 11:32 AM, it revealed that R30, On [DATE], weighed 118 lbs. On [DATE], the R30 weighed 110 pounds. This indicated that there is a recorded 6.78 % weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R30 was [AGE] years old, admitted to the facility on [DATE] with the diagnosis of Paraplegia, Hepatitis C, Chronic Pain Syndrome, Stage III pressure Ulcer of the sacrum, and Protein-calorie malnutrition in addition to other diagnoses. He is alert and oriented with a Brief Interview for Mental Status BIMS score of , d+[DATE]. A score of suggests the resident is cognitively intact.</p> <p>An interview with R30 was conducted on [DATE] at 11:43 AM. R30 revealed that he does not eat that much and lost weight since he had an infection. R30 could not recall the date of infection but claimed it was just recently, sometime this year.</p> <p>According to the medical director, MD, during an interview on [DATE] at 02:01 PM, MD reviewed R30's chart and indicated that R30 is stable. MD also explained the notification process of abnormal findings to each resident through the nurse practitioner, who updates, does assessments, and makes recommendations. The MD was queried regarding the recorded five percent (5%) significant weight loss. MD stated he was not made aware.</p> <p>R30's Care Plan for the potential for a nutritional/hydration problem was reviewed on ,d+[DATE] at 10:30 AM. One of the interventions was:</p> <p>Report any significant weight changes I have to my physician and Me/DPOA/Guardian. Date Initiated: [DATE] Created by: (Dietician)</p> <p>No further updates and revisions were noted.</p> <p>According to the Regional Dietician on [DATE] at 11:00 AM, A significant weight loss of 5% or more when triggered would mean that the department would evaluate and make changes to the plan of care. The RD stated he received no referral and has not evaluated R30.</p> <p>Resident #70</p> <p>Nutrition</p> <p>Resident#70 (R70), during the tour observation and interview on [DATE] at 09:47 AM, complained about the food served being cold and not hot when it was supposed to be. R70 indicated that an example was potpie, which was still cold in the middle but warm on the sides. The food is always cold and never cold. When queried, R70 denied wanting a desired weight loss.</p> <p>A record review of R70 revealed that R70, on [DATE], weighed 281 pounds (lbs). On [DATE], the R70 weighed 270.0 pounds. This indicated a 7.41 percent (%) weight loss in less than four weeks.</p> <p>R70 was admitted to the facility on [DATE] with a diagnosis of unspecified foreign body in the respiratory tract, urinary tract infection, type 2 diabetes, hemiplegia, and hemiparesis following cerebral infarction affecting left non-dominant side in addition to other diagnoses.</p> <p>A Nutritional assessment and a nutritional care plan dated [DATE] for the potential for a nutritional/hydration problem were conducted. No updates were noted for the significant 7.41 % weight loss dated [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Regional Dietitian on [DATE] 11:00 AM, A significant weight loss of 5% in one month will trigger the system. The dieticians then will clinically assess the resident, talk to staff and make recommendations. He stated there were no referrals received therefore no interventions in place to address the significant weight loss.</p> <p>37771</p> <p>Resident #62</p> <p>A review of Resident #62's medical record revealed an admission into the facility on [DATE] and readmission on [DATE] with diagnoses that included Parkinson's disease, acute respiratory failure, tracheostomy status, diabetes, muscle weakness and gastrostomy. A review of the Resident's Minimum Data Set assessment revealed a BIMS score of ,d+[DATE] that indicated intact cognition and was dependent for self-care that included bathing, dressing, and using the toilet.</p> <p>On [DATE] at 11:12 AM, an observation was made of Resident #62 lying in bed, awake. The Resident had a tracheostomy but was able to answer questions during interview. The Resident was observed to have a tracheostomy and a PEG tube (Percutaneous Endoscopic Gastrostomy tube) but did not have a foley catheter.</p> <p>A review of Resident #62's care plan revealed a Focus I have a condom/intermittent/indwelling suprapubic catheter r/t, with a Goal and Interventions/Tasks related to catheter care, initiated [DATE].</p> <p>On [DATE] at 11:35 AM, an interview was conducted with Unit Manager, Nurse I regarding Resident #62 and the care plan for a urinary catheter. The Unit Manager reported she did not think that the Resident had a urinary catheter. An observation was made with the Unit Manager of Resident #62 lying in bed and without a urinary catheter. The Unit Manager reported he had one at one time but was unable to find when it was removed and stated, that is old in the care plan.</p> <p>On [DATE] at 11:43, Nurse N was asked about the Resident's care plan for a urinary catheter. The Nurse indicated that the Resident had one, but it was removed and he was voiding just fine. When asked about updating the care plan, the Nurse stated, I didn't think of that. I will remove it, from the care plan.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review, the facility failed to provide timely assistance with activities of daily living (ADL's) including showers, bathing, dressing, transferring to wheelchair, nail care and shaving for 8 residents (#16, #22 #27, #35, #40, #46, #49, and #101), from a sample of 12 residents reviewed for ADL care, resulting in residents' feelings of frustration, discouragement, and embarrassment.</p> <p>Findings Include:</p> <p>Resident #35</p> <p>Activities of Daily Living</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #35 was admitted to the facility on [DATE] with diagnoses: Diabetes, COPD, anxiety, depression, hypertension and cataracts. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 14/15 and the resident was independent with most care and needed some assistance with transfer and showers, and supervision with mobility.</p> <p>On 5/19/24 at 10:56 AM, Resident #35 was interviewed and stated, I went a long time without a shower; it comes and goes. It was supposed to be twice a week Tuesday and Friday, I did have a shower Friday. The schedule says twice a week, but it doesn't usually happen.</p> <p>On 5/21/24 at 9:32 AM, reviewed with Resident #35 that in the electronic medical record/emr it was documented that he received a shower on Saturday (5/18/2024). The documentation showed he had 1 shower in 30 days. Resident #35 stated, They do not ask me for a shower. They stay away from me. I don't want a shower in my bathroom, water is all over the floor when they do that in there. It even came all over my room. I prefer to have a shower in the shower room; they don't want to do that. They tried to give me a shower last Tuesday and dropped me. I need 2 people with transfer, they were trying to transfer me to the rolling chair.</p> <p>A review of a nurses note on 5/21/2024, dated 5/3/2024 by Nurse Q indicated Resident #35 was to have his showers changed to Wednesday and Saturday. The note said this was reviewed with the resident. It said the resident would refuse a shower in the evening if he wsa already in bed. His shower time was to be changed to morning. There was still only 1 documented shower x 30 days; the last shower was documented on 5/10/24 at 8:00 PM.</p> <p>A review of the activities of daily living (ADL) Care Plan for Resident #35 identified, Shower/Bathing/Bed Bath scheduled Wed, Sat mornings; extensive two person assist with behaviors and anxiety, dated revised 5/3/2024. It did not mention the resident did not want to be showered in his bathroom shower.</p> <p>Resident #40</p> <p>Activities of Daily Living</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of the Face sheet and MDS assessment indicated Resident #40 was admitted to the facility on [DATE] with diagnoses: Heart failure, dementia, obesity, depression, anxiety, hypertension, anemia and a history of DVT (deep vein thrombosis) of the lower extremity. The MDS assessment dated [DATE] indicated the resident had moderate cognitive loss with a BIMS score of 9/15 and the resident needed some assistance with all care.</p> <p>On 5/20/24 at 9:10 AM, during an interview with Resident #40, she stated It takes an hour or longer sometimes for them to answer your call light. Today they still haven't changed my brief. They dropped off my breakfast and left. I have the same brief on that I had on all night. The girl came in at 4:00 am and said I was dry. If you ring your light they will ask you what you want and leave and it will be 2 hours before they come back. I asked for ice water this morning and they still haven't brought it. This is the same water I got last night. I have a breakout on my neck and it is itching. The nurse said he would call the doctor but I never heard anything else.</p> <p>On 5/20/2024, the Resident put her call light on again at 9:20 AM. The staff were in to assist her with her brief at 9:55 AM.</p> <p>On 5/28/24 at 9:39 AM, Resident #40 was interviewed, she said she had a shower about once a week.</p> <p>A record review of the Tasks documentation in the electronic medical record/emr, identified Resident #40 as having 1 shower documented in the past 30 days. There were 4 bed baths documented from 5/9/2024-5/27/2024. There were none documented the first week of May 2024.</p> <p>Resident #46</p> <p>Activities of Daily Living</p> <p>A review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #46 indicated the resident was readmitted to the facility on [DATE] and again on 8/16/2023 with diagnoses: history of a stroke, dysphagia, irritable bowel syndrome, epilepsy, dementia, depression, hypertension diabetes, atrial fibrillation, bipolar disorder, COPD, gastrostomy tube/feeding tube, asthma, chronic pain, acquired absence of left leg below knee, GERD and heart disease. The MDS assessment dated [DATE] indicated the resident had moderate cognitive loss with a Brief Interview for Mental Status (BIMS) score of 11/15 and the resident needed assistance with all care.</p> <p>During a tour of the facility on 5/19/24 at 11:34 AM, Resident #46 was observed lying in bed. The resident appeared unkempt. His hair appeared as if it hadn't been washed. The resident was asked if he received assistance with his care and he stated, I haven't had a shower. I never had a mustache and beard and now I do. I would like to get shaved. I would like my hair washed. The resident said his vision was poor and he needed assistance.</p> <p>On 5/21/2024 at 09:30 AM, there was a strong smell of urine noted in the hallway near the Resident #46's room. The smell worsened upon entering the resident's room; there was a strong smell of urine near the resident. When asked if his bed was wet, he said he did not think so. The resident showed his brief, it was very wet. The Nurse aides were with a different resident. The Housekeeper was in the hall and she was asked if she could identify where the smell was coming from, she pointed toward Resident #46's room.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Tasks Shower documentation in the emr for Resident #46 revealed he had 2 showers documented in the past 30 days.</p> <p>On 5/28/24 at 9:05 AM, Resident #46 was observed in bed, awake. He said he had not been assisted with shaving- As you can see, they still haven't done it. Resident rubbed his face. Nurse Q said all showers and bathing were documented in the computer. If he received it, then it should have been documented.</p> <p>A review of the Kardex for Resident #46 identified an entry for Bathing: Shower/Bed bath scheduled Tues, Fri pm; Dependent x1 staff. There was no mention of assisting the resident with shaving.</p> <p>37771</p> <p>Resident #16</p> <p>A review of Resident #16's medical record revealed an admission into the facility on [DATE] with diagnoses that included paranoid schizophrenia, dysphagia, dementia, diabetes, depression and malnutrition. A review of the Resident's MDS assessment revealed a BIMS score of 5/15 that indicated severely impaired cognition and the Resident needed substantial/maximal assistance with toileting hygiene, dressing, personal hygiene, bed mobility and transferring.</p> <p>On 5/19/24 at 11:48 AM, an observation was made of Resident #16 lying in bed. The Resident answered some questions but was unreliable with answers. An observation was made of the Resident nails very long and unclean under the nail beds.</p> <p>On 5/20/24 at 9:20 AM, an observation was made of Resident #16 lying in bed. An observation was made of the Resident's nails long with debris underneath the nails. Thumbnail was cracked and had a jagged edge. The Resident was asked if they allowed staff to trim their nails. The Resident stated, yes they can if they come in to do it.</p> <p>A review of Resident #16's the Task for Nail Care in the medical record revealed no documentation of nail care provided in the past 30 days. The question in the task was Did you complete nail care as care planned? the options included yes, no, Resident not available, and Resident refused. There was no documentation for nail care.</p> <p>A review of the care plan for the focus of ADLs (activities of daily living) revealed an intervention/task of Bathing/showering: Check nail length and trim and clean on bath day ad as needed and (Resident's name) may occasionally resist nail care, staff to continue to encourage .</p> <p>On 5/29/24 at 11:14 AM, an interview was conducted with Unit Manager, Nurse I regarding Resident #16's nail care. The Unit Manager reported the Resident refuses nails to get trimmed but would let staff clean them. The Unit Manager indicated staff should be documenting if they did the nail care or if she refused.</p> <p>Resident #27</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #27's medical record revealed an admission into the facility on [DATE] and re-admission on 11/10/23 with diagnoses that included stroke, hemiplegia and hemiparesis following a stroke affecting right dominant side, diabetes, dementia and arthritis. A review of Resident #27's MDS assessment revealed a BIMS score of 14/15 that indicated intact cognition and the Resident needed substantial/maximal assistance with oral hygiene and dressing and was dependent with toileting hygiene, bathing self.</p> <p>On 5/20/24 at 9:31 AM, an observation was made of Resident #27 lying in bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was upset because they were not out of bed yet and reported they like to get up earlier than this. The Resident reported not being able to use his right arm and needed help with bathing. The Resident indicated he would prefer a shower over a bed bath and stated, Got only two showers since I been her. When asked why he got a cleaned up in the room over going down to get a shower, the Resident stated, They don't ask really. Don't follow a schedule, and reported they were to get bathed on certain days, but it was not followed by staff. The Resident reported he like to be clean shaven when queried about the observed facial hair growth. The Resident indicated he needed help with his shaver. The Resident was observed to have long fingernails and they reported staff not trimming his nails.</p> <p>On 5/29/24 at 11:05 AM, an interview was conducted with Unit Manager, Nurse I regarding Resident #27's preference of a shower over a bed bath. The Unit Manager was unsure if the Resident refused showers and a review of the documentation did not indicate regular refusals of showers. The Unit Manager reported the CNA should offer a shower first then if refused, offer the bed bath. When asked about the Resident's preference documented in the care plan, the Unit Manager reviewed the Resident's care plan and reported the preference was not listed and that it indicated bathing on Tuesday and Saturday. The Unit Manager reported due to the right arm flaccid, the Resident would need help with ADL care. The Unit Manager indicated that they would have Activities staff do nail care for him. A review of the task for nail care, with the Unit Manager, revealed no documentation that nail care had been provided.</p> <p>Resident #49</p> <p>A review of Resident #49's medical record revealed an admission into the facility on [DATE] and re-admission on 3/20/24 with diagnoses that included acute respiratory failure, diabetes, altered mental status, fracture of the left humerus, difficulty in walking, dementia, falls and weakness. A review of the Resident's MDS assessment revealed a BIMS score of 14/15 that indicated intact cognition and the Resident needed setup assistance with eating, supervision or touching assistance with oral hygiene was dependent on bathing, toileting hygiene and dressing.</p> <p>On 5/20/24 at 9:48 AM, an observation was made of Resident #49 in their room, dressed and in a wheelchair. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about bathing. The Resident reported they needed help to set her up for a shower and reported they were supposed to get a shower on Saturday (5/18/24) but no staff came to get her to so she could shower. The Resident indicated she preferred to have a shower. The Resident stated, They don't do showers on Sunday, when asked if she didn't get one on Saturday, why not the next day, Sunday. The Resident indicated she would have taken one on Sunday, but that they don't give showers on Sundays. The Resident reported they were supposed to get a shower today (Monday, 5/20/24).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/28/24 at 1:10 PM, a record review was conducted for Resident #49's bathing activities. The Task for bathing indicated the Resident had refused bathing on 5/15/24, had received a bed bath on 5/18/24 and the next shower documented on 5/22/24. The Resident had last showered on 5/11/24 then not until 5/22/24. The task was documented on 5/18 as a bed bath and no documentation that the Resident had refused a shower on that day. The Resident had indicated during the interview with the surveyor that staff had not come to get her for a shower on 5/18, and it was not documented that the Resident had gotten the shower on Monday, 5/20 and the shower not given until 5/22/24.</p> <p>On 5/9/24 at 11:02, an interview was conducted with Unit Manager, Nurse I regarding Resident #49's shower preference. The Unit Manager indicated that the Resident needed set up assistance for a shower. The documented task for bathing was reviewed with the Unit Manager. The Unit Manager indicated that staff were to chart refusals and a plan for the refusals, accommodate when the Resident preferred to get a shower and indicated they should adjust the time and day for the resident's preference.</p> <p>On 5/29/24, an interview was conducted with the Director of Nursing (DON) regarding concerns regarding nail care, shaving and bathing activities. The concerns were reviewed with the DON for Resident #16, 27 and 49. The DON reported that any Resident requesting a shower or ADL care should be receiving it and stated, We can give a shower on Sundays, (Resident #49) should have gotten her shower on Sunday.</p> <p>49944</p> <p>Resident #22</p> <p>R22 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include multiple sclerosis, paraplegia, major depressive disorder and contractures of the right and left knee. R22 has a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment.</p> <p>On 05/19/24 at 10:13 AM, R22 was observed laying in bed with food in their beard, dressed in a gown, body odor was present.</p> <p>On 05/19/24 at 10:18 AM, R22 stated that they would like to get out of bed and be in their wheelchair, but says the staff won't get them out of bed. R22 stated that they just want to get out of bed and go to the vending machine. When asked why staff won't get them out of bed, R22 states the staff always say they are going to find help to get them up and then never come back or they'll wait for the second or third shift to do it and first shift is the only one that will get them out of bed.</p> <p>On 05/20/24 at 08:41 AM, R22 was asked if they got out of bed the day before and they said no despite asking the staff multiple times. R22 was asked what the staffs response was when he asked to get up, R22 stated the staff said they would get help and come back. R22 stated the staff members never came back.</p> <p>On 05/20/24 at 10:47 AM, R22 was observed laying in bed, dressed in a gown and a strong odor of urine was present in the room.</p> <p>On 05/21/24 at 08:55 AM, R22 was observed again laying in bed wearing the same gown from the previous day. R22 stated that he did not get out of bed yesterday. R22 stated he asked the first shift staff multiple times and they never got him up</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/21/24 at 11:05 AM, an interview was conducted with wound nurse 'K' as they were exiting R22's room after completing wound care. Wound nurse 'K' was informed that R22 wants to get out of bed more often. Wound nurse 'K' stated they were unaware that staff was not getting R22 up. Wound nurse 'K' was asked if R22 needs assistance getting out of bed and they stated yes, R22 needs a hoyer lift to get out of bed. Wound nurse 'K' stated they are going to put in an order to ensure staff offer and try to get the resident up and out of bed.</p> <p>On 05/22/24 at 08:47 AM, R22 was observed laying in bed and eating breakfast. R22 stated they did not get out of bed yesterday.</p> <p>On 05/22/24 at 08:48 AM, an interview was conducted with CNA 'B'. CNA 'B' stated they are one of a few people that can get R22 to get out of bed. CNA 'B' states that today R22 is going to get out of bed. CNA 'B' was asked if R22 refuses to get out of bed. CNA 'B' stated that R22 has a tendency to vary if they want to get out of bed. CNA 'B' stated that sometimes R22 will wait until 2:55pm-2:59pm and then ask to get out of bed. CNA 'B' stated they tell R22 they will let the next shift know that they want to get out of bed.</p> <p>On 05/22/24 at 12:21 PM, observation revealed that R22 was still laying in his bed.</p> <p>A review of R22's care plans revealed that they require assistance of two staff members and a hoyer lift to transfer.</p> <p>Resident #101</p> <p>R101 is [AGE] years old and admitted to the facility 04/01/24 with diagnoses that include quadriplegia, pressure ulcer of sacral region and non-pressure chronic ulcer of right heel and midfoot. R101 has a BIMS score of 15 indicating they are cognitively intact.</p> <p>On 05/19/24 at 11:06 AM, R101 was observed positioned supine in bed and dressed in a gown. R101 stated they want to get out of bed but the staff says they need to get help and then they never come back. R101 was asked how often this happens. R101 stated it happens all the time.</p> <p>A review of R101's care plans revealed they require total assistance of two staff and a mechanical lift to transfer.</p> <p>On 05/20/24 at 10:35 AM, R101 was observed sleeping in bed and positioned supine.</p> <p>On 05/21/24 at 09:14 AM, R101 stated they haven't gotten out of bed in days. R101 was asked if they had asked the staff to get out of bed today. R101 stated that they asked the nursing staff to assist them to get out of bed and the staff say they don't have enough help. R101 was positioned supine in bed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/21/24 at 10:46 AM, an interview was conducted with wound nurse 'K'. Wound nurse 'K' was asked if the staff should be turning and repositioning R101 based on the wounds he has on his back. Wound nurse 'K' stated that the certified nursing assistants (CNA's) should be turning R101 every 2 hours, but they are not. This surveyor, wound nurse 'K' and R101 were all present in the residents room. R101 told wound nurse 'K' that they have asked to get up all week and last week too but no one ever helps them get out of bed. R101 was asked if they get assistance from the staff to turn and reposition in bed to offload pressure on their coccyx wound. R101 stated that the staff does not provide assistance to turn and reposition. R101 stated they spend a lot of time laying on their back. Wound nurse 'K' stated they would put an order in to ensure R101 is getting turned and out of bed daily or at least being offered to turn and get up.</p> <p>Record review of the policy titled Activities of Daily Living (ADL's), implemented 2/25/24, revealed:</p> <p>Care and services will be provided for the following activities of daily living:</p> <ol style="list-style-type: none"> 1. Bathing, dressing, grooming and oral care 2. Transfer and ambulation 3. Toileting 4. Eating to include meals and snacks; and 5. Using speech, language or other functional communication systems. <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review, the facility failed to ensure appropriate interventions were in place to prevent facility acquired pressure ulcers for 2 residents (#s 31 and 55) and interventions were utilized as ordered to promote prevention and healing for 3 resident (#31, #55 and #101) of 5 reviewed for skin and pressure ulcers, resulting in Resident's # 31 developing a pressure ulcer on his toe; Resident #55 developing multiple pressure ulcers and Resident #101 lacking positioning devices to aid in pressure ulcer prevention.</p> <p>Findings Include:</p> <p>Resident #31</p> <p>Pressure Ulcer/Injury</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #31 indicated admission to the facility on [DATE] with diagnoses: Diabetes, kidney disease, left ankle pressure ulcer Stage 3, spine disorder, depression, history of seizures, prostate enlargement, right leg amputation below the knee, hypertension, and anemia. The MDS assessment dated [DATE] revealed the resident had moderate cognitive decline with a Brief Interview for Mental Status (BIMS) score of 9/15 and needed some assistance with eating and hygiene and dependence with all other care.</p> <p>On 5/19/24 at 10:09 AM, Resident #31 was observed lying in bed watching TV. He was lying on his back and his feet were up against the foot board of the bed. He was wearing heel boots that covered his foot and left the toes open. Certified Nurse's Aide S entered the room and assisted to remove the resident's left sock. Resident #31's left foot great toe had a dark purple mushy area at the tip of the toe: above the toenail. The dark purple area was about 1.5 cm in length x 0.25 cm width. The resident was also noted to have an area above the left ankle; it was a dark purple/red oval area with dry skin around it and bright red skin on the outside. There was no dressing or treatment present on the ankle or toe areas.</p> <p>On 5/21/24 at 9:45 AM, the resident was observed lying in bed with his left foot up against the foot board of the bed. The heel boot was on. He said no one had looked at his left great toe dark purple area.</p> <p>A record review of a Skin sweep assessment dated [DATE] did not mention any skin issues.</p> <p>A record review of the physician orders for Resident #31 revealed the following:</p> <p>Ensure resident is wearing booties and left lower limb is pressure off-loaded, date revised and started 12/29/2023.</p> <p>Skin, pressure ulcer & wound treatment protocol- May follow facility protocol, date revised 12/12/2023 with no start date.</p> <p>There were no orders addressing the left outer ankle or left great toe.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the May 2024 Medication Administration Record/Treatment Administration Record (MAR/TAR) for Resident #31 revealed the following:</p> <p>Ensure resident is wearing booties, and left lower limb is pressure off-loaded. Every day and night shift for Wound care, start date 12/29/2023. The entry had a documentation line for days and nights for the nurse to initial and a line above each reading Beh.O. There was no explanation. On the dayshift between 5/1/2024 and 5/19/2024 the nurse charted Yes 19 times. On the night shift between 5/1/2024 and 5/18/2024 the nurse charted No 14 times, Yes 3 times and one day had no charting (5/11/2024 on the night shift). It was unclear whether the resident was wearing the heel boots.</p> <p>There was an entry on the May 2024 MAR/TAR for Resident #31 for wound care of the left lateral ankle: Left lateral ankle-Cleanse wound with normal saline, dry, apply betadine-soaked gauze dressing over wound, and cover with border foam gauze or kerlex gauze. Every day shift every Mon, Wed, Fri for wound care, start date 4/8/2024 and discontinue date 5/7/2024.</p> <p>A review of a provider wound note by Physician T revealed . EXT: Right BKA, decreased range of motion left leg. Left foot deformity .Wound: Location- Left lateral ankle proximal aspect-Type: Pressure stage III . resolved; Wound #2 . left lateral ankle distal aspect-Type: Pressure stage III . closed . Strongl recommend booties with wedge. Please monitor pressure off-loading booties meticulously. Please apply foam wedge or pillows to off-load pressure. Reposition frequently .</p> <p>On 5/22/24 at 8:45 AM, during an interview with Wound Physician T and Wound nurse K about Resident #31, the physician said the resident's ankle wounds were resolved. Physician T was asked about the dark purple area on Resident #31's left great toe and Physician T said he did not know about that, That's new. I will look at it.</p> <p>A physician wound note dated 5/22/2024 identified the following:</p> <p>Wound Care Consultation: . there is area of concern appreciated to the patient's right (it was the left) distal hallux (toe) . right BKA (below the knee amputation) . Wound base shows a partially attached thin dark brown eschar which was easily removed without discomfort to the patient. The wound base shows a beefy red granulation tissue without odor or exudate. Surrounding tissue is clear . Dimensions: 0.7 cm x 0.5 cm x0.0 cm . Please apply betadine soaked to wound surface and cover with Kerlix gauze dressing or border foam dressing. Change Monday, Wednesday and Friday (and as needed) . Please apply foam wedge or pillows to off-load pressure, reposition frequently. Nutritional support and hydration .</p> <p>A review of the Care Plans for Resident #31 revealed the following:</p> <p>I am at risk for Impaired skin integrity related to : incontinence, immobility, date initiated 12/12/2023 and revised 12/14/2023 with Interventions including: Inspect skin daily with care-Report any concerns to nurse, date initiated 12/14/2023.</p> <p>I have a Pressure Injury, Stage 3 developed in facility, date initiated 2/16/2024 and revised 3/31/2024. There was no mention of the left ankle wounds or the left great toe.</p> <p>Resident #55</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Pressure Ulcer/Injury</p> <p>On 5/19/24 at 12:04 , Resident #55 was observed lying in bed, awake. The resident said he was waiting for lunch. The resident was observed to have no water at the bedside, when asked about it he stated, Why don't they bring me water anymore. He had an empty clear cup on the bedside table.</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Multiple sclerosis, severe protein-calorie malnutrition, chronic osteomyelitis (bone infection), Stage 2 and Stage 4 pressure ulcers, unstageable pressure ulcer, sepsis infection, contracture unspecified joint, and underweight. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 13/15 and the resident needed assistance with eating and was dependent with all other care.</p> <p>On 5/20/24 at 11:06 AM, Resident #55 was observed lying in bed, He was asked if he had any wounds or pressure ulcers and he said he was not sure.</p> <p>A review of a hospital note dated 4/28/2024 indicated Resident #31 was admitted to the hospital on 4/24/2024 for altered mental status and sepsis (a whole body response to infection that can lead to organ failure and death) related to infected pressure ulcers. The resident was treated in the hospital with IV antibiotics and returned to the facility on [DATE].</p> <p>A review of a Wound note dated 5/15/2024 provided, Left hip unstageable: resolved; left buttocks unstageable resolved; right lateral foot resolved; left medial leg Pressure ulcer stage II- 8.0 cm (length) x 3.0 cm (width) ; Right foot dorsum 5.7 cm x 4.2 cm x 0.2 cm (depth): Pressure Stage III; right buttocks Pressure Stage III- 6.0 cm x 4.5 cm x0.2 cm; .</p> <p>On 5/22/24 at 8:39 AM, during an interview Wound nurse K and Wound physician T about Resident #55's wounds, the Wound physician said the resident had multiple wounds including the right dorsal foot stage 2, left lower leg medial stage 2 both pressure, right lower leg stage 3, sacrum stage 3, some were present on admission and some were facility acquired.</p> <p>A review of the physician orders for Resident #55 identified the following:</p> <p>Santyl (a debriding agent for dead skin tissue) external ointment 250 units/gm: apply to right dorsal foot . date revised 5/24/2024 and started 5/25/2024.</p> <p>Cleanse right heel with normal saline, pat dry apply maxorb wound dressing to surface, cover with ABD pad wrap with kerlix, every shift . start date 5/3/2024.</p> <p>Cleanse right dorsum foot, right lower leg, right ischium, right buttocks and left medial leg with normal saline, pat dry. Apply Santyl to wound surfaces and cover with normal saline moistened gauze. Cover with kerlix gauze dressing and or border foam. Change daily and (as needed), start date 5/21/2024.</p> <p>A review of the May 2024 MAR/TAR for Resident #55 revealed numerous instances when the nurses did not complete the physician ordered wound care for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Cleanse right heel with normal saline, pat dry apply maxorb wound dressing to surface, cover with ABD pad wrap with kerlix every shift for wound care- Do not use wound cleanser, start date 5/3/2024. There were 7 instances the wound care was not documented as completed.</p> <p>Cleanse right lateral foot with normal saline, pat dry apply maxorb wound dressing to surface, cover with ABD pad wrap with kerlix; every shift for wound care; cleanse right lateral foot with normal [NAME], pat dry apply maxorb wound dressing to surface cover with ABD pad wrap with kerli, start date 5/3/2024 and discontinue date 5/21/2024. There were 5 instances the wound care was not documented as completed.</p> <p>Cleanse right lateral malleolus (ankle) with normal saline, pat dry, apply xeroform dressing, cover with border foam or kerlix gauze every shift for wound care, start date 5/2/2024 and discontinue date 5/21/2024. There were 5 instances the wound care was not documented as completed.</p> <p>Santyl external ointment 250 unit/gm Apply to left buttock topically every shift for wound care cleanse left buttock with normal saline, pat dry and apply Santyl moistened gauze, apply border gauze, start date 5/3/2024 and discontinue date 5/21/2024. There were 5 instances the wound care was not documented as completed.</p> <p>Santyl external ointment 250 unit/gm: Apply to left medial leg topically every shift for wound care, start date 5/2/2024. There were 6 instance the wound care was not documented as completed.</p> <p>Santyl external ointment 250 unit/gm Apply to right dorsal foot topically every shift for wound care, cleanse right dorsal foot with normal saline, pat dry, apply Santyl saline moistened gauze to wound bed, secure with border foam dressing, start date 5/3/2024 and discontinued 5/24/2024. There were 6 instances the wound care was not documented as completed.</p> <p>A review of the Care Plans for Resident #55 identified the following:</p> <p>I have actual impairment to skin integrity related to pressure ulcer right heel, pressure ulcer left ischium, pressure ulcer to right hip, date initiated 11/12/2022 and revised 4/18/2024 with Interventions including: Follow facility protocols for treatment of injury, date initiated 11/12/2022. The skin care plans had not been updated with the resident's current condition and wounds.</p> <p>A review of the facility policy titled, Wound Treatment Management and Documentation, date implemented 8/11/06 and reviewed and revised 2/24 provided, To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders . Wound treatment will be provided in accordance with physician orders . Dressings will be applied in accordance with manufacturer recommendations . Treatments will be documented on the Treatment Administration Record . Wound assessments are documented upon admission, weekly, and as needed . Wound treatments are documented at the time of each treatment .</p> <p>49944</p> <p>Resident #101</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R101 is [AGE] years old and admitted to the facility 04/01/24 with diagnoses that include quadriplegia, pressure ulcer of sacral region and non-pressure chronic ulcer of right heel and midfoot. R101 has a BIMS score of 15 indicating they are cognitively intact.</p> <p>On 05/19/24 at 11:07 AM, R101 was asked about the pressure injuries they have. R101 stated that they had pressure injuries on admission to the facility and they believe the wounds have gotten worse in the facility. R101 was observed lying supine in bed and has pressure relieving boots on both feet. A wedge cushion for repositioning was observed sitting on the window sill.</p> <p>On 05/21/24 10:32 AM, R101's wound care was observed with the wound nurse 'K'. R101 was positioned supine upon entering the room, pressure relieving boots were in place and a wedge cushion was observed to be laying on the window sill.</p> <p>On 05/21/24 at 10:50 AM, an interview was conducted with the wound nurse 'K'. Wound nurse 'K' was asked if the staff should be using the wedge cushion that was sitting in the window sill to reposition the resident. Wound nurse 'K' stated yes, the staff should be placing the wedge cushion under R101 it will help his wounds heal. Wound nurse 'K' placed the wedge cushion under the left side of the resident upon the completion of the wound care.</p> <p>On 05/21/24 at 11:15 AM, record review of care plans revealed to assist R101 with repositioning with body pillows/support devices, protect bony prominences as allowed.</p> <p>On 05/22/24 at 08:51 AM, R101 was observed laying supine in bed, sleeping. Pressure relieving boots were in place and the wedge cushion was sitting in the window sill again.</p> <p>On 05/22/24 at 10:46 AM, wound care was observed with the wound nurse 'K' and the wound care physician. At the completion of the wound care, R101 was positioned supine in bed and staff exited the room. Wedge cushion was not placed under R101.</p> <p>On 05/28/24 at 10:33 AM, R101 was observed lying supine in bed, no pillows or devices for repositioning were observed, wedge cushion for repositioning was observed on the floor under the bed. R101 was asked how often the staff place the wedge cushion under him. R101 stated that the staff doesn't place it under them very often and that they were not having a great day and were in pain, surveyor asked R101 if they had notified the nurse and R101 said yes and the nurse was coming to help. Upon exiting the room this surveyor notified the nurse that the residents wedge cushion was under the bed.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review, the facility failed to identify and implement interventions, to address changes in Range of Motion/ROM for one resident (#31) of one reviewed for range of motion, resulting in Resident #31 developing limited movement in 4 fingers and his thumb on the right hand.</p> <p>Findings Include:</p> <p>Resident #31</p> <p>Position, Mobility</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #31 indicated admission to the facility on [DATE] with diagnoses: Diabetes, kidney disease, left ankle pressure ulcer Stage 3, spine disorder, depression, history of seizures, prostate enlargement, right leg amputation below the knee, hypertension, and anemia. The MDS assessment dated [DATE] revealed the resident had moderate cognitive decline with a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] and needed some assistance with eating and hygiene and dependence with all other care.</p> <p>On [DATE] at 10:17 AM Resident #31 was observed lying in bed watching TV. He showed his left hand; his fingers were curled under. He said he could partially uncurl them. He grabbed his left hand fingers with his right hand and slowly opened the left hand fingers. When he released the fingers, they closed towards the palm of his left hand. When asked if he had a brace or splint, or some type of device to aid in preventing the fingers from contracting, he said he did not. The resident was asked if he received any type of exercise program for his left hand and he said he did not, but he would like some.</p> <p>On [DATE] at 9:33 AM, Resident #31 was observed lying in bed watching TV. He showed his left hand and it continued with the fingers curled under. When he opened it with his right hand, it looked like a claw.</p> <p>A review of the physician orders for Resident #31 revealed orders for Physical Therapy/PT, and Occupational Therapy/OT x 12 weeks beginning [DATE]. It also identified BUE/BLE (bilateral upper extremity/bilateral lower extremity) PROM/AROM (passive range of motion/active range of motion as tolerated during self care tasks; FMP (Functional maintenance program): ,d+[DATE] x wee for 12 weeks, beginning [DATE]. (This order had ended on [DATE]).</p> <p>A review of the Care Plans for Resident #31 revealed the following:</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>I have an ADL (activities of daily living) Self Care Performance deficit related to: Metabolic encephalopathy, weakness, history of acute respiratory failure, GERD, hypertension, date initiated [DATE] and revised [DATE] with Interventions including: BUE/BLE PROM/AROM as tolerated during self care tasks, FMP: ,d+[DATE]x week for 12 weeks, date initiated [DATE]. This intervention was expired. There was no mention of the resident's impaired function of his left hand and no interventions mentioning it.</p> <p>On [DATE] at 8:45 AM, Therapy Manager P was interviewed about Resident #31's left hand. She was asked if the facility had a Restorative Nursing program and she said there was no Restorative Nursing program. She said the facility had a Functional Maintenance program. She said the staff caring for the resident were supposed to provide passive or active range of motion, with the resident during care. The therapist reviewed the resident's orders and therapy notes and said the resident received therapy from [DATE]-[DATE]. She said it was 3 times a week for 12 visits: both PT and OT. The Therapy Manager was asked about the resident's left hand contracture; she said she didn't think he had one. She said there was no word of a splint or brace, therapist said she would go see him now.</p> <p>On [DATE] at 9:45 AM, Nurse Q was interviewed while speaking with Resident #31. The resident showed his left hand; his fingers were curled under. He said no one provided exercises to his hand, not the aides or therapists. He said he would like something. Nurse Q said Resident #31 had trouble using his left hand.</p> <p>On [DATE] at 10:15 AM, the Therapy Manager provided a copy of the following note:</p> <p>Pt (patient) assessed for reported concern of contracture LUE. Pt upon assessment demo the following: . LUE (left upper extremity) digit WNL (within normal limits) for Flexion of digits with PROM and WNL for extension of digits with PROM (the resident could open and extend his left hand fingers when someone else assisted or the resident using his other hand assisted him) . Demo tightness at DIP (no explanation) with PROM .</p> <p>There was no plan to provide the resident with services to aid in restoring function to his left hand or preventing it from worsening.</p> <p>A review of the facility policy titled, Restorative Nursing Programs, date implemented ,d+[DATE] and reviewed/revised ,d+[DATE] provided, 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 .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>Based on observation, interview and record review, the facility failed to 1.) correctly document a fall timely and complete neurological monitoring for Resident #104, who had a fall with a head injury; 2.) ensure fall prevention interventions were in place for Resident #58; 3.) ensure supervision and safety interventions were in place for Resident #12, who went out of the facility to smoke; and 4.) ensure safe water temperatures, of four reviewed for accident and falls and one reviewed for smoking safety, resulting in the lack of documentation accuracy in the medical record and the potential for signs and symptoms of a head injury to not be detected or treated, falls to reoccur, injury, burns and pain.</p> <p>Findings include:</p> <p>Resident #104</p> <p>A review of Resident #104's medical record revealed an admission into the facility on [DATE] with diagnoses that included heart disease, chronic obstructive pulmonary disease, diabetes, bipolar disorder, and need for assistance with personal care. A review of Resident #104's MDS revealed a BIMS score of 12/15 that indicated moderately impaired cognition and the Resident needed maximal assistance with toileting hygiene, mobility and transfers.</p> <p>On 5/19/24 at 12:19 PM, an observation was made of Resident #104 in their room in bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about falls and he had reported having multiple falls and that he had fallen out of bed three of four weeks ago, and reported it took two or three hours before they came and got me.</p> <p>A review of Resident #104's medical record revealed the following:</p> <p>-Type: eInteract SBAR Summary for Providers with an effective date 5/12/24 at 4:30 AM, created by Nurse - with a Created Date: 5/14/24 at 12:11 PM. The progress note revealed the Resident had a fall on 5/12/24, Skin Evaluation: Bruise under right eye, and name of family/health care agent notified: Attempted to call guardian without success. Listed phone number is out of service Date: 5/12/24 Time: 4:30 AM. The SBAR progress note and SBAR Summary was documented two days after the fall documented on 5/12/24.</p> <p>-Dated 5/13/2024 at 8:08 AM, Nursing Progress Note: Note Text: Resident was heard yelling out help from hallway. CNA (Certified Nursing Assistant) entered room and the resident was observed on the floor face down, lying on his stomach in a prone position. He had a small dark red bruise noted underneath his right eye, nearest cheek. I want to ask what he was doing prior to the fall, he stated I was adjusting my position and before I knew it I slid to the floor. Otherwise no injuries noted. Neurochecks initiated per protocol. DON (Director of Nursing), administrator, and NP (Nurse Practitioner, Name) notified of eyewitness fault (unwitnessed fall). Will continue to monitor.</p> <p>-Type: Nursing: Antigravity Team Note, effective date 5/15/24 at 11:35 AM, revealed date of fall on 5/12/24 with a new intervention: floor mat.</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 - Some</p>	<p>A review of the facility Incident and Accident report revealed a fall on 5/12/24 at 4:30 AM with a Nursing Description:</p> <p>- Resident was heard yelling out help in the hallway by CNA. Upon entering the room, resident was observed on the floor on his stomach in a prone position. He sustained a small bruise underneath his right eye. He stated that he was trying to change his position in bed, and started slipping out of the bed. HX (history) of CVA (stroke) with residual, ROM (range of motion) x4 extremities performed, no complaints of pain and ROM within normal limits. Neurochecks were initiated per protocol. Resident was transferred back into bed via Hoyer lift. DON, administrator, and nurse practitioner notified. Will pass on in shift report and continue to monitor.</p> <p>A review of Resident #104's Neurological Assessment Flow Sheet revealed neuro checks dated 5/13/24 at 4:30 AM. The documentation revealed directive For head injury or unwitnessed fall complete neuro checks: q (every) 15 (minutes) x (times) 4, q30 x4, q2 hrs (hours) x 4 hours, q shift x2 days, q day x2 days. The Neurological Assessment Flow Sheet was not filled out for the monitoring for two 2 hour checks, the midnight shift and the day shift monitoring. This left a lack of neurological monitoring from the last check on 5/13/24 at 7:30 AM to 5/15/24 at 12:00 AM.</p> <p>On 5/28/24 at 2:49 PM, an interview was conducted with Unit Manager, Nurse I regarding Resident #104's fall. The discrepancy in the documentation of the fall. The Unit Manager was asked about the late entry done on 5/14/24 that documented the fall on 5/12/24 and the progress note dated 5/13/24. The Unit Manager indicated that facility policy was to document the fall as soon as able and before leaving the shift and reported that the Nurse had not documented at the time of the fall or directly after the fall. The neurological monitoring was started on 5/13/24 not 5/12/24. The Unit Manager attempted to call the Nurse but was not answered. The Unit Manager indicated she would follow up and find out what day the fall had actually happened. The Neurological Assessment Flow Sheet was reviewed, and the Unit Manager indicated that the assessments were to be completed and staff had not completed the monitoring on Resident #104 after the fall with bruising to his face.</p> <p>On 5/29/24 at 10:51 AM, Unit Manager, Nurse I reported that Resident #104's fall had occurred on 5/13/24 not 5/12/24. When asked about the documentation of the Incident and Accident report of the Agencies/People Notified with the Legal Guardian not notified until 5/15/24 at 11:34 AM, Physician notified on 5/12/24 at 4:30 AM, Administrator at 5/12/24 at 4:30 AM and DON at 5/12/24 at 4:16 AM, the Unit Manager did not have an answer except that the SBAR should have been filled out after the fall occurred, not on 5/14/24. The Unit Manager reported contacting the Legal Guardian on 5/15/24 and reported she will call when they have not been called and/or do a follow-up phone call with the responsible party.</p> <p>22348</p> <p>Resident #12</p> <p>Accidents</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 - Some</p>	<p>05/28/24 11:20 AM, the surveyor observed a group of smokers smoking at the gazebo. There were 15 residents at the Peaceful Garden where residents were designated to smoke outside the facility. Three staff members were outside, RN U, CNAV, and CNA W, overlooking the 15 smokers. R12 was among the 15 residents. The CNA lighted his cigarette, and R12, while smoking, was observed with an apparent left-sided weakness. R12 was not wearing an apron, and the nearest staff member was approximately 12 steps away from R12. When queried, CNA V' stated they did not have the list of unsafe smokers with them and would not be able to know who were the safe and unsafe smokers from the group. The surveyor asked if she knew R12's smoking status. CNA W revealed that R12 was an unsafe smoker. However, she indicated that she forgot about putting on their aprons for unsafe smokers. The list and the aprons were stored behind the reception desk. RN U revealed that she was not assigned to watch the smoker and had no idea who the safe smokers were and who needed supervision.</p> <p>The Director of Nursing (DON), 05/28/24 11:32 AM, was queried about the staff's responsibilities if assigned to watch the smokers. The DON explained that the policy is to ensure safety for the identified unsafe smokers, and that means to make sure they wear their aprons if they are care planned as unsafe smokers.</p> <p>On 5/28/24 at 12:30 PM, R12's Electronic Medical Record (EMR) revealed that he was admitted on [DATE] with a diagnosis of Aphasia secondary to Cerebral Infarction, Hemiparesis, and Hemiplegia affecting the dominant left side and Dementia in addition to other diagnoses. The Brief Interview for Mental Status (BIMS) Score dated 5/21/24 assessment was four. A score of zero to seven indicates the person is severely impaired. R12's Determination of Decision-Making Ability, signed on 2/15/2024 by the attending physician and psychologist, determined that R12 was NOT able to make decisions to participate in medical treatment decisions and handle his own financial affairs.</p> <p>A review of R12's Care Plan date created on 12/19/2019 revealed:</p> <p>.Focus: I am a supervised smoker.</p> <p>Interventions:</p> <ol style="list-style-type: none"> 1. I wear a smoking apron. 2. Instruct (Resident's name) about smoking risks and hazards and about smoking cessation aids that are available. 3. Smoking assessment per facility policy. 4. The resident requires SUPERVISION while smoking. <p>The facility's Smoking Policy dated 06/2023 was reviewed on 5/22/24. It was noted:</p> <p>This facility provides a safe and healthy environment for residents, visitors, and employees, including smoking-related safety. Safety protections apply to smoking and non-smoking residents. Policy Explanation and Compliance Guidelines:</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 - Some</p>	<p>. 6. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan .</p> <p>Resident #58</p> <p>Accidents</p> <p>On 05/22/24 at 12:15 PM, R58 was observed in his room on the ground with his face on the floor, torso on the floor mat, and his hips and bilateral post-amputated legs positioned on top of the bed. R58 was wearing a gown with only an incontinence pad and no pants. The privacy curtain was not drawn, and R58 was exposed as you entered his room. He was incontinent and soiled with bowel and urine at the time of the observation.</p> <p>On 5/22/24 at 1:30 PM, a review of the record for R58 revealed he was not interviewable with a Brief Interview Mental Status (BIMS) Score of 01 on 2/01/2024. A BIMS score of zero to seven points suggests severe cognitive impairment. R58 was admitted to the facility with a primary diagnosis of Type 2 Diabetes with Hyperglycemia, Paraplegia, Hepatitis C, and Polyneuropathy in addition to other diagnoses. R58's Minimum Data Set, dated dated [DATE] assessment revealed that R58 was always incontinent with bowel and bladder elimination patterns, always dependent on lower body dressing, showers, and personal hygiene.</p> <p>The assigned Certified Nurses Aide (CNA R) was interviewed on 5/22/24 at 12:19 PM. CNA R indicated that he went to lunch at 11:40 PM and recalled that the last time he cared for R58 was before 11:00 AM. R58 was lying on his bed. CNA R revealed he did not have another staff member assigned to take his place when he left for lunch.</p> <p>The incident report (I/A) was reviewed on 5/27/24 at 12:00 PM. The I/A noted that on 05/22/2024 at 12:00 PM. Staff informed resident was On the floor, in his room. Upon entering his room, the nurse observed the resident lying on his stomach on his bed with his head resting on the floor mat next to the bed. Resident awake & alert, moving all extremities without S/S of pain. PROM without S/S of pain or discomfort. Resident lifted to bed via Hoyer lift, & several staff members. R58's Care Plan was reviewed on 5/27/24 at 12:05 PM and revealed that it was not updated based on the recent fall on 5/22/24.</p> <p>On 5/22/24 at 11:55 AM, Nurse RW stated that R58's CNA was on the smoker's duty at 11:00 AM and then went for lunch. Nurse RW revealed that R58 was found soiled, there was no staff to keep an eye on him, and he was unsure when he was last checked or changed.</p> <p>On 5/22/24 at 12:05 PM, the nurse manager revealed that she had gone down to the laundry room to find a clean Hoyer lift sling, which was why getting him off the floor and back to his bed took longer. The nurse manager explained that R58 required a mechanical lift for safe transfers, and they did not have the sling readily available anywhere, so she had to find them on all floors.</p> <p>On 5/27/24 at 12:00 PM, a review of the Facility's Incident Report dated 5/22/24 was conducted. The incident report reflected:</p> <p>.Date of Fall: 5/22/24</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 - Some</p>	<p>Root Cause(s) of Fall: Resident was soiled and requires assistance.</p> <p>Prior Interventions:</p> <p>Fall mat placed on the left side of bed for extra safety.</p> <p>I have been provided with a calendar of scheduled activities and will be notified of any changes.</p> <p>I have been provided with the facility wifi.</p> <p>I require set up assistance with some activity task.</p> <p>I will be invited and encouraged to participate in activities for social stimulation.</p> <p>Resident to be offered sensory activities such as aroma therapy, music, and food activities.</p> <p>New Interventions: Check and change me frequently.</p> <p>The Facility Fall Reduction Policy, dated 04/2023, was reviewed on 5/27/2024 at 12:15 PM. It clearly noted:</p> <p>a. Interventions will be monitored for effectiveness.</p> <p>b. The plan of care will be revised as needed.</p> <p>4. When any resident experiences a fall, the facility will:</p> <p>a. Assess the resident.</p> <p>b. Complete a Post-Fall Assessment.</p> <p>c. Complete a Risk Management Incident Report.</p> <p>d. Notify the physician and responsible party.</p> <p>e. Review the event as an interdisciplinary team.</p> <p>f. Implement (or revise) new fall prevention intervention(s) .</p> <p>39083</p> <p>On 5/20/24 at 2:00 PM, the water temperature of the hand sink in room [ROOM NUMBER] was observed to be 126 degrees F, measured by a digital probe thermometer. At this time, Maintenance Director CC was made aware of the finding. The boiler system set point, located on the roof, was found to be heating water to 125.6 degrees. No mixing valve was observed within the system to temper down the water temperature. Maintenance Director CC proceeded to adjust the boiler set point to 120 degrees.</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 - Some</p>	<p>On 5/22/24 at 3:54 PM, the water temperature of the hand sink in room [ROOM NUMBER] was observed to be 125 degrees F, measured by a digital probe thermometer. At this time, the boiler set point was back to 125 degrees F. Maintenance Director CC stated that the temperature jumps up and that it hasn't been adjusted by anyone.</p> <p>During an interview on 5/22/24 at 4:26 PM, The Administrator was made aware of the hot water findings and stated they will call a boiler company to inspect the boiler system. The Administrator continued to say they will audit all the rooms for resident safety.</p> <p>A review of the facility's Hot Water Temperature Log, dated 2024, it notes five entries (4-22, 121 degrees; 4-29, 120 degrees; 5-6, 120 degrees; 5-13, 120 degrees; 5-20, 120 degrees) with no designation of room number or corrective action for temperatures exceeding 120 degrees. Additionally, the log is noted to be a dietary policy with the following instructions, Instructions: -Take temperature of hot water directly from the tap at the pot wash sink. - Hot tap water must be 120[degrees]F or above at all times ., contradicting the requirements of safe water temperatures for residents.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944</p> <p>Based on observation, interview and record review the facility failed to assess and maintain an indwelling urinary catheter for three residents (#30, #41, #55) of three residents reviewed for indwelling catheters, resulting in unmet care needs, missing dignity bags and the potential for infection. Findings include:</p> <p>Resident #41</p> <p>Record review revealed that R41 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, chronic kidney disease, peripheral vascular disease and type 2 diabetes.</p> <p>On 05/20/24 at 11:24 AM, observation revealed that R41 had an indwelling catheter, the catheter bag was uncovered and full of urine. R41 was asked about the indwelling catheter and how long they had it in for. R41 would not respond to the surveyor.</p> <p>On 05/20/24 at 04:09 PM, record review revealed no physicians order, no care plan, no justification and no certified nursing assistant (CNA) tasks in the electronic health record (EHR) for the indwelling catheter.</p> <p>On 05/21/24 at 09:50 AM, observation revealed R41's catheter bag was uncovered and there was urine present in it.</p> <p>On 05/21/24 09:56 AM, an interview was conducted with Licensed Practical Nurse (LPN) 'L' about the indwelling catheter that R41 has in place. LPN 'L' was asked if they knew why R41 had an indwelling catheter and if there was a diagnosis, order or a care plan for the catheter. LPN 'L' stated they believe R41 had some issues with urinary retention but they weren't completely sure of that. LPN 'L' could not locate an order, diagnosis or care plan in the EHR. LPN 'L' was asked if there should be an order, diagnosis and care plan in the EHR for R41's indwelling catheter. LPN 'L' stated yes, all of that should be in the EHR and said they would take care of the missing items in the EHR. LPN 'L' was asked how would the CNA's know to provide catheter care if there isn't a task for them in the EHR. LPN 'L' stated CNA's would see the task on their point of care (POC) charting after the care plan is created. LPN 'L' was unable to locate a task for the CNA's to provide catheter care.</p> <p>Record review revealed a progress note dated 4/26/24 from the nurse practitioner. The progress note indicated that R41 is being seen for a follow up after being hospitalized recently with a urinary tract infection (UTI) and the note indicates that R41 has an indwelling catheter present.</p> <p>Record review revealed that a physicians order for the indwelling catheter and indwelling catheter care was entered in the EHR on 5/21/24.</p> <p>37666</p> <p>Resident #55</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>Urinary Catheter or UTI</p> <p>On 5/19/24 at 12:04 , Resident #55 was observed lying in bed, awake. The resident said he was waiting for lunch. The resident was observed to have no water at the bedside, when asked about it he stated, Why don't they bring me water anymore. He had an empty clear cup on the bedside table. The resident said he had a catheter. A urinary catheter (foley) was observed foley lying on its side in a basin on the floor. The urine was dark orange to red in the catheter bag and tubing; the urine was not flowing freely.</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Multiple sclerosis, severe protein-calorie malnutrition, chronic osteomyelitis (bone infection), Stage 2 and Stage 4 pressure ulcers, unstageable pressure ulcer, sepsis infection, contracture unspecified joint, and underweight. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 13/15 and the resident needed assistance with eating and was dependent with all other care.</p> <p>On 5/19/2024 at 12:35 PM, the Director of Nursing was interviewed about Resident #55's catheter lying flat on its side in a basin, preventing it from flowing freely. He said he would look into it, but it should not be lying flat.</p> <p>A review of the physician orders for Resident #55 identified the following:</p> <p>Indwelling catheter 16 fr with 10 cc balloon to bedside drainage: every shift, date revised 5/21/2024 and started 5/21/2024.</p> <p>Monitor for potential complications of indwelling urinary catheter use such as redness, irritation, signs/symptoms of infection obstruction, urethral erosion, bladder spasms, hematuria (blood in urine), or leakage around the catheter, date revised 5/21/2024 and started 5/21/2024.</p> <p>A review of the Medication Administration Record/MAR for May 2024 revealed there was no documentation of monitoring or maintenance of the urinary catheter until 5/21/2024.</p> <p>A review of the Care Plans for Resident #55 identified the following:</p> <p>I have an indwelling catheter related to aggressive wound care management to my buttocks and hip area, date initiated 5/7/2024 and revised 5/7/2024, with Interventions including: Position catheter bag and tubing below the level of the bladder and covered for dignity, date initiated 12/29/2023; Check catheter tubing for kinks throughout the shift, date initiated 12/29/2023. There was no mention of not laying the catheter flat on it's side or monitoring for discoloration of the urine in the tubing or bag.</p> <p>A review of the facility policy titled, Care and removal of an indwelling catheter, dated 2017 provided, In an indwelling catheter is in place, ongoing monitoring for signs of UTI (urinary tract infection) and proper cleansing of the external portion of the catheter and the patient's perineum are necessary to reduce the risk of infection. The maintenance of a closed drainage system is also essential .</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>22348</p> <p>Resident #30 (R30)</p> <p>Suprapubic Catheter or UTI</p> <p>Resident #30, on 5/20/24 at 12:52 PM, was observed with a suprapubic catheter attached to a urinary tubing that has a drainage bag. The drainage bag was not secured in a dignity bag. The drainage bag showed yellowish-colored urine, and whitish and cloudy sediments were observed in the tubing. Although R30 did not have complaints of pain, discomfort, or signs of infection, R30 stated that he had urinary Tract Infections (UTI) before but not recently. The surveyor noticed a new urinary drainage bag and tubing on the bed and sheets. When R30 was asked when and how often his urinary bag and tubing were changed, he indicated that he could not recall but said, Maybe once a month.</p> <p>R30 was [AGE] years old and admitted to the facility on [DATE] with the diagnosis of Paraplegia, Hepatitis C, Chronic Pain Syndrome, Stage III pressure Ulcer of the sacrum, and Protein-calorie malnutrition in addition to other diagnoses. He is alert and oriented with a Brief Interview for Mental Status score of 15/15. A score of suggests the resident is cognitively intact.</p> <p>A request for records related to any recent urinary or blood test from the laboratory that may indicate an infection or no infection was not received from the Director of Nursing at the date and time of exit.</p> <p>R30's care plan for Suprapubic Catheter dated 1/18/24 was reviewed. No updates on interventions were noted. Recent progress notes dated 5/01/24 to 5/22/24 did not reflect any observations or notes about the whitish, cloudy sediments in the catheter tubing. No laboratory testing was ordered for potential UTIs.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review the facility failed to ensure interventions were enacted to promote nutrition and prevent weight loss for two residents (# 30 and #70) and provide hydration for one resident (#55), of 7 reviewed for food, nutrition, and hydration, resulting in Resident # 30 developing significant weight loss, #70 developing weight loss and Resident #55 lacking access to fresh water, which could lead to a decline in condition and a decreased quality of life.</p> <p>Findings Include:</p> <p>Resident #55</p> <p>Hydration</p> <p>On 5/19/24 at 12:04 , Resident #55 was observed lying in bed, awake. The resident said he was waiting for lunch. The resident was observed to have no water at the bedside, when asked about it he stated, Why don't they bring me water anymore. He had an empty clear cup on the bedside table.</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Multiple sclerosis, severe protein-calorie malnutrition, chronic osteomyelitis (bone infection), Stage 2 and Stage 4 pressure ulcers, unstageable pressure ulcer, sepsis infection, contracture unspecified joint, and underweight. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 13/15 and the resident needed assistance with eating and was dependent with all other care.</p> <p>A Nutritional Assessment, dated 5/8/2024 for Resident #55 revealed the resident received a regular diet, nutritional supplements Proheal and Medpass; needed set up assistance with meals Extensive 1-person assist/fed by staff. Must be at 30 degree angle while eating; appetite was 25-50% of meals; preferred beverage was water; noted to have pressure ulcers; I have the potential for a nutritional/hydration problem . My Nutrition goal, while I am here, is to tolerate my diet & consume at least ~50% of my meals .</p> <p>A review of the Care Plans for Resident #55 identified the following:</p> <p>I have the potential for a nutritional/hydration problem related to: osteomyelitis ankle and foot, Multiple Sclerosis, diabetes ., date initiated 5/8/2024 with Interventions including: Monitor me for signs and symptoms of poor hydration, date initiated 10/7/2022; Document my daily food acceptance, date initiated 10/7/2022; My preferred beverage between meals is water, date initiated 9/27/2023;</p> <p>On 5/28/24 at 9:52 AM, during a tour of the facility, Resident #55 was observed to have no water at the bedside.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/28/24 at 9:55 AM, the Director of Nursing/DON was interviewed about the residents on the 400 hall, including Resident #55 not receiving routine water passes. The DON approached both nurse aides on the 400 hall and asked them to please begin a water pass and provide water to the residents. The DON was asked if the staff were to routinely provide water for the residents and he said they were supposed to.</p> <p>A review of the facility policy titled, Hydration, date reviewed/ revised 1/21 provided, The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health .</p> <p>22348</p> <p>Resident #30 (R30)</p> <p>During the record review conducted on 05/22/24 at 11:32 AM, it revealed that R30, On 04/19/2024, weighed 118 lbs. On 05/18/2024, the R30 weighed 110 pounds. This indicated that there is a recorded 6.78 % weight loss.</p> <p>R30 was [AGE] years old, admitted to the facility on [DATE] with the diagnosis of Paraplegia, Hepatitis C, Chronic Pain Syndrome, Stage III pressure Ulcer of the sacrum, and Protein-calorie malnutrition in addition to other diagnoses. He is alert and oriented with a Brief Interview for Mental Status BIMS score of 15/15. A score of suggests the resident is cognitively intact.</p> <p>An interview with R30 was conducted on 05/22/24 at 11:43 AM. R30 revealed that he does not eat that much and lost weight since he had an infection. R30 could not recall the date of infection but claimed it was just recently, sometime this year.</p> <p>According to the medical director, (MDA), during an interview on 05/22/24 at 02:01 PM, MD A reviewed R30's chart and indicated that R30 is stable. MD A also explained the notification process of abnormal findings to each resident through the nurse practitioner, who updates, does assessments, and makes recommendations. The MD A was queried regarding the recorded five percent (5%) significant weight loss. MD stated he was not made aware.</p> <p>R30's Care Plan for the potential for a nutritional/hydration problem dated 1/11/24, as reviewed on 5/2021 at 10:30 AM. One of the interventions was:</p> <p>Report any significant weight changes I have to my physician and Me/DPOA/Guardian. Date Initiated: 01/11/2024 Created by: (Dietician)</p> <p>No further updates and revisions were noted.</p> <p>According to the Regional Dietician on 5/22/24 at 11:00 AM. A significant weight loss of 5% or more when triggered would mean that the department would evaluate and make changes to the plan of care. The RD stated he received no referral and has not evaluated R30.</p> <p>Resident #70 (R70)</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R70, during the tour observation and interview on 5/20/24 at 09:47 AM, complained about the food served being cold and not hot when it was supposed to be. R70 indicated that an example was potpie, which was still cold in the middle but warm on the sides. The food is always cold and never cold. When queried, R70 denied wanting a desired weight loss.</p> <p>A record review of R70 revealed that R70, on 04/25/24, weighed 281 pounds (lbs). On 05/18/2024, the R70 weighed 270.0 pounds. This indicated a 7.41 percent (%) weight loss in less than four weeks.</p> <p>R70 was admitted to the facility on [DATE] with a diagnosis of unspecified foreign body in the respiratory tract, urinary tract infection, type 2 diabetes, hemiplegia, and hemiparesis following cerebral infarction affecting left non-dominant side in addition to other diagnoses.</p> <p>A nutritional assessment and a nutritional care plan dated 5/11/24 for the potential for a nutritional/hydration problem were conducted. No updates were noted for the significant 7.41 % weight loss dated 5/18/24.</p> <p>An interview with the Regional Dietician AA was conducted on 05/22/24 at 11:00 AM. RD revealed that any significant weight loss is triggered in the system, for example, a significant change of 5% in 1 month. When it is triggered, the RD assesses and talks to the resident. RD stated he was not referred despite a 7.41 % weight loss. No referral was received.</p> <p>The facility's Weight Monitoring Policy with the revised date of 1/2024 was reviewed on 5/22/24 at 11:30 AM. The policy noted:</p> <p>. Policy: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Compliance Guidelines: Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem.</p> <p>. 6. Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight to determine if a re-weight is necessary. 7. A significant change in weight is defined as: a. 5% change in weight in 1 month (30 days) b. 7.5% change in weight in 3 months (90 days) c. 10% change in weight in 6 months (180 days).</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review, the facility failed to ensure 1. Enteral nutrition (tube feeding/nutrition through a feeding tube into the stomach or intestines) was provided as ordered for Resident #46; 2. the feeding tube was managed and documentation provided per standards of care for 1 resident # (62); and 3. Enteral feeding equipment was properly labeled for Resident #62, resulting in Resident #46 receiving the wrong dose of Enteral feeding, Resident's #62 lacking documentation of care of the Enteral feeding and Resident #62 had unlabeled/dated equipment that could lead to infection.</p> <p>Findings Include:</p> <p>Resident #46</p> <p>Tube Feeding</p> <p>A review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #46 indicated the resident was readmitted to the facility on [DATE] and again on 8/16/2023 with diagnoses: history of a stroke, dysphagia, irritable bowel syndrome, epilepsy, dementia, depression, hypertension diabetes, atrial fibrillation, bipolar disorder, COPD, gastrostomy tube/feeding tube, asthma, chronic pain, acquired absence of left leg below knee, GERD and heart disease. The MDS assessment dated [DATE] indicated the resident had moderate cognitive loss with a Brief Interview for Mental Status (BIMS) score of 11/15 and the resident needed assistance with all care.</p> <p>During a tour of the facility on 5/19/24 at 11:34 AM, Resident #46 was observed lying in bed, awake. He was observed to have an IV pole with a tube feeding pump and a bottle of enteral/tube feeding hanging on the pole. The bottle of enteral feeding was labeled Glucerna 1.5 and was dated 5/19/24 at 0600 (6:00 AM). The rate to be administered was written on the bottle label as 70 ml/hr. The tube feeding pump was set at 85 ml/hr with 1829 ml infused and a water flush of 65 ml every hour and 1301 ml infused.</p> <p>On 5/20/24 at 10:04 AM, Resident #46 was observed sleeping in bed. The tube feeding was running and the bottle of Glucerna 1.5 was labeled to be given at 80 ml/hr. The tube feeding pump was set at 85 ml/hr.</p> <p>A review of the physician orders on 5/20/2024 indicated the following: Enteral feed: in the evening, Glucerna 1.5 @ 70 ml/hr x 20 hr= 1400 ml (2100 kcal); up @ 5 pm until dose complete. Auto flush (with water) 45 ml/hr x 20 hr = 900 ml/H2O (water); up @ 5pm until dose complete, dated revised 5/13/2024 and start date 5/13/2024.</p> <p>On 5/21/24 at 8:59 AM, Resident #46 was observed sleeping in bed. The enteral feeding Glucerna 1.5 was running via pump at 85 m/hr.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/22/24 at 8:40 AM, Unit Manager I was observed outside Resident #46's room, she came into the resident's room with the surveyor and looked at the tube feeding, settings and pump. She confirmed the tube feeding pump was running at 85 ml/hr and the tube feeding bottle said 85 ml hr. Nurse O was assigned to care for the resident that day and she went to her medication cart and showed the Medication Administration Record/MAR entry for Resident #46 on the computer; it said Glucerna 1.5 at 70 ml hr, she said it was running at the wrong dose and should be 70 ml hr not 85 ml hr. She said the tube feeding goes up (is started) at 5:00 pm and is supposed to be finished by 1:00 PM each day. A review of the MAR with Nurse O identified an entry for the tube feeding to be documented at 5:00 PM each day, beginning 5/13/2024 and no one had documented on it.</p> <p>On 5/22/24 11:45 AM , Registered Dietitian J was interviewed about Resident #46's enteral feeding. He said the order was updated on 5/13/2024 for Glucerna 1.5 to run at 70 ml/hr with a 65 ml/hr water flush. He was asked if he was aware that the Nurses were administering the Glucerna at 85 ml/hr and he said he was not aware of that. He said he was usually in the building two days a week and if there was a problem they could also contact him.</p> <p>A review of the Care Plans for Resident #46 identified the following:</p> <p>I have the potential for a nutrition/hydration problem . date initiated 9/28/2021 and revised 5/13/2024 with Interventions including: Provide TF (tube feeding) and water flushes per order, date initiated 8/17/2023.</p> <p>I am unable to meet nutritional needs by mouth as evidenced by: dysphagia (difficulty swallowing), need for tube feeding . date initiated 11/14/2022 and revised 8/17/2023 with Interventions including: Administer tube feeding as ordered, date initiated 5/21/2024.</p> <p>A review of the facility policy titled, Enteral tube Medication Administration, dated revised January 2018 provided, The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes .</p> <p>37771</p> <p>Resident #62</p> <p>A review of Resident #62's medical record revealed an admission into the facility on [DATE] and readmission on 5/2/24 with diagnoses that included Parkinson's disease, acute respiratory failure, tracheostomy status, diabetes, muscle weakness and gastrostomy. A review of the Resident's Minimum Data Set assessment revealed a BIMS score of 14/15 that indicated intact cognition and was dependent for self-care that included bathing, dressing, and using the toilet. The Resident had a tracheostomy tube (a curved tube placed through a surgical opening through the neck into the trachea (windpipe)) and PEG tube (Percutaneous Endoscopic Gastrostomy tube-a tube surgically placed through the abdominal wall and into the stomach to administer enteral nutrition, fluids and/or medication).</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/19/24 at 11:10 AM, an observation was made of Resident #62 lying in bed, awake. The Resident had a tracheostomy but was able to answer questions during interview. An observation was made of the Residents tracheostomy tube and dressing that was partially not in place around the stoma and trach tube. The Resident had a cart next to the bed that had drawers with supplies and supplies on top of the cart with oxygen machine, suction machine. The Resident had a tube feeding that was hanging and a label was not found on the bottle of enteral nutrition and the tubing of the administration set was not labeled with a date that it was started. The partially used enteral nutrition was turned off and the end of the tubing was draped over the machine and not capped with tube feeding solution noted on the machine and pole. The feeding pump was dirty with dried tube feeding that had turned brown. There was a yanker suction or oral suctioning that was open, had been used and not dated with an open date. The tube feeding syringe and canister on the overbed table was not labeled with a date of when the equipment was opened and another syringe that was not dated was on top of the equipment cart.</p> <p>On 5/19/24 at 2:25 PM, an observation was made of Resident #62's room with the Director of Nursing (DON) and Nurse L. The enteral nutrition hanging was reviewed, the DON and Nurse took down the tube feeding and there was a sticker on the nutrition bottle. The DON indicated the tubing set should be dated. The date on the tube feeding was 5/17/24. When queried if the solution was only good for 24 hours, the Nurse indicated that the Resident had been refusing his tube feeding due to eating his meals. The DON indicated it should have been taken down. The DON threw out the syringes and canister that were not dated.</p> <p>On 5/21/24 at 1:27 PM, a record review of Resident #62's Medication Administration Record and Treatment Administration Record revealed an order Enteral Feed Order every shift for nutrition Glucerna 1.5 at 60 CC/hr per g-tube with a start date on 5/3/24 that was documented on 5/3/24 on the 7am-7pm shift. There was no other documentation of the when the enteral tube feeding was administered, taken down, or refused by the Resident. The progress notes lacked documentation of the Resident refusing the tube feeding or that the practitioner was notified.</p> <p>On 5/21/24 at 2:01 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #62's lack of documentation of when the tube feeding had been administered or when the Resident had refused the tube feeding. There was no documentation found of how much tube feeding the Resident had received or when he had refused it. The DON reported there should be documentation that it was getting hung or when the resident refused and stated, No, there is none (documentation). The DON indicated that the enteral feeding and tubing should be dated and was good for 24 hours and that the syringe should be dated and discarded daily.</p> <p>On 5/22/24 at 11:46 AM, an observation was made of Resident #62 lying in bed with the head of the bed elevated. The tube feeding was infusing at 70 milliliters per hour on the controller that was clean. The Glucerna enteral nutrition was dated and the tubing set was dated. The syringe and graduated container was not dated with a date and time of when it had been opened.</p> <p>A review of facility policy titled, Care and Treatment of Feeding Tubes, reviewed/ revised 6/23, revealed, Policy: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . b. Disposable equipment to be replaced daily .</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>Based on observation, interview and record review, the facility failed to ensure 1.) emergency tracheostomy equipment was readily available at the Resident's bedside, ensure tracheostomy equipment was properly dated and oxygen humidification and tracheostomy equipment was discarded timely for Resident #62 and 2.) nebulizer equipment was stored in a sanitary manner for Resident #33, of four reviewed for tracheostomy and respiratory care, resulting in tracheostomy cannula not readily available for emergent use for decannulation and the potential for respiratory distress, exposure to infectious organisms, and respiratory infections.</p> <p>Findings include:</p> <p>Resident #62</p> <p>A review of Resident #62's medical record revealed an admission into the facility on [DATE] and readmission on 5/2/24 with diagnoses that included Parkinson's disease, acute respiratory failure, tracheostomy status, diabetes, muscle weakness and gastrostomy. A review of the Resident's Minimum Data Set assessment revealed a BIMS score of 14/15 that indicated intact cognition and was dependent for self-care that included bathing, dressing, and using the toilet. The Resident had a tracheostomy tube (a curved tube placed through a surgical opening through the neck into the trachea (windpipe)) and PEG tube (Percutaneous Endoscopic Gastrostomy tube-a tube surgically placed through the abdominal wall and into the stomach to administer enteral nutrition, fluids and/or medication).</p> <p>On 5/19/24 at 11:10 AM, an observation was made of Resident #62 lying in bed, awake. The Resident had a tracheostomy but was able to answer questions during interview. An observation was made of the Residents tracheostomy tube and dressing that was partially not in place around the stoma and trach tube. The Resident had a cart next to the bed that had drawers with supplies and supplies on top of the cart with oxygen machine, suction machine. The water for humidification on the oxygen machine was dated 5/9/24 that had a trach collar connected to tubing that was not dated. Another container of oxygen humidification was opened and placed on the bottom shelf of the cart that was not dated. There was a small plastic bag with white powder substance inside of it. The bag was sealed. Connected to the suction machine was a used tracheostomy suction tubing that was placed back into the opened packaging and did not have a date on it. Oral suctioning Yanker was opened with out a date of when the equipment was opened. A suction catheter tray kit on the bottom shelf of the supplies cart had splashed brown substance on the packaging. An observation was made of the tracheostomy equipment that lacked readily accessible emergency equipment of an outer cannula in case of decannulation.</p> <p>On 5/19/24 at 2:25 PM, an observation was made of Resident #62's room with the Director of Nursing (DON) and Nurse L. The equipment for the tracheostomy was reviewed with the DON. When asked if tracheostomy suction catheters were reused, the DON stated, No, they should be getting a new one each time and discard after use, and threw out the used suction catheter and yanker that was not dated and indicated it should be dated when opened.</p> <p>The DON indicated that the humidification for the tracheostomy oxygen was to be changed weekly. The date on the humidification was 5/9/24.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON and Nurse was asked what the white substance was in the sealed package. Neither knew what it was, and it was discarded. The DON and Nurse were asked where the emergency equipment was located. The DON and Nurse reviewed the top of the supplies cart and inside the cart and were unable to find the emergency equipment of the outer cannula. The Nurse indicated the Resident took a size 6. The DON indicated he knew the Resident had one on Friday due to being called up to the floor regarding trach issues. The DON indicated that the emergency equipment should be easily accessible. The DON looked in the medication cart and in the storage room and was unable to find the necessary emergency equipment.</p> <p>The DON left the floor to retrieve the trach equipment and in the meantime the Unit Manager, Nurse I reported the emergency trach cannula had fallen behind the equipment cart that was in the room. The emergency equipment was reviewed and was the correct size. When the DON arrived, he indicated it would be taped to the wall by the Resident's bed.</p> <p>A review of facility policy titled, Tracheostomy Care, reviewed/ revised 1/24, revealed, . 2.) Purpose: Tracheostomy and stoma care are essential to prevent infections and to preserve the patency of the airway. Clean technique may be use to remove and replace the inner cannula, but sterile technique must be used for all contact inside the tracheostomy tube, e.g., cleaning the inner cannula, suctioning, etc .</p> <p>49944</p> <p>Resident #33</p> <p>Resident #33 is [AGE] years old and was admitted to the facility on [DATE] with diagnoses that include asthma, obstructive sleep apnea, chronic obstructive pulmonary disease and hypertension.</p> <p>On 05/19/24 at 11:46 AM, R33's nebulizer was observed intact, sitting on the bedside table. There was no barrier under it and there was visible residue still in the medication cup. R33 was asked if the staff leaves their nebulizer on the bedside table like that after completion. R33 said yes, the staff leaves it there often.</p> <p>On 05/21/24 at 10:00 AM, R33's nebulizer was observed on the bedside table, intact, no barrier under it and residue noted in the medication cup.</p> <p>On 05/21/24 at 08:52 AM, record review of the medication administration record (MAR) for R33 revealed the last documented administration of a nebulizer treatment was on 05/21/24 was at 0400.</p> <p>On 05/21/24 at 09:46 AM, an interview was conducted with the nurse for R33. Licensed Practical Nurse (LPN) 'L' was asked about how nebulizer treatments should be stored after residents are done using them. LPN 'L' stated that the nebulizers should be separated, rinsed out, stored on a barrier until they dry and then placed in a bag. LPN 'L' and this surveyor went to R33's room and observed that there was a used nebulizer treatment on the bedside table. LPN 'L' removed the used nebulizer from the bedside table and discarded it in the garbage.</p> <p>05/21/24 09:46 AM Nebulizer Therapy Policy Revised 6/23. Read:</p> <p>12. Disassemble and rinse the nebulizer and allow to air dry.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. Disassemble parts after every treatment. 2. Store dry nebulizers mesh bags, clear plastic bag or proper clean storage per the facility's preference. 3. Replace nebulizer tubing, cup, and mouthpiece weekly and as needed. 4. Periodically disinfect unit and replace applicable filters per manufacturer's recommendations.

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on interview and record review, the facility failed to ensure that a resident's pain medication was administered as ordered to treat pain for one resident (Resident #46) of 1 resident reviewed for pain management, resulting in the resident's verbalizations of unrelieved pain, frustration and helplessness.</p> <p>Findings Include:</p> <p>A review of the facility policy titled, Pain Management, date reviewed/ revised 1/24 provided, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standard of practice, the comprehensive person-centered care plan, and the resident's goals and preferences .The facility utilizes a systematic approach for recognition, assessment, treatment, and monitoring of pain .To help a resident attain or maintain his/her highest practicable level of well-being and to prevent or manage pain, the facility should: Recognize when the resident is experiencing pain . The interventions for pain management will be incorporated into the components of the comprehensive care plan . As general reference, unless otherwise specified, when a numerical scale is utilized to evaluate level or severity of pain, consider the scale as below: a. Mild Pain (#1-3); Moderate Pain (#4-7); Severe Pain (#8-10)</p> <p>Resident #46:</p> <p>Pain Management</p> <p>A review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #46 indicated the resident was readmitted to the facility on [DATE] and again on 8/16/2023 with diagnoses: history of a stroke, dysphagia, irritable bowel syndrome, epilepsy, dementia, depression, hypertension diabetes, atrial fibrillation, bipolar disorder, COPD, gastrostomy tube, asthma, chronic pain, acquired absence of left leg below knee, GERD and heart disease. The MDS assessment dated [DATE] indicated the resident had moderate cognitive loss with a Brief Interview for Mental Status (BIMS) score of 11/15 and the resident needed assistance with all care.</p> <p>During a tour of the facility on 5/19/24 at 11:39 AM, Resident #46 was observed rubbing his legs, especially his left upper leg. The resident was asked if he was having pain and he stated, My knee and hip are killing me and have been for the last week, but especially today. The resident was asked if he normally received pain medication and he said he usually received pain medication. When asked if he received it that morning, he said he didn't know.</p> <p>On 5/19/2024 at 11:40 AM, Nurse K was observed outside the door of Resident #46 with her medication cart. The nurse was asked if the resident received pain medication and she said Resident #46 was scheduled to receive a Norco/oxycodone/acetaminophen at 12:00 noon. Nurse K said she would give it to him soon. Discussed with Nurse K that the resident appeared very uncomfortable and was repeatedly rubbing his legs. The Nurse said Resident #46 was to receive the Norco every 4 hours via a feeding tube/peg tube.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During the interview with Nurse K on 5/19/2024 at 11:40 AM, the surveyor asked Nurse K to review the narcotics log for Resident #46's Norco pain medication. The narcotics log showed the Norco was signed out on 5/19/2024 at 8:00 AM and 11:00 AM. The nurse was asked if she already gave Resident #46 the pain medication and she said she was going to give it. Nurse K was asked where the Norco pill was if she already took it out of the cassette but did not give it to the resident. The nurse did not respond and then pointed at the top drawer of the medication cart. It was unclear what she was pointing at; she then removed a small medication cup from the back of the drawer; the medication cup said 16-2. The nurse said the resident was in room [ROOM NUMBER]-2. There were approximately 10 pills in the cup. Nurse K was asked if it contained the Norco and she said it did. The Norco pills in the medication cassette were compared to the pills in the medication cup and it was confirmed there were 2 Norco in the cup, plus a variety of other medications. The resident had not received his morning medications, including the Norco at 8:00 AM or 12:00 PM.</p> <p>On 5/19/2024 at 11:50 AM, Nurse K took the resident's medications including the 2 Norco, crushed them and administered them to Resident #46 via the feeding tube/peg tube.</p> <p>A review of the physician orders for Resident #46 revealed he had an order for Hydrocodone-Acetaminophen tablet 5-325 mg every 4 hours, revision date 4/1/2024 and start date 4/1/2024.</p> <p>A review of the May 2024 Medication Administration Record for Resident #46, identified the following: Hydrocodone-Acetaminophen 5-325 mg: Give 1 tablet by mouth every 4 hours for pain, start date 4/1/2024. This included a Pain Level assessment to be completed every 4 hours when the resident received his pain medication. On 5/19/2024 the resident had the following Pain Level ratings on a scale of 0-10 with 10 being the highest level of pain experienced: 12:00 AM = 0; 4:00 AM = 4; 8:00 AM = 0; and 12:00 PM = 8. The resident's pain scores were usually between 0-5.</p> <p>The resident was asked what his pain level was based on the 0-10 scale and then the nurse recorded it. On 5/19/2024 at approximately 12:00 PM, Resident #46 rated his pain a high score of 8. He had not received his 8:00 AM or 12:00 PM doses of pain medication.</p> <p>On 5/19/2024 at 12:20 PM, the Director of Nursing/DON was interviewed related to Nurse K removing Resident #46's medications including narcotic pain medication from the narcotics drawer and not providing them to the resident. He said he was not aware of that. He said Nurse K was a Nurse Manager and had picked up an extra shift 5/19/2024 (Sunday). Reviewed with the DON that Nurse K had signed Resident #46's narcotics out of the double locked medication drawer, placed them into a single locked drawer and chose not to give them to the resident, until she was repeatedly asked where the medication was. He said that was not acceptable and he would look into it. The DON was asked for a copy of the Medication Administration Record with times administered for Resident #46 on 5/19/2024.</p> <p>Resident #46's 7:00 AM medications were all documented on the Medication Admin Audit Report as given at 9:30 AM, but they were still in the medication cup in the top drawer of the medication cart at 11:40 AM, as confirmed with Nurse K.</p> <p>The 8:00 AM Norco was documented as given at 9:24 AM, but it was also in the medication cup.</p> <p>The 12:00 PM Norco was documented as given at 11:47 AM. This was the time Nurse K was observed giving all of the morning and noon medications.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the nurses notes on 5/19/2024 and on 5/22/2024 indicated the nurse had not notified the physician that she had withheld two doses of Resident #46's narcotic pain medication and did not provide the resident with his medications as ordered.</p> <p>An MDS note dated 5/17/2024 identified the following: Interview and assessment done, resident is alert and able to make needs known . Resident states frequent left hip pain over last 5 days and rates it an 8 on zero to 10 scale, states that pain meds help to relieve pain .</p> <p>A review of the Care Plans for Resident #46 provided: I am at risk for pain related to diabetes, COPD, PVD(peripheral vascular disease), CAD(coronary artery disease), phantom pain left limb status post below the knee amputation, date initiated 8/17/2023 and revised 5/21/2024, with Interventions including: Administer analgesia as per orders. Give 1/2 hour before treatments of care, date initiated 5/21/2024; Anticipate my need for pain relief and respond immediately to any complaint of pain, date initiated 8/17/2023 and revised 5/21/2024.</p> <p>On 5/29/2024 at 8:45 AM, the Administrator was interviewed about Nurse K intentionally not providing Resident #46 with his medications, including his narcotic pain medication. The Administrator said Nurse K walked out of the facility and quit 5/22/2024 in the middle of her shift.</p> <p>A review of the facility policy titled, Resident Rights, dated reviewed/revised 2/24 provided, The facility will inform the resident both orally and in writing, in a language that the resident understands of his or her rights . All residents will be treated equally . The facility will ensure that all direct care and indirect care staff members, including contractor and volunteers, are education on the rights of the residents and the responsibility of the facility to properly care for its residents . The right to receive the services and/or items included in the plan of care .</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review the facility failed to ensure coordination of dialysis care for one Resident (#2) of 1 reviewed for Dialysis services, resulting in a lack of assessment for the left arm Dialysis fistula, dressing and site, resulting in the potential for unidentified complications.</p> <p>Findings Include:</p> <p>Resident #2</p> <p>Dialysis</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Respiratory failure (5/14/2024), COPD, end stage renal disease, dependence on renal dialysis, heart disease, anemia, atrial fibrillation, pain, depression, hypothyroidism, history of venous thrombosis and GERD. The MDS assessment dated [DATE] indicated the resident had moderate cognitive loss with a Brief Interview for Mental Status (BIMS) score of 10/15 and the resident needed some assistance with all care.</p> <p>On 5/20/24 at 9:22 AM, during a tour of the facility, Resident #2 was observed lying in bed with her meal tray on the bedside table in front of her. She said she was supposed to leave for dialysis but wanted to finish her tea and a muffin. The resident fell asleep while trying to drink her tea. The Emergency Medical Services transport staff entered the room and said the resident had a change of condition. They said she usually wasn't like that. She was usually awake, alert and talking with them.</p> <p>On 5/21/24 at 9:14 AM, Resident #2 was observed lying in her bed alert and talkative. She said she felt much better. The resident said for the past 3 weeks she had been very tired and sleepy. She said it sometimes happened to her and she did not know why. She said she had a bad cough for a long time and stated, The last time I was in the hospital, I had breathing medicine 6 times a day. It cleared me up. She said she went to dialysis 3 times a week on Monday, Wednesday and Friday. She said she took a packet of papers with her and the dialysis center cent a packet back with her and she gave them to the nurse.</p> <p>A review of the Hemodialysis Communication, forms for Resident #2 indicated there was no mention of the dialysis access site. It did not identify the type of dialysis access site, whether it was a fistula or IV dialysis catheter. It did not mention the location of the access site, if there were any complications such as discoloration, redness, bruising, drainage, pain etc. Neither the facility or dialysis facility documented the resident's dialysis access site on the Hemodialysis Communication form.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/2024 during a review of the physician orders, it indicated there were no orders for monitoring of the resident's dialysis site until 5/21/24: Monitor Fistula to (right) site for bruit and thrill. Document in (progress notes) and notify MD of any abnormal findings: Bleeding, redness, swelling, warmth, drainage, edema, pain, numbness/tingling, no thrill, or change in sound of bruit, dated 5/21/2024 and started 5/21/2024.</p> <p>An order dated revised 5/14/2024 but never started said: D-if AV (arteriovenous) fistula/graft site is bleeding apply pressure and notify MD/Physician if bleeding does not stop.</p> <p>Resident requires services at dialysis center. Renal physician to manage treatment at the center. Treatment days are Monday, Wednesday and Friday, dated 5/14/2024 with no start date.</p> <p>A review of Resident #2's Medication Administration Records/MAR for May 2024 indicated there were no entries for monitoring the resident's dialysis access device, site or dressing until 5/21/2024. The resident was admitted to the facility on [DATE] and was receiving dialysis services since then.</p> <p>A review of the progress notes indicated Resident #2 was transferred to the hospital on 5/2/2024 for increased confusion, bilateral lung sounds diminished in all four quadrants, blood pressure 90/76 (low). The resident readmitted to the facility on [DATE].</p> <p>On 5/28/24 at 9:35 AM, Resident #2, was observed lying in bed, talking with her roommate. The resident said she had a bruise on her left upper arm and pulled up the sleeve of her gown. Her left upper arm above the dialysis fistula dressing had a large lump and dark purple bruising/approximately 4 inches in width and 3 inches in length. When asked what happened, she said she did not have a fall.</p> <p>A review of the progress notes revealed an: Summary for Providers, note dated 5/21/2024 at 12:00 PM, Situation: . Change in skin color or condition . Discoloration . Recommendations: soft tissue ultrasound ordered for left upper extremity .</p> <p>On 5/28/24 at 9:55 AM, The Director of Nursing was interviewed about the dialysis forms not mentioning the dialysis access site. Reviewed Resident #2 had a left arm fistula with no orders to monitor the site until 5/21/24. The DON said he input the order (5/21/2024), but there was nothing prior. Also reviewed the dialysis forms did not have an area to document related to the access site: there was no documentation of the resident's dialysis site until 5/21/24; ultrasound ordered 5/21/24 and there were no nurses notes related to the raised/bruised area on the resident's left arm. There was no indication when it occurred. A policy for hemodialysis was requested and not received prior to exit.</p> <p>The next note that mentioned the bruising and lump on Resident #2's arm was dated 5/28/2024, a Nursing progress note, dated 5/28/2024 at 6:38 PM, Monitored fistula site no redness or drainage, no edema, no bleeding, no warmth, no numbness or tingling, no change in bruit sound or thrill noted. There was no description of the resident's left upper arm.</p> <p>A review of the Care Plans for Resident #2 revealed the following:</p> <p>I need Hemodialysis due to end stage renal disease, date initiated 5/15/2024 and revised 5/15/2024, with Interventions: After dialysis my pressure dressing removal instructions are as ordered, date initiated 2/14/2024. There was no information about the dressing.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Do not draw my blood or take my blood pressure in (right) arm with graft, date initiated 5/21/2024. The resident's fistula was in her left arm.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944</p> <p>This Citation pertains to Intake Number MI00144249.</p> <p>Based on observation, interview and record review the facility failed to provide sufficient staffing levels, including days with less than eight hours of Registered Nurse (RN) coverage, to meet the residents' needs for the facility census of 118, 6 residents (#27, #33, #49, #62, #101, #104) and a Confidential Group of residents, resulting in late medication administration, long call light wait times and unmet care needs.</p> <p>Findings include:</p> <p>On 05/28/24 at 10:57 AM, record review of nurse staffing assignments and time cards revealed that there were multiple days where the facility had less than eight hours of RN coverage.</p> <p>Reviewed staffing for eight hours of RN coverage:</p> <p>-01/01/24 5.51 hrs</p> <p>-01/15/24 0 hrs</p> <p>An interview was conducted with the Nursing Home Administrator (NHA). The NHA was asked why the facility did not have an RN in the building on those days and if they were aware of this. The NHA stated they were unsure why there were less than eight hours of RN coverage for these two days listed.</p> <p>Scheduler 'C' provided additional information to the surveyor that confirmed there were less than eight hours of RN coverage on 01/01/24 and 01/15/24.</p> <p>Resident #33</p> <p>Resident #33 is [AGE] years old and was admitted to the facility on [DATE] with diagnoses that include asthma, obstructive sleep apnea, chronic obstructive pulmonary disease and hypertension. R33 has a Brief Interview for Mental Status (BIMS) score of 14 indicating they are cognitively intact. R33 resides on the 200 unit of the facility.</p> <p>On 05/19/24 at 11:47 AM, R33 was asked if the staff answers their call light in a timely fashion. R33 stated that the staff is slow to answer call lights and they didn't receive water from the aides. R33 thinks the facility is short of staff and sometimes there is one nurse for up to fifty people.</p> <p>Resident #101</p> <p>Resident #101 is [AGE] years old and admitted to the facility 04/01/24 with diagnoses that include quadriplegia, pressure ulcer of sacral region and non-pressure chronic ulcer of right heel and midfoot. R101 has a BIMS score of 15 indicating they are cognitively intact. R101 resides on the 200 unit of the building.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 05/19/24 at 11:01 AM, R101 was asked how long it takes the staff to answer the call light when they turn it on. R101 stated that most times it takes 30 minutes on average for the call light to be answered.</p> <p>37771</p> <p>Resident Group Meeting</p> <p>On 5/21/24 at 10:02 AM, a group meeting was held with 10 Confidential Residents. The group was asked about call light response times and the majority rarely use the call light due to being able to take care of themselves. One Resident had an issue and reported when he does not get a response with his call light on, he will go out into the hallway and find staff to take care of his needs. A couple of Residents indicated that they hear other Residents yelling for help over and over and they are not attended to timely. Two Residents reported that call lights will go off over a Residents' doorway and not answered timely with one Resident that stated, I see the lights beeping a lot, takes a while to answer.</p> <p>The Residents were asked about sufficient staffing to meet Resident needs. Seven of the 10 Residents reported that there was not enough staff, and they would benefit from more nurse and CNA coverage. The group indicated that third shift needed another nurse and discussed late medication pass, call lights going off for long periods of time, Residents yelling out for help and one Resident reported seeing a Resident crying and staff did not attend to her right away.</p> <p>Call Lights</p> <p>Resident #27</p> <p>A review of Resident #27's medical record revealed an admission into the facility on [DATE] and re-admission on 11/10/23 with diagnoses that included stroke, hemiplegia and hemiparesis following a stroke affecting right dominant side, diabetes, dementia and arthritis. A review of Resident #27's MDS assessment revealed a BIMS score of 14/15 that indicated intact cognition and the Resident needed substantial/maximal assistance with oral hygiene and dressing and was dependent with toileting hygiene, bathing self.</p> <p>On 5/20/24 at 9:29 AM, an interview was conducted with Resident #27 who answered questions and engaged in conversation. When asked about call light response times, the Resident stated, They don't have enough help, and reported he has had to wait one hour or longer at times. When asked if he has had to wait two hours, the Resident report he has waited that long and stated, They avoid it. They don't like this light, and indicated his call light.</p> <p>Resident #49</p> <p>A review of Resident #49's medical record revealed an admission into the facility on [DATE] and re-admission on 3/20/24 with diagnoses that included acute respiratory failure, diabetes, altered mental status, fracture of the left humerus, difficulty in walking, dementia, falls and weakness. A review of the Resident's MDS assessment revealed a BIMS score of 14/15 that indicated intact cognition and the Resident needed setup assistance with eating, supervision or touching assistance with oral hygiene was dependent on bathing, toileting hygiene and dressing.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 5/20/24 at 9:48 AM, an observation was made of Resident #49 in their room, dressed and in a wheelchair. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about call light response times and reported that call lights take a long time to get answered, and reported 30 minutes to an hour or more.</p> <p>Resident #62</p> <p>A review of Resident #62's medical record revealed an admission into the facility on [DATE] and readmission on 5/2/24 with diagnoses that included Parkinson's disease, acute respiratory failure, tracheostomy status, diabetes, muscle weakness and gastrostomy. A review of the Resident's Minimum Data Set assessment revealed a BIMS score of 14/15 that indicated intact cognition and was dependent for self-care that included bathing, dressing, and using the toilet.</p> <p>On 5/19/24 at 11:30 AM, an observation was made of Resident #62 lying in bed, awake. The Resident had a tracheostomy but was able to answer questions during interview. An observation was made of the Resident in a hospital gown. He lifted the gown around his chest area and shakes his head back and forth. The gown was so thin and was see through. An observation was made of the Resident's call light clipped to his pillow. When asked about response time when he used the call light, the Resident stated, depends. When asked if he had to wait more than a half an hour, the Resident stated, Yes, when asked if he had to wait more than an hour the Resident nodded and stated, Uh-huh.</p> <p>Resident #104</p> <p>A review of Resident #104's medical record revealed an admission into the facility on [DATE] with diagnoses that included heart disease, chronic obstructive pulmonary disease, diabetes, bipolar disorder, and need for assistance with personal care. A review of Resident #104's MDS revealed a BIMS score of 12/15 that indicated moderately impaired cognition and the Resident needed maximal assistance with toileting hygiene, mobility and transfers.</p> <p>On 5/19/24 at 12:19 PM, an observation was made of Resident #104 in their room in bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident had his call light positioned inside a bedside table drawer. When asked if he could reach it, the Resident indicated it was in reach for him. The Resident was asked if he used his call light, the Resident indicated that he does use it when he needs something. The Resident was asked about call light response times when he used the call light. The Resident stated, It all depends, if you call at three in the morning, you will be waiting a while. When asked if he had to wait more than 30 minutes, the Resident stated, Oh yeah. When asked if he has had to wait an hour, the Resident stated, Yes, queried if had to wait for call light response up to two hours, the Resident stated, Yes it has been that long.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>49944</p> <p>Based on observation and interview the facility failed to ensure that nurse staffing information was posted in a prominent area of the building that is accessible to residents and visitors. Findings include:</p> <p>On 05/19/24 at 02:21 PM, observation revealed that nurse staffing information was not posted in the building. An empty, hard plastic sheet protector was observed on the wall by the front desk.</p> <p>On 05/20/24 at 08:51 AM, observation revealed that nurse staffing information was not posted in the building.</p> <p>On 05/20/24 at 04:16 PM, an interview was conducted with scheduler 'C'. Scheduler 'C' was asked where the nurse staffing posting would be and they responded that the posting is usually located on the wall by the front desk. Scheduler 'C' was observed holding the current nurse staffing posting for 05/20/24 in their hand and they were posting it by the front desk. Scheduler 'C' was asked who is responsible for posting the nurse staffing on the weekends. Scheduler 'C' replied that they print the nurse staffing information on the Friday before the weekend and the staff on duty make sure they are posted. Scheduler 'C' was informed there was no posting up yesterday 5/19/24 or this morning 5/20/24. Scheduler 'C' stated they were unsure why there wasn't a posting yesterday or this morning.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>Based upon interview and record review, the facility failed to act upon recommendations regarding medication irregularities timely and produce pharmacy recommendation reports from monthly medication regimen reviews for two Residents (#42 and 49), of five reviewed for unnecessary medication regimen reviews, resulting in the potential for inadequate monitoring, missed gradual dose reductions of psychotropic medications, medication side effects and adverse reactions.</p> <p>Findings include:</p> <p>Resident #49</p> <p>A review of Resident #49's medical record revealed an admission into the facility on [DATE] and re-admission on 3/20/24 with diagnoses that included acute respiratory failure, diabetes, altered mental status, depression, neurocognitive disorder with lewy bodies, bipolar disorder, anxiety and dementia.</p> <p>A review of Resident #49's prescription medication orders, in the Order Summary Report, revealed the Resident was on Duloxetine for depression, gabapentin for neuropathy, insulin for diabetes, Lamictal that did not have a diagnoses listed, (an anti-epileptic medication used to treat seizures and bipolar disorder), Quetiapine that did not have a diagnoses listed with the order (an atypical antipsychotic medication used to treat schizophrenia, bipolar disorder, and major depressive disorder).</p> <p>A review of Resident #49's Medication Regimen Reviews revealed a Pharmacy Progress Note that indicated to See report for any noted irregularities for 3/22/24, 1/13/24, and 12/14/23. Review of the electronic medical record revealed no pharmacy report of noted irregularities was found.</p> <p>On 5/29/24 at 1:21 PM, the Director of Nursing was asked for the Pharmacy reports of irregularities found on the Medication Regimen Reviews.</p> <p>On 5/29/24 at 1:44 PM, the Director of Nursing reported the Pharmacy reports of irregularities was not located for the dates requested.</p> <p>49944</p> <p>Resident #42</p> <p>R42 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include dementia, bipolar disorder, major depressive disorder, generalized anxiety disorder and adjustment disorder.</p> <p>On 05/22/24 at 10:05 AM, record review revealed there were irregularities noted on medication regimen reviews (MRR) for R42 on 5/12/23, 7/15/23, 10/20/23, 11/12/23, 2/14/24 and 3/14/24.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/22/24 at 10:15 AM, record review revealed there was no documentation of the acknowledgement of the irregularities and no documentation of what the irregularities were for R42 on 5/12/23, 7/15/23, 10/20/23, 11/12/23, 2/14/24 and 3/14/24.</p> <p>On 05/22/24 at 10:40 AM, an interview was conducted with the Director of Nursing (DON), the DON was asked where the pharmacy irregularities in the electronic health record (EHR) were located, the DON stated the signed pharmacy reviews will be located in the scanned documents area in the EHR. The DON and this surveyor reviewed the scanned documents and were unable to locate the documents. The DON stated they would contact the facility nurse practitioner (NP), the DON said the NP handles all of the reviews and they should have them.</p> <p>On 05/22/24 at 01:30 PM, the DON was able to locate MRR irregularity reviews for 10/19/23, 11/11/23, 2/12/24 and 3/11/24, the reviews on 10/19/23 and 11/11/23 were not signed by the practitioner. No MRR irregularity reports were able to be located for 5/12/23 and 7/15/23.</p> <p>On 05/22/24 at 01:42 PM, the MRR irregularities for 10/19/23 and 11/11/23 were both for Pristiq (a medication that treats depression) 50mg, they were not signed and the gradual dose reduction (GDR) recommendattion was not completed until 12/19/23.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>22348</p> <p>Based on observation, interview, and record review the facility failed to store and handle medications in accordance with acceptable pharmaceutical standards of practice: 1.) for three of three (3 or 3) medication rooms 2.) ensure medication refrigerator temperatures outside of acceptable parameters were addressed; 3.) ensure medication carts and treatment carts were secured and locked when unattended; 4.) ensure medications were not expired in all three medication (med) storage room and med carts; and 5.) ensure the freezer in the 4th floor med room was maintained regularly without ice build-up, resulting in the potential for contamination of medications, incorrect administration of medications, a lack of therapeutic benefits necessary to promote healing for residents, increased potential for adverse effects, and resident, staff or visitor access to unsecured medication cart.</p> <p>Findings Include:</p> <p>During the observation tour on the Fourth (4th) Floor on 05/21/24 at 09:52 AM, the following were observed:</p> <p>Fourth Floor</p> <p>4th Floor Med Storage Room:</p> <p>On 5/21/24 at 09:52, during an observation tour of the med storage room on the 4th Floor, it was observed that the Refrigerator #1 storing medications had a temperature reading of 40 degrees Fahrenheit. These medications were Lantus, other liquid prescription formulations, insulin pens, TB (tuberculosis) skin test vials, and other medicines stored in the 4th Floor medication room refrigerator. Inside the refrigerator were five (5) ampules of Insulin (lispro) found with an expiration date of 4/2024. Nurse BB validated that the expiration date was 4/2024, and when asked, she revealed that she did not know whose medication it belonged to and why it was stored in the refrigerator when it had expired last month.</p> <p>Med Storage Room Refrigerator</p> <p>The 4th-floor refrigerator had a freezer compartment. The freezer did not have a door to separate the freezer compartment from the refrigerator section. The opening of the freezer is all covered with ice build-up. No one can see the contents or what is inside the freezer because of too much ice accumulation in the freezer section. Nurse BB was questioned about the refrigerator maintenance policy and the freezer ice build-up. Nurse BB did not answer.</p> <p>The rest of the medication, OTCs, supplies, and supplements on the shelves were examined. Here are the rest of the findings:</p> <p>> Needles (hypodermic) used for labs stored in the med room had an expiration date printed in 2018. Other medications found in the med storage room were:</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>> 4 Bisacodyl rectal suppository (Individually packed) -Expired 02/24</p> <p>> Folic Acid 400 mcg 01/24</p> <p>> Folic Acid 800 mcg open date 10/28/22 Exp 03/24</p> <p>> Vit D 10 mcg 3/23</p> <p>> Zinc 50 mg 1/24</p> <p>> Glucosamine Sulfate 500 mg open date 2/2022 Exp 3/24</p> <p>> Vit D open date 4/28/23 Exp 11/23</p> <p>4-East Med Cart:</p> <p>The following were found during the med cart observation for Med Cart-4 East conducted on 5/21/24 at 9:52 AM:</p> <p>> Several multi-dose over-the-counter OTC medication containers/bottles were found in the 4 East Medcart with the seal tampered, opened, and used that did not have an open date written.</p> <p>> The omeprazole bottle had no printed expiration date on the manufacturer's label.</p> <p>> Calcium Carbonate 500 mg. was found with an expiration date of 6/23. The written open date was noted: 7/18/2022</p> <p>> A multi-dose bottle of liquid Geri-Lanta (regular strength) with an expiration date of 02/24 on the manufacturer's label. The open date written was 12/17/2023.</p> <p>The License Practical Nurse LPN (Q) was asked regarding the open date policy. LPN Q indicated that she was unsure of the open-date policy because it is an over-the-counter (OTC) medication. LPN Q continued by asking, Should we follow the expiration date as indicated on the label?</p> <p>On 05/21/24 at 10:49 AM, the Director of Nursing (DON) came up to the 4th Floor and verified the findings of expired medications and the built-up ice in the freezer inside the storage room refrigerator. All these findings were also validated by the 4th-floor nurses: Nurse Q and LPN BB on 05/21/24 at 10:59 AM</p> <p>2nd Floor</p> <p>During the observation tour on the 2nd Floor on 05/21/24 at 11:02 AM, the following were observed:</p> <p>2nd Floor Med Storage Room:</p> <p>RN F proceeded to the 2nd Floor Med Storage room. The refrigerator temperature reading was 44 degrees Fahrenheit (According to the log, the temperature guide must be maintained within 31-41 degrees temp). RN was asked what the safe temperatures they need to keep it. RN F stated 42 or below.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the observation, on 5/21/24 at 11:05 AM, the Temperature checklist (log) was not found for the 2nd Floor Med storage room Refrigerator.</p> <p>In the Med storage room, on 5/21/24 at 11:10 AM, a bag of prescription medication with a patient's name on each container was found inside the Med room. RN F indicated they did not have a patient with that name currently and did not know why it was kept in the med storage room.</p> <p>A Paliperidone ER 6 mg, an antipsychotic prescription medication, was found with a discard after the date of 3/31/24. Nurse F indicated that it is an expired medication that needs to be discarded.</p> <p>2-East Med Cart:</p> <p>Agency Nurse (RN F) on 5/21/24 at 11:03 AM, RN F left the 2East-MedCart unlocked as he was headed to the med storage room. Some residents were near the hallway close to the medcart. When reminded by the surveyor. Nurse F immediately walked back and locked the medcart.</p> <p>On 05/21/24 at 11:20 AM, the 2 East Med Cart on the 2nd Floor was assessed and found the following expired items:</p> <p>At the bottom drawer: UA Vaccullette for Urinalysis (UA) 4 ml package label had an expiration date: 10/7/2022.</p> <p>Inside the OTCs drawer:</p> <p>Vit D 10 mcg best by date: 3/23</p> <p>Gericare Aspirin 325 mg Expiration date: 01/24</p> <p>Aspirin 325 Expiration date: 6/23</p> <p>On 05/21/24 at 11:52 AM, Nurse F verified that best by date means it is considered the expiration date and must be discarded.</p> <p>2nd Floor Medstorage Refrigerator</p> <p>On 5/21/24 at 11:55 AM, two nurses looked for the temperature log in the 2nd-floor med room. The med room Refrigerator Temp log sheet was missing. None of the nurses found the May 2024 Temperature Log in the 2nd-floor med room.</p> <p>3rd Floor</p> <p>Med Storage Room:</p> <p>The two nurses were Nurse X and Nurse U. During the observation tour on the 3rd Floor on 05/21/24 at 1:41 PM, the following was observed:</p> <p>3rd Floor Medstorage Room Refrigerator</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/21/24 at 01:57 PM, the thermometer inside the refrigerator was 50 degrees according to both nurses X and U. Upon query, both Nurses X and U were unsure what Temperature the refrigerator needed to be maintained at. Although they have identified that the Temperature was hitting 50 degrees Fahrenheit, they have not called the maintenance to have the refrigerator checked.</p> <p>Meds such as insulin pens and other medications needing refrigeration were found inside the 3rd Floor Medstorage refrigerator.</p> <p>The May 2024 3rd Floor Refrigeration Checklist (Temperature Log) revealed:</p> <p>May 10, 2024, 47 degrees AM/ 47 degrees PM, signed by SS</p> <p>May 11, 2024, 47 degrees AM/ 45 degrees PM, signed by SS (note: adjusted Temperature)</p> <p>May 12, 2024, 42 degrees AM/ 42 degrees PM, signed by SS</p> <p>May 13, 2024, 43 degrees AM/ 45 degrees PM signed initials not legible</p> <p>May 14, 2024, 47 degrees AM/ 47 degrees PM, signed by SM</p> <p>May 15, 2024, (blank) AM/ 44 degrees PM (note: adjusted Temp 1252)</p> <p>May 21, 2024, 50 degrees AM/50 degrees PM signed initials not legible (Noted: adjusted)</p> <p>The Refrigeration Checklist noted: Temperature must be maintained at or below 41 degrees.</p> <p>3-East MedCart:</p> <p>On 05/21/24 at 01:16 PM, Nurse X, who was the nurse assigned to 3 East MedCart, found the following:</p> <p>Prostat15 g of protein, one (1) fl. oz open date of 5/17/24 written, showed a manufacturer's expired date of 5/5/24. Nurse X revealed it was given to residents today.</p> <p>ASA (Aspirin Chewable 81 MG had no expiration date on the manufacturer's label, was opened, and in the med cart accessible to administer to residents.</p> <p>Regular ASA (enteric-coated) 81 MG had no expiration date on the manufacturer's label, was opened and in the med cart accessible to administer to residents.</p> <p>Upon query, Nurse X validated she has given these medications to residents today during her shift.</p> <p>The Director of Nursing (DON) was notified of the findings on 5/21/24 at 2:00 PM. The expired medications and medical supplies were pulled out from storages and medcarts and placed in a bag. The bag with the expired contents was submitted to the DON at that time. The facility's refrigerator checklist (temperature log) Policy in the Med storage room and Labeling and Storage of Medication Policy were requested.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Administrator was notified of the findings during the QAPI Meeting on 5/22/24 at 12:30 PM.</p> <p>37771</p> <p>Secured and Locked medication cart and treatment cart</p> <p>On 5/21/24 at 8:55 AM, an observation was made of the treatment cart unattended and not locked on the 3rd floor. A Nurse was seen passing medication with a medication cart down the hall from the treatment cart and her back turned towards the treatment cart. An observation was made of Resident's propelling themselves in the hallway. At 9:00 AM, Nurse X was queried regarding the unsecured treatment cart. The treatment cart had prescription ointments, wound and skin treatments and dressing supplies in the cart. The Nurse stated, It should be locked, and secured the treatment cart.</p> <p>On 5/22/24 at 12:04 PM, an observation was made of Nurse Z during the medication administration task of the survey doing blood glucose monitoring. After the observation was made of the Nurse doing the blood glucose testing, an incident occurred on the floor where a Resident had fallen. The Nurse was called to the Residents room. Nurse Z was not assigned care of the Resident that had fallen. An observation was made of the medication cart that the Nurse had been at was left unlocked, and not attended by a nurse. Residents were observed to be in the hallway and within vicinity of the medication cart.</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>Based on observation, interview and record review, the facility failed to ensure a substantial evening snack was consistently offered to one Resident (#55) and a group of confidential residents that attended the Resident group meeting, potentially affecting all residents who receive meals in the facility with 14 or more hours between the last evening meal and breakfast the next day, resulting in Resident dissatisfaction, frustration and potential uncontrolled blood sugars, signs and symptoms of hypoglycemia, feelings of hunger, and weight loss.</p> <p>Findings include:</p> <p>Resident Group Meeting</p> <p>On 5/21/24 at 10:02 AM, a group meeting was held with 10 Confidential Residents. The group was asked about nighttime snacks being available. The Residents expressed that snacks were not consistently brought up and that other Residents would raid the snacks leaving nothing left for others. Three of the Residents voiced that they were diabetics, and a substantial snack was not always available before they went to bed due to other Residents raiding the snacks and taking out an armful from the refrigerator. One Resident reported that their blood sugar would drop and they needed something without a substantial snack available late at night. A couple Residents expressed that: not enough snacks were brought up; crackers or a cookie was not always enough of a snack; and that on the weekends sometimes the snacks would not be brought up.</p> <p>Some of the Residents expressed that dinner comes at 5:30 PM, with some saying earlier or later and that breakfast does not get there until 8:30 AM with one saying 8:00 and others saying 9:00 in the morning. The Residents expressed that there was a long period between the evening meal and breakfast the next morning with up to 15 hours between meals and stated, That's too long, you get hungry, the diabetics need something, and they are not getting what is needed, and some take 5 or 6 snacks at a time and shoot out of there. The Residents expressed frustration with not having available substantial nighttime snacks. A Resident stated there were vending machines but they take your money without getting the snack and they cost too much from the vending machine.</p> <p>On 5/22/24 at 12:46 PM, an interview was conducted with Unit Manager I regarding snacks provided at HS (nighttime). A review of the concern that Residents were taking multiple snacks at a time and then not enough snacks were provided to other residents including Residents with a diagnosis of diabetes. The Unit Manager indicated that they have had to replace the lock on the fridge because the lock had been broken off. An observation was made of the refrigerator located in the common area on the 3rd floor of the snack bin in the refrigerator that had multiple packages of crackers and a couple cookies and some condiments. The sheet that indicated the snacks had been sent up and signed for was reviewed. The last weekend had a signature that the snacks had been sent but there was no signature that they had been received. The Unit Manager indicated the nurse must forgot to sign.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Unit Manager was asked about the facility procedure on getting snacks to the Residents with a diagnosis of diabetes or that require a HS snack. The Unit Manager reported they used to have snacks set aside for diabetics that were put in the medication room refrigerator and reported that right now, nothing comes up specifically for the diabetics.</p> <p>On 5/28/24 at 11:17 AM, an interview was conducted with Dietary Manager (DM) Y regarding the provision of HS snacks. The Dietary Manager reported they had no issues with dietary staff getting the snacks to the floor, even on the weekends. A review of Resident complaints of not enough snacks provided or that some Residents were raiding the refrigerator, the DM stated, We send enough snacks up for everyone, all the Residents. The DM indicated that the refrigerators had locks on the doors or if the staff were leaving the refrigerator open at night, that's out of my hands. The DM indicated that especially the diabetics those are really important, to get their HS snack. The DM reported the dietary department was sending up snacks but did not designate specific snacks for the Resident's with a diagnosis of diabetes and stated, We are sending up extra, monitoring has to do with the CNAs and Nurses.</p> <p>A review of facility policy titled, Nourishments/HS Snacks, revised 1/5/2021, revealed, I. Policy: All residents will be offered a HS snack according to menu, individual needs and preference. II. Purpose: To provide snacks and promote quality of life. III. Procedure: .diabetic resident will be offered a protein source with their HS snack in accordance with their individual preference .</p> <p>37666</p> <p>Resident #55</p> <p>On 5/19/24 at 12:04 , Resident #55 was observed lying in bed, awake. The resident said he was waiting for lunch.</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Multiple sclerosis, severe protein-calorie malnutrition, chronic osteomyelitis (bone infection), Stage 2 and Stage 4 pressure ulcers, unstageable pressure ulcer, sepsis infection, contracture unspecified joint, and underweight. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 13/15 and the resident needed assistance with eating and was dependent with all other care.</p> <p>A Nutritional Assessment, dated 5/8/2024 for Resident #55 revealed the resident received a regular diet, nutritional supplements Proheal and Medpass; needed set up assistance with meals Extensive 1-person assist/fed by staff. Must be at 30 degree angle while eating; appetite was 25-50% of meals; preferred beverage was water; noted to have pressure ulcers; I have the potential for a nutritional/hydration problem . My Nutrition goal, while I am here, is to tolerate my diet & consume at least ~50% of my meals .</p> <p>A review of Resident #55's Tasks documentation in the electronic medical record/emr,HS (night time) Snack Offered, from May 1, 2024 - May 27, 2024 revealed the facility staff documented the resident received an HS snack 14 of the 27 days.</p> <p>A review of the Care Plans for Resident #55 identified the following:</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>I have the potential for a nutritional/hydration problem related to: osteomyelitis ankle and foot, Multiple Sclerosis, diabetes ., date initiated 5/8/2024 with Interventions including: Monitor me for signs and symptoms of poor hydration, date initiated 10/7/2022; Document my daily food acceptance, date initiated 10/7/2022; My preferred beverage between meals is water, date initiated 9/27/2023;</p> <p>On 5/22/24 at 11:30 AM, Registered Dietitian J was interviewed and said all residents able to eat should be offered a bed time snack.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>Based on observation, interview and record review, the facility 1) Failed to maintain a sanitary kitchen by not properly cleaning and drying cookware/food containers/food trays/hot plate dispenser prior to stacking/storing, and ensuring dish machine sanitation of washed items; 2) Failed to dispose of expired food items; 3) Failed to ensure that plates were safe for use; and 4) Failed to maintain sanitary and safe cereal containers, resulting in the potential contamination of food, bacterial harborage, the increased potential for food borne illness and injury from chipped plates. This deficient practice had the potential to affect all residents that consume food prepared in the kitchen.</p> <p>Findings include:</p> <p>On [DATE] at 9:55 AM, an initial tour of the kitchen was conducted with Dietary Manager Y. The following observations were made:</p> <ul style="list-style-type: none"> -Stacked dirty plastic food storage containers. The Dietary Manager was asked if the stacked items were ready for use, and he indicated they were and removed the items with debris on them. -Large drink dispenser containers, wet inside, not allowed to air dry and had tops on the containers. -Crock pot with a lid on that was stored wet inside. The Dietary Manager reported the large drink dispensers, and the crock pot was items from the Activities department. When asked when they were last used, the Dietary Manager was unsure. -Plate lids stacked and some of them wet. -A review of the hot plate dispenser revealed debris on the sides and bottom where the plates are stored. Many of the plates were chipped along the edge. The edges of the chipped plates were sharp in areas when a finger was rubbed on the edge. The Dietary Manager indicated that they had received new plates due to the condition of the plates seen in the plate warmer, but staff had not gotten them into circulation yet. The Dietary Manager was asked why the plates that needed to be replaced were not taken out of circulation if they were a risk for injury. -Metal top to steam table food container, stacked ready for use but had food debris on it. -Inside the walk-in freezer, bowls of ice cream were set on trays and were not covered to protect the food product. -Plastic containers for cereal storage had cracked and broken plastic tops to the containers leaving air gaps and potential plastic to fall into the cereal. The Dietary Manager reported that they had ordered new containers but had not gotten them in yet. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-In the dry storage area, sub buns were found to have mold on the bread. Fourteen bags of sub buns were removed that had visible mold on the bread. The packages did not have a date when the sub buns were received, did not have a use by date or a manufacturer expiration or use by date on the packaging. The bread and croissants had no date of when the items were received into the facility and did not have an expiration or use by date on the packaging.</p> <p>On [DATE] at 11:33 AM, an interview was conducted with the Dietary Manager Y. The Dietary Manager reported a system of labeling and that the sub buns were not labeled at the time the initial tour of the kitchen was conducted.</p> <p>On [DATE] at 11:53 PM, an interview was conducted with Dietician AA regarding concerns during the initial tour of the facility. The Dietician indicated that education would be provided to dietary staff regarding drying of dishes and cookware. The Dietician indicated that an audit was performed in the kitchen about a week prior and that new dishes (plates) had arrived but had not yet been put into service. It was discussed that once the plates were identified as an issue, they were not removed from service as also the case with the plastic cereal containers.</p> <p>A review of facility policy titled, Food Storage, reviewed/revise ,d+[DATE], revealed, Policy: Food storage areas shall be maintained in a clean, safe and sanitary manner . a. Food items in dry storage not in the original delivery box will be dated upon receiving with month, day and year . 7. Food items that are opened shall be put into sealable container or bag, labeled and dated with open and use-by-date .</p> <p>A facility documents titled, Food Dating, revealed, .Bread Use By or Best By date if un-opened on packaging. Bread with no used by date, 7 days from delivery (delivery day as day 1), 7 days once removed from freezer .</p> <p>A review of facility policy titled, Cleaning Equipment and Utensils, revised ,d+[DATE], revealed, Policy: Equipment and utensils will be properly cleaned and sanitized to prevent contamination. Purpose: Safe food handling and minimize the risk of cross contamination. Procedure: 1. Equipment that comes in direct contact with food (counters, blenders, slicers, toasters, mixers, etc.) a. Clean with hot soapy water, b. After cleaning, rinse equipment with clean water, c. Allow equipment to air dry .</p> <p>39083</p> <p>On [DATE] at 10:46 AM, during an inspection of the kitchen, assisted by Dietary Manager Y, the dish machine sanitizer concentration was tested using color indicating test strips and no chlorine sanitizer was detected after the first cycle. A second wash cycle was done, and a faint color change was indicated on the test strips, less that 25 parts per million. At this time, Dietary Manager Y stated that they will use the three-compartment sink while they wait for a technician to inspect the dish machine.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>According to the 2017 FDA Food Code Section According to the 2017 FDA Food Code Section ,d+[DATE]. 114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under ,d+[DATE].11(C) shall meet the criteria specified under S,d+[DATE].11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, P and shall be used as follows: (A) A chlorine solution shall have a minimum temperature based on the concentration and PH of the solution as listed in the following chart; P</p> <p>Concentration Range (mg/L) ,d+[DATE], ,d+[DATE], 100</p> <p>Minimum Temperature pH 10 or less [Celsius] ([Fahrenheit]) 49 (120), 38 (100), 13 (55)</p> <p>Minimum Temperature pH 8 or less [Celsius] ([Fahrenheit]) 49 (120), 24 (75), 13 (55)</p> <p>On [DATE] at 11:02 AM, a large dried spill and food debris accumulation was observed on the floor in the walk-in cooler. Additionally, an accumulation of a white mold-like substance was observed on the wire racks in the walk-in cooler. At this time, Dietary Manager Y stated they need to take the time to take the racks out back to wash them.</p> <p>According to the 2017 FDA Food Code Section ,d+[DATE].12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing.</p> <p>On [DATE] at 11:50 AM, the ice machine drain line was observed to have a small leak with water accumulating on the floor.</p> <p>According to the 2017 FDA Food Code Section ,d+[DATE].15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; P and (B) Maintained in good repair.</p>		

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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	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>This Citation has 2 Deficient Practice Statements (DPS):</p> <p>Deficient Practice Statement #1:</p> <p>Based on interview and record review, the facility failed to follow Standards of Practice for Infection Control, including collection of infection surveillance data, analysis of surveillance data to identify trends and patterns, and routine reporting of the surveillance findings to aid in preventing the spread of infection, which could result in infectious illness and unidentified outbreaks.</p> <p>Findings Include:</p> <p>FACILITY</p> <p>Infection Control</p> <p>On [DATE] at 11:17 AM, the Infection Prevention and Control program was reviewed with the Director of Nursing/DON and the new Infection Prevention and Control/IPC Nurse I. The DON said IPC Nurse I was new to the role and had been working in it about 1 month. He said over the past year, there had been 3 or 4 staff in the role.</p> <p>During the interview, the DON said the facility used McGeer's Criteria for surveillance of infections, to determine a Healthcare Associated Infection/HAI vs a Community Acquired Infection/CAI.</p> <p>The DON said the facility met monthly for QAPI (Quality Assurance and Performance Improvement) meetings; the Infection Control Committee/ICC meeting was monthly prior to the QAPI meetings.</p> <p>The DON was asked if the facility provided a monthly summary report analyzing infection surveillance data and he said they did not have a report. He said they reported it verbally at the monthly ICC meeting.</p> <p>A review of the monthly infection surveillance from [DATE]- [DATE] revealed there were no summary reports of infection data, including types of infections, infectious organisms, trends or resistance patterns. The DON was asked about this during the IPC program review, [DATE] at 11:50 AM. He said he had been at the facility for 1 month, but he thought this would have been discussed in the monthly Infection Control Committee meeting. He said there were no written reports, but they would have talked about it.</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 - Many</p>	<p>Upon further review of the monthly infection surveillance/Line listings for [DATE]-[DATE], revealed there were no infection surveillance Line listings for [DATE], [DATE] and December of 2023. The DON was asked about this, and he stated, That is all we have. I wasn't here then. The facility was not able to analyze data for trends because there were limited monthly infection line listings. Each month from [DATE]-[DATE] had individual resident Infection Reports for some of the residents, but most were incomplete. There was no information received for March or [DATE]. There were a few antibiotic lists in some of the months (, but they did not match with the resident Infection Reports or Line lists if present that month. The antibiotics were not compared to resident infections, or documented if they were appropriate or effective. There was no documentation that the facility was monitoring for Multi-drug Resistant Organisms.</p> <p>The Infection Surveillance Line Listings for [DATE]- [DATE] and [DATE] had incomplete information, some only included type (such as UTI) and antibiotic, some identified HAI or CAI and some did not. There were no culture results to identify infectious organisms on the Line listings; many did not identify signs or symptoms of illness. When there was a skin infection, it did not identify where. There were numerous entries Systemic but there was no clarification what this was, no signs or symptoms: only the antibiotic prescribed. There was no Line Listing for [DATE].</p> <p>There were several residents listed as having pneumonia, but no signs or symptoms were identified on the Line Listings. There was no analysis to compare where the residents were located in the facility or if there were contributing factors. The Line Listings were not a working tool to assist the IPC Nurse in identifying infections and trends to aid in preventing continued infections or outbreaks.</p> <p>A review of the Centers for Disease Control and Prevention's CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in all Settings, dated [DATE] provided the following: Adherence to infection prevention and control practices is essential to providing safe and high quality patient care across all settings where healthcare is delivered .</p> <p>APIC (Association for Professional in Infection Control and Epidemiology) Text: Surveillance, revised publication [DATE] provided, . Surveillance can be defined as a comprehensive method of measuring outcomes and related processes of care, analyzing the data, and providing information to members of the healthcare tea to assist in improving those outcomes. Surveillance is an essential component of an effective IPC program. Infection surveillance is a process that includes review of both laboratory data and clinical data to allow for identification of specific infection types .</p> <p>A review of the facility policy titled, Infection Prevention and Control Program, date implemented ,d+[DATE] and reviewed and revised ,d+[DATE] provided, . a System of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases . Antibiotic Stewardship: a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program .</p> <p>39083</p> <p>Deficient Practice Statement #2:</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 - Many</p>	<p>Based on observation, interview, and record review, the facility failed to monitor and remediate Legionella presence in premise plumbing, resulting in the potential for increased respiratory disease, for 13 residents (#2, #19, #31, #41, #49, #62, #90, #93, #101 and 4 supplemental residents (S1, S2, S3 and S4) and potentially affecting all residents in the facility.</p> <p>Findings include:</p> <p>A record review of Legionella Summary Sheet, from [certified laboratory], dated [DATE], noted 8 of 16 water samples taken from the facility had Legionella isolated with multiple serogroups detected, ranging from 0.4 to 12.0 colony forming units (CFU).</p> <p>A record review of Legionella Summary Sheet, from [certified laboratory], dated [DATE], noted 3 of 16 water samples taken from the facility had Legionella isolated with multiple serogroups detected, ranging from 0.5 to 4.0 CFU's.</p> <p>According to the CDC's Routine Legionella testing: A multifactorial approach to performance indicator interpretation, at https://www.cdc.gov/control-legionella/media/pdfs/Control-Toolkit-Routine-Testing.pdf, Figure 1, it notes, Concentration indicates that Legionella growth appears: Uncontrolled - (equal to or greater than) 10 CFU/mL in potable water, and Poorly Controlled - 1.0 - 9.9 CFU/mL in potable water .</p> <p>During an interview on [DATE] at 3:00 PM, Maintenance Director CC was queried on the water management plan legionella testing frequency and stated that a contracted company comes out around each quarter to draw water samples to test for legionella. Maintenance Director CC was then queried on what remediation efforts occurred after the positive legionella samples were identified and stated that they had increased flushing at those positive sample locations. When asked if the legionella positive water samples were re-sampled, Maintenance Director CC stated they were not.</p> <p>During an interview on [DATE] at 3:04 PM, the Administrator was queried on facility control measures to reduce legionella in premise plumbing and stated they flush water fixtures in resident rooms daily and flush the legionella positive water sources for a longer period. When asked why the facility didn't re-sample the positive legionella water sources after the extended flushing, the Administrator stated that they determined those areas were not high risk, and if residents are exhibiting symptoms of legionellosis, they are tested if they go to the hospital.</p> <p>According to the U.S. Center for Disease Control and Prevention (CDC), Clinical Overview of Legionnaires' Disease, at https://www.cdc.gov/legionella/hcp/clinical-overview/index.html, it notes, Risk factors for legionellosis include: - Age [equal to or over] [AGE] years - Chronic lung disease (such as emphysema or COPD) - Immune system disorders due to disease or medication - Smoking (current or historical) - Systemic malignancy - Underlying illness such as diabetes, renal failure, or hepatic failure</p> <p>A review of 30 hospital laboratory reports for residents tested for Legionnaires' disease show that all laboratory tests were Legionella Urinary Antigen test and no cultures of lower respiratory secretions were tested . According to the result comments in the Laboratory Report [Hospital], it notes, Infection can't be ruled out since the antigen present in the sample may be below the detection limit of the test. Additionally, this test will not detect infections caused by other Legionella pneumophilia serogroups or by other Legionella species.</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 - Many</p>	<p>According to the CDC's What Clinicians Need to Know about LEGIONNAIRES' DISEASE, at https://www.cdc.gov/legionella/downloads/fs-legionella-clinicians.pdf, it notes, "The preferred diagnostic test for Legionnaires' disease are culture of lower respiratory secretions (e.g., sputum, bronchoalveolar lavage) on selective media and the Legionella urinary antigen test. Serological assays can be nonspecific and are not recommended in most situations. Best practice is to obtain both sputum culture and a urinary antigen test concurrently. Sputum should ideally be obtained prior to antibiotic administration, but antibiotic treatment should not be delayed to facilitate this process. The urinary antigen test can detect Legionella infections in some cases for days to weeks after treatment. The urinary antigen test detects Legionella pneumophila serogroup 1, the most common cause of Legionnaires' disease; isolation of Legionella by culture is important for detection of other species and serogroups and for public health investigation. Molecular techniques can be used to compare clinical isolates to environmental isolates and confirm the outbreak source."</p> <p>During an interview on [DATE] at 2:16 PM, Medical Director A was queried if they were aware of the presence of Legionella in the water system and stated, "I didn't even know there was Legionella in the water. When the Surveyor referred to the CDC's Routine Legionella testing: A multifactorial approach to performance indicator interpretation, document indicating poorly controlled Legionella growth, Medical Director A stated, "I agree."</p> <p>Legionella</p> <p>On [DATE] at 11:17 AM, the Infection Prevention and Control program was reviewed with the Director of Nursing/DON and the new Infection Prevention and Control/IPC Nurse I. The DON said IPC Nurse I was new to the role and had been working in it about 1 month. He said over the past year, there had been 3 or 4 staff in the role.</p> <p>During the interview the DON and IPC were asked about the facilities Water Management Program, they said the Maintenance Director handled that. Reviewed with them the importance of the IPC and Maintenance department working together to identify presence of Legionella in the facilities water. They said they were aware.</p> <p>On [DATE] at 3:00 PM, during a review of the facilities water test analysis Legionella Summary Sheet, for [DATE] and [DATE]. They indicated positive Legionella results in the facilities water in various sites tested in the building, including the following:</p> <p>[DATE]: Resident Rooms- 214, 303, 334 and 426. The results for Legionella were also high in the Hot water recirculating line.</p> <p>[DATE]: Resident Rooms- 333, 420 and 426.</p> <p>When the positive Legionella samples were identified in the water in the residents' rooms, additional resident rooms were not tested to see if they also had high levels of Legionella in the water.</p> <p>A review of the monthly infection surveillance data for [DATE]-[DATE] indicated no mention of Legionella in the water or monitoring residents for signs and symptoms of Legionellosis (including Legionnaires disease or Pontiac fever).</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 - Many</p>	<p>A review of the CDC's guidelines for Legionella ([DATE]) identified the following list of potential signs and symptoms of illness from the bacteria: . Legionnaires disease and Pontiac fever are two illnesses caused by bacteria called Legionella. They present differently in terms of clinical features, symptoms, and complications. The organism can be isolated in Legionnaires' disease cases, but not for Pontiac fever . Legionnaires disease is characterized by illness with pneumonia . Pontiac fever is a milder, self-limiting illness without pneumonia . Legionnaires disease: Clinical symptoms may vary but include acute onset of lower respiratory illness with fever or cough. Additional symptoms may be present: Chest discomfort, headache, malaise, nausea, diarrhea, or abdominal pain. Pontiac fever: Symptoms include- Chills, fatigue, fever, headaches, malaise, myalgia, nausea or vomiting . Legionnaires disease: hospitalization is common . For healthcare associated infections, the case-fatality rate averages 25%. Pontiac fever: hospitalization is uncommon. The case-facility rate is extremely low.</p> <p>During resident reviews, it was identified there were residents with respiratory signs and symptoms, including pneumonia who were transferred to the hospital from [DATE]- [DATE]; this included 13 residents (#s 2, 19, 31, 41, 49, 62, 90, 93, 101 and 4 supplemental residents (S1, S2, S3 and S4).</p> <p>Resident #2: room [ROOM NUMBER]</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Respiratory failure ([DATE]), COPD, end stage renal disease, dependence on renal dialysis, heart disease, anemia, atrial fibrillation, pain, depression, hypothyroidism, history of venous thrombosis and GERD. The MDS assessment dated [DATE] indicated the resident had moderate cognitive loss with a Brief Interview for Mental Status (BIMS) score of , d+[DATE] and the resident needed some assistance with all care.</p> <p>On [DATE] at 9:22 AM, during a tour of the facility, Resident #2 was observed lying in bed with her meal tray on the bedside table in front of her. She said she was supposed to leave for dialysis but wanted to finish her tea and a muffin. The resident fell asleep while trying to drink her tea. The Emergency Medical Services transport staff entered the room and said the resident had a change of condition. They said she usually wasn't like that. She was usually awake, alert and talking with them.</p> <p>On [DATE] at 9:14 AM, Resident #2 was observed lying in her bed alert and talkative. She said she felt much better. The resident said for the past 3 weeks she had been very tired and sleepy. She said it sometimes happened to her and she did not know why. She said she had a bad cough for a long time and stated, The last time I was in the hospital, I had breathing medicine 6 times a day. It cleared me up.</p> <p>A record review indicated Resident #2 was transferred to the hospital 5 times between [DATE]-[DATE]: [DATE], [DATE], [DATE], [DATE], [DATE]. Each times was for hypoxia (shortness of breath) and a change of condition.</p> <p>Resident #2's room in the facility was 423. It was not tested for presence of Legionella in the water.</p> <p>The additional 12 residents were each transferred to the hospital for acute changes of condition with changes in respiratory status.</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 - Many</p>	<p>Resident #19 was transferred to the hospital on [DATE] with a change of condition. She was unable to eat or drink.</p> <p>Resident #31: room [ROOM NUMBER]</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #31 indicated admission to the facility on [DATE] with diagnoses: Diabetes, kidney disease, left ankle pressure ulcer Stage 3, spine disorder, depression, history of seizures, prostate enlargement, right leg amputation below the knee, hypertension, and anemia. The MDS assessment dated [DATE] revealed the resident had moderate cognitive decline with a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] and needed some assistance with eating and hygiene and dependence with all other care.</p> <p>Resident #31 was transferred to the hospital on [DATE] with respiratory distress. He was in room [ROOM NUMBER].</p> <p>Resident #41: room [ROOM NUMBER]</p> <p>Resident #41 was transferred to the hospital on [DATE] and [DATE] with changes of condition including respiratory issues.</p> <p>Resident #49: room [ROOM NUMBER]</p> <p>A review of Resident #49's medical record revealed an admission into the facility on [DATE] and re-admission on [DATE] with diagnoses that included acute respiratory failure, diabetes, altered mental status, fracture of the left humerus, difficulty in walking, dementia, falls and weakness.</p> <p>The resident was transferred to the hospital for a change of condition on [DATE].</p> <p>Resident #62: room [ROOM NUMBER]</p> <p>A review of Resident #62's medical record revealed an admission into the facility on [DATE] and readmission on [DATE] with diagnoses that included Parkinson's disease, acute respiratory failure, tracheostomy status, diabetes, muscle weakness and gastrostomy. The Resident had a tracheostomy tube (a curved tube placed through a surgical opening through the neck into the trachea (windpipe).</p> <p>The resident was transferred to the hospital on [DATE] with a fever, low blood pressure and a change in respiratory status.</p> <p>Resident #90: room [ROOM NUMBER]</p> <p>A review of the Face sheet indicated Resident #90 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses: COPD exacerbation, heart disease, a pulmonary nodule depression, anxiety, hypertension and atrial fibrillation.</p> <p>Resident #90 was transferred to the hospital on [DATE] for shortness of breath.</p> <p>Resident #93: room [ROOM NUMBER]</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 - Many</p>	<p>A review of the Face sheet and progress notes indicated Resident #93 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: diabetes, bipolar disorder, kidney disease, right ankle osteomyelitis (bone infection), and right knee pain.</p> <p>The resident was transferred to the hospital on [DATE] with a change of condition, tiredness, weakness and a headache; and on [DATE] with changes in breathing.</p> <p>Resident #101: room [ROOM NUMBER]</p> <p>Resident #101 was readmitted to the facility on [DATE] with diagnoses: quadriplegia, pressure ulcer of sacral region and non-pressure chronic ulcer of right heel and midfoot.</p> <p>Resident #101 was transferred to the hospital on [DATE] for a change of condition.</p> <p>Supplemental Resident #1</p> <p>Supplemental Resident #1 was admitted to the facility on [DATE] with diagnoses: history of pneumonia, weakness, dysphagia, history of head, face and neck cancer, and heart disease.</p> <p>Supplemental Resident #1 was transferred to the hospital on [DATE] with shortness of breath, and unresponsiveness.</p> <p>Supplemental Resident #2 was transferred to the hospital on [DATE] for swollen glands and did not return prior to exit on [DATE].</p> <p>Supplemental Resident #3</p> <p>Supplemental Resident #3 was readmitted to the facility on [DATE] with diagnoses: COPD, diabetes, morbid obesity, acute cough ([DATE]), hypertension, depression, heart failure and chronic pain.</p> <p>The resident was transferred to the hospital on [DATE] with pneumonia, decreased mentation, difficult to arouse. The resident did not return to the facility.</p> <p>Supplemental Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: history of a stroke, COPD, heart disease, history of a myocardial infarction and anxiety.</p> <p>The resident was transferred to the hospital on [DATE] with a change of condition.</p> <p>Supplemental Resident #5</p> <p>Supplemental Resident #5 was admitted to the facility on [DATE]. The resident was transferred to the hospital on [DATE] for an acute change in respiratory status and died that day.</p> <p>The residents did not have their rooms tested for Legionella in the water. The facility had the hospitals perform urine antigen tests for Legionella when the residents were transferred to the hospital, but they were only able to detect L. pneumophila serogroup 1 antigen and some of the prior rooms and facility samples had tested positive for other serogroup types. The tests were not considered diagnostic for Legionellosis.</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 - Many</p>	<p>On [DATE] at 2:25 PM, during the interview with Medical Director A, he was asked what he would do for the resident's that had signs and symptoms of potential Legionellosis and he said he would have ordered the urine antigen tests and sputum samples; he would have monitored them differently. He said he did not know that the facility continued to test positive for Legionella in the water.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>37666</p> <p>Based on interview, and record review the facility failed to ensure that resistance patterns of infectious organisms were identified, analyzed and reviewed in the Antibiotic Stewardship Program, potentially affecting all residents with exposure to unnecessary medications, antibiotic resistance and infection.</p> <p>Findings Include:</p> <p>FACILITY</p> <p>Infection Control</p> <p>On 5/21/24 at 11:17 AM, the Infection Prevention and Control program was reviewed with the Director of Nursing/DON and the new Infection Prevention and Control/IPC Nurse I. The DON said IPC Nurse I was new to the role and had been working in it about 1 month. He said over the past year, there had been 3 or 4 staff in the role.</p> <p>During the interview, the DON said the facility used McGeer's Criteria for surveillance of infections, to determine a Healthcare Associated Infection/HAI vs a Community Acquired Infection/CAI. He said they had identified that some providers were ordering antibiotic treatment for resident infections, but the nurses weren't documenting signs and symptoms of the infections.</p> <p>The DON said the facility met monthly for QAPI (Quality Assurance and Performance Improvement) meetings; the Infection Control Committee/ICC meeting was monthly prior to the QAPI meetings. He said the Antibiotic Stewardship Program included ensuring antibiotic use met McGeer's criteria and if it didn't the provider had to explain their risk vs benefit for using the antibiotic.</p> <p>The DON was asked if the facility provided a monthly summary report analyzing antibiotic use, resident infections, and antibiotic culture reports and he said they did not. When asked if the facility utilized an Antibiogram (a summary of antimicrobial susceptibility rates for select microbial pathogens that aids in identifying resistance patterns), he said they did not.</p> <p>A review of the monthly infection surveillance from June 2023- May 2024 revealed there were no summary reports of infection data or antibiotic stewardship including resistance patterns. The DON was asked about this during the IPC program review, 5/21/2024 at 11:50 AM. He said he had been at the facility for 1 month, but he thought this would have been discussed in the monthly Infection Control Committee meeting. He said there were no written reports, but they would have talked about it.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Upon further review of the monthly infection surveillance/Line listings, there were none for October 2023, November 2023 and December of 2023. The DON was asked about this, and he stated, That is all we have. I wasn't here then. The facility was not able to analyze data for trends because there were limited monthly infection line listings. Each month from June 2023-May 2024 had individual resident Infection Reports for some of the residents, but most were incomplete. There was no information received for March or April 2024. There were a few antibiotic lists in some of the months, but they did not match with the resident Infection Reports or Line lists if present that month. The antibiotics were not compared to resident infections, or documented if they were appropriate or effective. There was no documentation that the facility was monitoring for Multi-drug Resistant Organisms.</p> <p>A review of the CDC (Centers for Disease Control and Prevention) Core Elements of Antibiotic Stewardship for Nursing Homes, dated March 18, 2024 revealed the following: .Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use . Tracking and Reporting Antibiotic Use and Outcomes: Nursing homes monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness .</p> <p>A review of the facility policy titled, Infection Prevention and Control Program, date implemented 04/17 and reviewed and revised 1/24 provided, . a System of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases . Antibiotic Stewardship: a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program .</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview, and record review the facility failed to ensure residents were 1) consistently assessed for Influenza, Pneumococcal and COVID-19 immunization on admission, 2) offered Influenza, Pneumococcal and COVID-19 vaccinations, , 3) documented the vaccinations were accepted or declined for one (Resident #2), of 5 residents reviewed for respiratory care and immunizations, resulting in a potential for widespread Influenza, Pneumonia and COVID-19 exposure and infection throughout the facility.</p> <p>Findings Include:</p> <p>FACILITY</p> <p>Infection Control</p> <p>Resident #2</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Respiratory failure (5/14/2024), COPD, end stage renal disease, dependence on renal dialysis, heart disease, anemia, atrial fibrillation, pain, depression, hypothyroidism, history of venous thrombosis and GERD. The MDS assessment dated [DATE] indicated the resident had moderate cognitive loss with a Brief Interview for Mental Status (BIMS) score of 10/15 and the resident needed some assistance with all care.</p> <p>On 5/20/24 at 9:22 AM, during a tour of the facility, Resident #2 was observed lying in bed with her meal tray on the bedside table in front of her. She said she was supposed to leave for dialysis but wanted to finish her tea and a muffin. The resident fell asleep while trying to drink her tea. The Emergency Medical Services transport staff entered the room and said the resident had a change of condition. They said she usually wasn't like that. She was usually awake, alert and talking with them.</p> <p>On 5/21/24 at 9:14 AM, Resident #2 was observed lying in her bed alert and talkative. She said she felt much better. The resident said for the past 3 weeks she had been very tired and sleepy. She said it sometimes happened to her and she did not know why. She said she had a bad cough for a long time and stated, The last time I was in the hospital, I had breathing medicine 6 times a day. It cleared me up. She said she went to dialysis 3 times a week on Monday, Wednesday and Friday. She said she took a packet of papers with her and the dialysis center cent a packet back with her and she gave them to the nurse.</p> <p>On 5/21/24 at 11:17 AM, the Infection Prevention and Control program was reviewed with the Director of Nursing IC DON and the new Infection Prevention and Control/IPC Nurse I. They said the nurses assessed the residents for Flu and Pneumonia on admission and the IPC nurse provided the vaccinations.</p> <p>A record review of the immunizations for Resident #2 documented in the electronic medical record revealed the following information:</p> <p>(continued on next page)</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Influenza Not Eligible (undated).</p> <p>PPV23 11/30/2017 Historical</p> <p>SARS-COV-2 (COVID-19) (Dose 1) -Immunization Req.</p> <p>PCV20 Immunization Req.</p> <p>The immunization documentation was incomplete. It said Resident #2 was not eligible for the Influenza vaccination, but did not say why or when it was assessed.</p> <p>It indicated PCV20 vaccination was required, but there was no acceptance or declination indicating why it wasn't provided.</p> <p>The SARS-COV-2 (Covid-19) vaccination was identified as required, but there was no acceptance or declination form. There was no documentation explaining why the resident was not provided the vaccinations.</p> <p>A review of the facility policy titled, Infection Prevention and Control Program, date implemented 4/17 and revised 1/24 provided, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . Influenza and Pneumococcal Immunization: . Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time . Residents will be offered the pneumococcal vaccines recommended by the CDC (Centers for Disease Control and Prevention), upon admission, unless contraindicated or received the vaccines elsewhere . Education will be provided to the residents and /or representatives regarding the benefits and potential side effects . Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations . Residents and staff will be offered the COVID-19 vaccine . Residents and staff will be screened prior to offering the vaccination for prior immunization . Education about the vaccine, risks, benefits, and potential side effects will be given . Documentation will reflect that education was provided .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>Based on observation, interview and record review, the facility failed to ensure a safe, functional, sanitary and comfortable environment on the 2nd, 3rd and 4th floors with furniture/fixtures/walls/flooring in disrepair, ventilation system with dust and debris, unsecured oxygen tank stored in a Resident's room, odors in rooms/hallways, and a wet floor in the 2nd floor common area. This deficient practice has the potential to affect all Resident's residing in the facility with a census of 118, resulting in the potential for accidents, fall or injury, respiratory illness, infection and dissatisfaction of living conditions.</p> <p>Findings include:</p> <p>Initial tour of the facility</p> <p>On 5/19/24 at 10:58 AM, an observation was made on the 2nd floor common area with a large wet area near the two air conditioners. Residents were observed to be coming in and out of the common area. A round table in the middle of the room that was positioned on a pedestal that was loose or broken causing the table to have an extreme wobble. Staff had come into the room and were not aware of the puddle of water that extended across the back portion of the room.</p> <p>On 5/19/24 at 11:06 AM, during the initial tour of the facility, an observation was made in room [ROOM NUMBER]. The room had an odor of urine. An observation was made of a brief discarded in the garbage in the room with lines on the brief that indicated it was wet.</p> <p>On 5/19/24 at 11:53 AM, an observation was made in the bathroom of 307 of the bathroom floor broken at the entrance with a piece missing out of the flooring. There is a bedpan stored on the counter next to the sink with paper towels in the indentation of the bedpan. The bedpan looks as if has been used.</p> <p>On 5/19/24 at 12:05 PM, an interview was conducted with a Resident in room [ROOM NUMBER]. An observation was made of an oxygen tank set by the bedside of bed A. The Resident indicated she did not use oxygen and did not know why it was there. The oxygen tank was partially full, standing upright and not in a holder.</p> <p>On 5/19/24 at 12:32 PM, an observation was made of room [ROOM NUMBER] during the initial tour of the facility. The bathroom smelled like urine. A bedpan was positioned on a chair in the bathtub. The bedpan looked like it had been used due to scant amount of debris on the inside edge. A pair of jeans were folded and placed inside the bedpan. There were no paper towels in the towel paper dispenser and no paper towels on or around the sink area.</p> <p>On 5/19/24 at 12:48 PM, an observation was made during the initial tour of the facility of the bathroom in room [ROOM NUMBER]. The sink is not secured in the hole in the counter and the cut edge of the counter can be seen around the edge of the sink.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/19/24 at 2:21 PM, an interview and observation were conducted with the Director of Nursing (DON) regarding the free-standing oxygen tank in room [ROOM NUMBER]. The DON indicated that an oxygen tank needed to be in a holder. The DON retrieved an oxygen tank holder with wheels and removed the oxygen tank from the room.</p> <p>On 5/20/24 at 9:39 AM, an observation was made in the bathroom of room [ROOM NUMBER]. The bathroom had a strong odor of urine. A brief that was used for incontinent episode was in the bathroom wastebasket. The jeans remained in the bedpan that was on a chair in the bathtub that was observed on 5/19/24.</p> <p>On 5/20/24 at 11:16 PM, an observation was made in room [ROOM NUMBER] of a door on the closet that was off the hinge and loose on the other hinge making the closet door sit at an angle.</p> <p>On 5/20/24 at 11:19 PM, an observation was made in room [ROOM NUMBER] of the bed closest to the door to have a foot board on the end of the bed held on with two bolts on one side and no bolts on the other side. The footboard was loose and wobbly.</p> <p>On 5/20/24 during the initial tour of the facility, the vent near the elevator on the 2nd and 3rd floors, positioned on the wall next to the wall where the elevators were located, had very thick dust and debris that covered the venting area and visible through the vent covering.</p> <p>39083</p> <p>On 5/20/24 at 10:11 AM, the window valance, located in room [ROOM NUMBER], was observed to be approximately 75% stained with an unknown substance. Additionally, the bathroom floor of room [ROOM NUMBER] was observed to be soiled behind the toilet.</p> <p>On 5/20/24 at 10:14 AM, the 2nd floor shower room was observed to be missing a toilet paper holder next to the toilet, and no toilet paper was available.</p> <p>On 5/20/24 at 12:07 PM, dust and lint accumulation was observed on the floor in the 2nd floor clean linen room.</p> <p>On 5/20/24 at 12:14 PM, a box of foam cups was observed stored on the floor in the 3rd floor clean utility room.</p> <p>On 5/20/24 at 12:16 PM, the sink basin was observed not properly set into the bathroom vanity in room [ROOM NUMBER], leaving a half-inch gap around the sink basin.</p> <p>On 5/20/24 at 12:18 PM, the closet door, provided for room [ROOM NUMBER], bed 1, was observed to be hanging off of the hinges.</p> <p>On 5/20/24 between 1:55 PM and 2:43 PM, during an environmental tour, assisted by Maintenance Director CC, the following observations were made:</p> <p>- Three stains were observed in the ceiling tile in room [ROOM NUMBER]. Two stains were observed in the ceiling tile in the hall outside room [ROOM NUMBER] and 434.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - An oxygen canister, located in the 4th floor clean utility room, was observed to not be secured properly to prevent tipping, and was leaning against a wire rack. At this time, Maintenance Director CC informed nursing staff of the unsecured oxygen canister. - Lint and dust accumulation was observed on the floor in the 4th floor clean linen room. Maintenance Director CC confirmed the finding and stated that housekeepers are supposed to be cleaning the clean linen room floors. - Broken bed frame parts were observed stored leaning against the bathroom wall of room [ROOM NUMBER]. Additionally, the bath tub spout was dripping water and a pink biofilm was accumulating around the tub drain. - The hand rail, located in the hall near the 3rd floor clean linen room, was observed pulled out of the wall and unable to support minimal weight. - The closet door of room [ROOM NUMBER] was observed to be unattached from the closet and stored in the bathroom. Maintenance Director CC confirmed the finding and stated that staff didn't report the issue into the electronic maintenance management program. - During an interview at 2:00 PM, Resident 82 was queried if they have any issues with their room and stated that their over-bed light hasn't been working for a few months. Resident 82 proceeded to demonstrate the light not working. - The sink basin of room [ROOM NUMBER] was observed to not be properly set into the bathroom vanity top, leaving a half-inch gap around the edge of the sink basin. -During an interview at 2:34 PM, Housekeeper DD was queried on what rooms were cleaned on the 2nd level at this time, to which Housekeeper DD pointed to a wing and stated those rooms were cleaned. room [ROOM NUMBER] (cleaned room) was observed to have a large, dried spill under the bedside table of Bed 2, and the floor was observed to have food debris throughout. Additionally, the bathroom of room [ROOM NUMBER] was observed to have a dried yellow substance on the floor around the toilet. - A working spray bottle, located in the laundry room, was observed to not have a label to identify the contents. Maintenance Director CC confirmed the finding. <p>49944</p> <p>On 05/19/24 at 9:55 AM, an initial tour of the 200 unit was conducted:</p> <ul style="list-style-type: none"> -It was noted the 200 unit had a strong smell of urine upon exiting the elevator near the nurses station. -room [ROOM NUMBER] had a strong scent of urine, no resident was present during observation. The hallway outside of room [ROOM NUMBER] had a strong smell of air freshener to mask the urine smell. -room [ROOM NUMBER]-1 had a mattress in poor condition, the top coating was cracked and chipping off. <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-room [ROOM NUMBER]-2 had a bedside table in poor repair, the top of it was bubbled and peeling. There was mold noted on the floor by the bathtub.</p> <p>-room [ROOM NUMBER]-2 had a mattress in poor condition, the top coating was cracked and peeling. The bathroom needs drywall repair over the toilet. the toilet was turned on an angle and not secured to the floor, no bag in the garbage can.</p> <p>-The second floor shower room revealed no bag in the garbage can and no paper towels in the holder by the sink.</p> <p>-One of the elevators had cracked moulding near the floor with a visible hole and a picture on the back wall with a broken frame.</p>