

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235366	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Forest Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 1095 Medical Park Dr Grand Rapids, MI 49506	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>41027</p> <p>This citation pertains to Intake #MI00147517</p> <p>Based on interview, and record review, the facility failed to prevent the misappropriation of resident medications in 2 of 5 residents (Resident #109 & #110) reviewed for misappropriation of property, when a licensed nurse diverted controlled medications for personal use, resulting in the potential for all residents in the facility to be affected.</p> <p>Findings include:</p> <p>Review of a facility reported incident (FRI) submitted on 10/12/24 at 9:30 PM revealed, Perpetrator: (Registered Nurse (RN) M) .Type of Alleged Incident: Misappropriation, Date/Time Incident Discovered: 10/12/24 at 8:40 PM, Incident Summary: At approximately 8:40 PM NHA (Nursing Home Administrator (NHA) A) was notified that the (local police department) notified the Director of Nursing (DON B) that four cards and one bottle were found in the nurse's house with resident names on them, however, did not state the names of the residents and would not release the names of the residents, counts of the medications or the types of the medication to NHA .Employee suspended pending investigation .Full narcotic count of medications in the facility completed, and pain assessments completed for all residents residing in the facility.</p> <p>Review of a statement from DON B dated 10/12/24, indicated that she had received a call from the local police notifying her that while inside RN M's home, they had discovered narcotic medications that belonged to residents at the facility.</p> <p>Review of a statement from NHA A dated 10/14/24 at 1:22 PM, indicated that he had spoken to the local police department that day and confirmed that they had responded to an incident at RN M's home on 10/12/24. The police department verified the information but was not able to provide any additional details at that time.</p> <p>Review of a statement obtained via phone from RN M dated 10/15/24 revealed, .(RN M) was able to confirm that the medication that was misappropriated was one during the destruction process. (RN M) was also able to confirm that it was around a year ago when their medications were misappropriated. When asked about the resident's names and what medications they were, she stated she was unable to remember the names of the residents and stated that she believes it was Ativan (controlled anxiety medication) and Oxy (Oxycodone: a narcotic pain reliever) that she took from the facility during the destruction process.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235366
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the police report, obtained by this surveyor on 10/16/24 revealed, .Event occurred from 10/12/24 7:30 PM-10/12/24 9:29 PM .Suspect: (RN M) .located three sheets of prescriptions .All three sheets of prescriptions were prescribed to subjects other than (RN M) .Unprescribed/Stolen Medications: Lorazepam (Ativan) 0.5 mg tablet (sheet): prescribed to: (Resident #109). Prescription # 14275710. 18/60 pills are missing out from the prescription sheet .Oxycodone 5 mg (sheet): Prescribed to: (Resident #110). Prescription #12207906. 44/58 pills are missing out of the prescription sheet. Tramadol HCL (narcotic pain medication) 25 mg (sheet): Prescribed to: (Resident #109). Prescription #14288137. 6/26 pills are missing out of the prescription sheet .</p> <p>In an interview on 10/16/24 at 9:22 AM, Pharmacy Technician (PT) G confirmed that Prescription #14275710 was, Lorazepam prescribed to Resident #109 in March 2024, Prescription #14288137 was Tramadol, prescribed to Resident #109 in June 2024, and Prescription #12207906 was Oxycodone, prescribed to Resident #110 in November 2023.</p> <p>Review of Resident #109's Controlled Substance Proof-Of-Use Record revealed, .RX# (Prescription) 14275710 .Lorazepam 0.5 mg tablet .#60 . The record did not have any doses accounted for and was signed by RN M and witnessed by LPN (Licensed Practical Nurse) K on 7/18/24, indicating that all 60 tablets were destroyed. This was 1 of 2 records for RX# 14275710.</p> <p>Review of Resident #109's Controlled Substance Proof-Of-Use Record revealed, .RX#14275710 . Lorazepam 0.5 mg tablet .#52 . The record indicated that the resident had received 3 doses, and was signed by RN M and witnessed by LPN K on 7/18/24, indicating that 49 tablets were destroyed. This was 2 of 2 records for RX #14275710.</p> <p>Review of Resident #109's Controlled Substance Proof-Of-Use Record revealed, .RX# 14288137 .Tramadol 25 mg tablet .#26 . The record indicated that 2 doses had be administered to the resident. RN M signed to indicate destruction of 24 tablets on 7/18/24 and LPN K signed as a witness to the medication destruction.</p> <p>Review of Resident #110's Controlled Substance Proof-Of-Use Record revealed, .RX# #12207906 . Oxycodone 5 mg tablet .#58 . The record showed zero doses were administered to Resident #110. RN M signed to indicate destruction of 58 tablets on 12/12/23, and RN H signed as a witness to the medication destruction.</p> <p>In an interview on 10/16/24 at 10:09 AM, NHA A reported that LPN K and RN H were both suspended from work, due to their signatures being on the controlled medication records, listed as witness to the destruction of controlled medications that were then located in RN M's home and not destroyed.</p> <p>In an interview on 10/16/24 at 1:29 PM, LPN K reported that she had signed to verifying the destruction of narcotic medication at least 5 times over the past 6 months without visualizing the medication and/or medication card. LPN K reported that RN M would bring her a narcotic medication sheet, saying that she had already destroyed the medications. LPN K reported that she knew the policy was to witness the destruction of narcotic medications, but that she trusted RN M. LPN K reported that she never considered professional standards and/or notifying management regarding the breach of policy.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/17/24 at 12:21 PM, RN H reported that occasionally she would sign that she witnessed the destruction of narcotic medications, without seeing the medication and/or after the first nurse had already popped the pills out of the medication card. RN H reported that there were only a couple of nurses that did it that way, and RN M was the only name she could remember. RN H reported that she knew this was against facility policy but did not report it to anyone.</p> <p>Multiple attempts were made to interview RN M via phone on 10/16/24 and 10/17/24. RN M responded on 10/17/24 at 12:11 PM and declined an interview.</p> <p>In an interview on 10/16/24 at 12:22 PM, Unit Manager (UM) J reported that a controlled substance would be destroyed if a resident discharged, or the medication was discontinued. UM J reported that 2 nurses were required to complete the Controlled Substance Proof-Of-Use record together, indicating the medication destruction was witnessed.</p> <p>Resident #109</p> <p>Review of Resident #109's Physician Orders for March 2024 revealed, 3 separate orders for Lorazepam 0.5 mg written on 3/14/24, 3/21/24 and 3/27/24.</p> <p>Review of Resident #109's Physician Orders for June 2024 revealed, 1 order for Tramadol 25 mg PRN (as needed) written on 6/14/24.</p> <p>Resident #110</p> <p>Review of Resident #110's Physician Orders for November 2023 revealed, 1 order for Oxycodone 5 mg written on 11/14/23.</p> <p>In an interview on 10/17/24 at 10:10 AM, DON reported that she had started re-education and was implementing a new policy that would require narcotic medications to be destroyed by only nurse managers, and she would be tracking all narcotics that come into the facility herself going forward. Review of the education log dated 10/15/24 revealed 9 nurses had received re-education on 10/15/24, 4 nurses on 10/16/24, and 1 nurse on 10/17/24. The staff list provided by NHA A indicated a total of 10 nurses employed by the facility and 19 agency nurses.</p> <p>During an observation and interview of medication administration on 10/17/24 at 10:40 AM, the controlled substance proof-of-use binder was reviewed. on B hall. There was a Controlled Substance Shift Inventory record in the front of the binder. The last entry was not dated, indicated a total of 31 RX's were present at the start of the shift, 1 RX was added, and 32 were present at the end of the shift. The entry was signed by an outgoing nurse but was not witnessed by the oncoming nurse. LPN L reported that she had counted that morning when she started her shift, but did not sign the oncoming nurse space, and typically waits to sign until the end of the shift when she counts again.</p> <p>In an interview on 10/17/24 at 10:51 AM, UM C reported that when completing the controlled substance counts at shift change, the outgoing and oncoming nurses should sign at the same time, to ensure the medication counts are witnessed. UM C reported that the re-education related to the controlled substance destruction process did not clarify that the signatures should be recorded at the same time to attest to the count of narcotics.</p> <p>(continued on next page)</p>		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/17/24 at 10:54 AM, DON B reported that the nurses that count narcotics during shift change should sign the record at that time, to show that they were present, and witnessed the counts. DON B reported that the record for that day was not completed accurately.		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>41027</p> <p>This citation pertains to Intake #MI00147517</p> <p>Based on interview, and record review, the facility failed to maintain professional standards of nursing in 2 of 5 residents (Resident #109 & #110) reviewed for misappropriation of controlled medication, when licensed nurses falsely witnessed to the destruction of controlled medications, resulting in the diversion of narcotic medications for staff personal use.</p> <p>Findings include:</p> <p>Review of a facility reported incident (FRI) submitted on 10/12/24 at 9:30 PM revealed, Perpetrator: (Registered Nurse (RN) M) .Type of Alleged Incident: Misappropriation, Date/Time Incident Discovered: 10/12/24 at 8:40 PM, Incident Summary: At approximately 8:40 PM NHA (Nursing Home Administrator (NHA) A) was notified that the (local police department) notified the Director of Nursing (DON B) that four cards and one bottle were found in the nurse's house with resident names on them, however, did not state the names of the residents and would not release the names of the residents, counts of the medications or the types of the medication to NHA .Employee suspended pending investigation .Full narcotic count of medications in the facility completed, and pain assessments completed for all residents residing in the facility.</p> <p>Review of the police report, obtained by this surveyor on 10/16/24 revealed, .Event occurred from 10/12/24 7:30 PM-10/12/24 9:29 PM .Suspect: (RN M) .located three sheets of prescriptions .All three sheets of prescriptions were prescribed to subjects other than (RN M) .Unprescribed/Stolen Medications: Lorazepam (Ativan) 0.5 mg tablet (sheet): prescribed to: (Resident #109). Prescription # 14275710. 18/60 pills are missing out from the prescription sheet .Oxycodone 5 mg (sheet): Prescribed to: (Resident #110). Prescription #12207906. 44/58 pills are missing out of the prescription sheet. Tramadol HCL (narcotic pain medication) 25 mg (sheet): Prescribed to: (Resident #109). Prescription #14288137. 6/26 pills are missing out of the prescription sheet .</p> <p>In an interview on 10/16/24 at 9:22 AM, Pharmacy Technician (PT) G confirmed that Prescription #14275710 was, Lorazepam prescribed to Resident #109 in March 2024, Prescription #14288137 was Tramadol, prescribed to Resident #109 in June 2024, and Prescription #12207906 was Oxycodone, prescribed to Resident #110 in November 2023.</p> <p>Review of Resident #109's Controlled Substance Proof-Of-Use Record revealed, .RX# (Prescription) 14275710 .Lorazepam 0.5 mg tablet .#60 . The record did not have any doses accounted for and was signed by RN M and witnessed by LPN (Licensed Practical Nurse) K on 7/18/24, indicating that all 60 tablets were destroyed. This was 1 of 2 records for RX# 14275710.</p> <p>Review of Resident #109's Controlled Substance Proof-Of-Use Record revealed, .RX#14275710 . Lorazepam 0.5 mg tablet .#52 . The record indicated that the resident had received 3 doses, and was signed by RN M and witnessed by LPN K on 7/18/24, indicating that 49 tablets were destroyed. This was 2 of 2 records for RX #14275710.</p> <p>(continued on next page)</p>		

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