

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Clarkston		STREET ADDRESS, CITY, STATE, ZIP CODE 4800 Clintonville Rd Clarkston, MI 48346	

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 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283</p> <p>This citation pertains to Intake # MI00145010</p> <p>Based on interview and record review, the facility failed to accurately transcribe admission orders and follow up timely for one (R504) of two Residents reviewed for admission orders, resulting in R504 missing four days of their medications, including their blood thinner, diabetic, blood pressure and Gout medications.</p> <p>Findings include:</p> <p>R504</p> <p>A record review revealed that R504 was a long-term resident of the facility. They were originally admitted to the facility on [DATE]. R504 had multiple hospitalizations during their stay at the facility. R504 was recently admitted to the hospital on 3/21/24 and they were readmitted back to the facility on [DATE]. R504's diagnoses included respiratory failure, seizures, cerebral palsy with quadriplegia (weakness and decreased mobility of all four limbs), failure to thrive, and wound infection. Based on Minimum Data Set (MDS) assessment dated [DATE], R504 had severe cognitive impairment. R504 were dependent on staff assistance for their Activities of Daily Living (ADLs) including eating, toileting, bathing etc. R504 was dependent on staff assistance for their mobility.</p> <p>A complaint received by the State Agency revealed that the facility had failed to order all the medications that were ordered for R504 during their hospital stay after they were readmitted to the facility, including some critical medications.</p> <p>Review of R504's Electronic Medical Record (EMR) from the facility and the readmission records from the hospital revealed that R504 had multiple comorbidities that included chronic respiratory failure (from 2015) and recurrent aspiration pneumonia (from 2015), contractures of extremities, and anemia. R504 was hospitalized on [DATE] with the worsening of wound; had debridement and they were readmitted back to the facility on [DATE].</p> <p>Review of the discharge summary from the hospital dated 4/1/24, revealed the medications that included:</p> <p>Allopurinol 100 mg. (Milligram) one time/day (Gout medication).</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 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Cholecalciferol Tab. 25 Mcg (Microgram) (supplement).</p> <p>Pantoprazole Sodium 40 mg. (Medication for acid reflux) one time a day.</p> <p>Montelukast Sodium 10 mg. (allergy medication) one tablet at bedtime.</p> <p>Apixaban 5 mg. (blood thinner) one tablet two times/day.</p> <p>Metformin 500 mg. (diabetic medication) one tablet two times/day.</p> <p>Metoprolol Tartrate 12.5 mg. every 12 hours (blood pressure medication).</p> <p>Insulin 100 unit/ml (milli liter) per sliding scale with meals for diabetes.</p> <p>Diazepam rectal gel 20 mg rectally as needed for seizures lasting more than 3-5 minutes.</p> <p>Zofran 4 mg. one tablet by mouth every 6 hours as needed for nausea.</p> <p>Albuterol sulphate inhalation (2.5 mg/3ml) for wheezing.</p> <p>Review of the of the readmission physician orders dated 4/1/24 did not reveal that the above medications were ordered upon readmission back to the facility. Further review of Medication Administration Record (MAR) for April 2024 revealed that R504 did not receive any of the above medications as ordered. The above medications administered as ordered as of 4/5/24.</p> <p>Further record review revealed that facility staff failed to check R504's blood sugar until 4/4/24. Review of the blood sugar report revealed R504 had a (higher) blood sugar level of 224 mg/dL (milligrams per deciliter). Review of MAR and nursing progress note did not reveal that any follow up with physician was completed to address the high blood sugar level. R504 received their first dose of diabetic medications on 4/5/24 later in the afternoon.</p> <p>An e-mail request was sent to the facility administrator to provide the incident/accident reports for R504. A facility provided incident report revealed that the facility identified the medication error due to all the missed medications and follow up assessments were completed by the practitioner. The medications were ordered on 4/5/24.</p> <p>A nursing progress note dated 4/1/24 at 18:54 read, Readmit this (age and gender omitted) to 410B. Familiar with staff and facility. Reviewed meds (medications) with NP (Nurse Practitioner) and placed in e-MAR (electronic Medication Administration Record).</p> <p>A physician progress notes dated 4/2/24 revealed a medication list included some of the medications from the above list that were ordered to receive upon (re)admission to the facility. The medication list on the physician progress note did not accurately reflect the medications that R504 were receiving since their (re) admission to the facility.</p> <p>(continued on next page)</p>

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<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with MDS Nurse (MN A) who had completed the med error report was conducted on 6/25/24, at approximately 10:15 AM. During the interview they were inquired about the medication error for R504. MN A reported that they typically reviewed all resident's EMR upon admission or readmission within 24 hours. They were unavailable during that week and when they had reviewed the records a few days later. During their review they identified that multiple medications that were ordered from the hospital were not transcribed and ordered. They had followed with the physician, leadership team and the R504's guardian. MN A was asked about the facility process to ensure the accuracy of all medications/treatments that were ordered from the hospital. They reported that they were reviewing the orders and they were also in the process of training the unit managers. They also stated that the physicians/providers had checked to ensure the accuracy.</p> <p>An interview with Director of Nursing (DON) was completed on 6/25/24, at approximately 10:25 AM. During the interview, the DON was inquired if they were aware of the medications that were not ordered for R504 after they had returned from the hospital on 4/1/24. The DON reported that they were aware and did not know how it had happened. They added that the facility process was to have the admitting nurse verify the orders upon admission/readmission, followed by their unit managers within 24 hours, typically during their clinical meeting. There were also verified by the pharmacy and a copy of the hospital discharge orders were sent to the pharmacy and verified by the attending physician/providers. When notified that R504 had missed multiple medications that included blood thinners, diabetic medications etc. they reported that they understood the concern.</p> <p>A facility provided document that titled New admission/Readmission Checklist revealed the facility processes that included the following:</p> <p>Reconcile orders printed on the hospital 'discharge instructions' with the assigned physician/extender; fax narcotic scripts AND full medication list to pharmacy asap (as soon as possible) upon entry; enter e-MAR/e-TAR (electronic-Treatment Administration Record) and standing orders .</p>		