STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235511	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab of Roscommon	1290 E Michigan Hwy Roscommon, MI 48653

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397 Based on observation, interview and record review, the facility failed to ensure interventions to address fall prevention were implemented for two Residents (#5 & #6) of four residents reviewed for falls. Findings Include: Resident #5 (R5) Review of the care plan revealed R5 was identified on 11/21/23 at risk for accidents, injuries, and falls r/t (related to) hx (history) of falls with major injury, insomnia, heart failure, COPD (Chronic Obstructive Pulmonary disease) & emphysema with dependence on oxygen, impaired mobility and balance, generalized weakness, forgetfulness, impaired vision . Interventions on 11/21/23 included: Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance. Ensure that I am wearing non-skid footwear prior to assisting me with transfers and/or ambulation. Reduce my risk for falling by cleaning up spills or clutter from my floor, provide glare-free lighting, accessible working call light, bed set at height deemed appropriate by PT (Physical Therapy)/OT (Occupational Therapy)/Nurse (as applicable), my personal items within reach. Review fall risk factors on admission, quarterly, change of condition and with each fall. Review information on past falls and attempt to determine cause of falls. Record possible root cause(s) and remove any potential causes as applicable. On 11/27/23 R5's care plan was updated to include: (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encourage me to participate in activities that promote exercise, physical activity for strengthening and maintain mobility. On 5/5/24 the care plan was updated with: Offer reminders with routine checks to use call light for assistance with mobility needs. O 8/14/24 R5's care plan was update to include 15-minute visual safety checks. Review of R5's progress notes revealed the following: Event occurred on 08/14/2024 3:30 AM. Heard yelling coming from (R5's) room. Upon arrival to room, (R5) observed on floor laying on right side between bed and bathroom. [NAME] noted to be tipped over to the left of resident. Small amount of blood noted on floor, (R5) yelling my leg! Right lower leg noted to have bone protruding through skin. Minimal bleeding noted on floor and to pant leg. No other injuries observed. Floor was noted clean and dry, resident had grip socks in place. Call light within reach, but (R5) did not use call light at time of occurrence. Physician and responsible party notified. R5's care plan was update on 8/14/24 to include 15-minute visual safety checks. R5 fell again on 10/4/24, where the progress notes at 3:41 AM indicated (R5) was assisted to the commode next to her bed in her room. CNA went back into assist (R5) back to bed and resident asked for a few more minutes. (R5) was attempting to wipe herself falling forward, she did use her call light for assistance at that time. (R5) was observed on the floor on her right-side walker was laying on its side above her. noted urine on floor, (R5) did not have footwear on. (R5) stated she went down on her right knee; (R5) denied hitting her head and she denied any pain. Head to Toe assessment was completed no noted injuries . The facility failed to ensure R5 was wearing non-skid footwear per her care plan prior to getting up to the commode. Review of the progress note dated 11/29/24 at 5:10 AM, revealed R5 was found on the floor in their room . sitting on floor on buttock with back to bed and feet toward bathroom door . Review of facility incident report's root cause analysis revealed the facility did not include an analysis for effectiveness of 15-minute safety checks. The EMR (electronic medical record) revealed the last documented 15-minute check was more than an hour before the fall occurred. 15-minute checks on the 11/29/24 were documented as follows 12:03 AM, 3:00 AM, 4:07 AM, 8:05 AM, 8:05 AM, 10:07 AM, 2:07 PM, 2:07 PM, 4:17 PM, 6:55 PM, 8:52 PM, and 11:00 PM. The documentation on the date of the incident revealed inconsistencies with completing and documenting the required 15-minute checks. Resident #6 (R6) R6 was admitted to the facility on [DATE] with diagnoses including Parkinsonism, diabetes type II, generalized osteoarthritis, encephalopathy, motor and sensory neuropathy. R6 had a BIMS score of 15 indicating R6 was cognitively intact. R6's care plan implemented on 1/27/25, revealed : (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I am at risk for accidents, injuries, and falls r/t (related to) generalized weakness, diabetic neuropathy, Parkinsonism, impaired balance and mobility, Charcot-[NAME]-Tooth disease, and elevated ammonia levels. R6's care plan was updated on 3/5/25 post fall, to include: 15-minute visual safety checks with frequent reminders on call light use. R6's Current Care Record was updated to include: observe resident for visual safety check, offer frequent reminders on call light use every 15 minutes, charting Q2 hours. On 3/11/25, R6 was observed for a continuous period of 30 minutes revealed no staff completing the care planned 15-minute safety checks of R6, from 2:00 PM -2:30 PM. On 3/12/25 at 11:09 AM during an interview, the Director of Nursing (DON) stated the Q2 hour time frame for charting close supervision was to ensure staff were completing the 15-minute checks. When asked how the facility could ensure the checks were being completed if charting was only to be documented every 2 hours, the DON stated the documentation every two hours is the Certified Nursing Assistant's way of stating they had completed the 15-minute checks during that 2-hour time span. The DON explained the multiple exact times documented were due to staff charting at the end of their shifts and staff do not remember to change the time. When asked how the facility could determine 15-minute checks were being completed or if they were effective when staff are charting at the end of their shift, or only being required to chart in 2-hour increments, the DON did not provide an answer.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397 Based on observation, interview and record review, the facility failed to implement and maintain accurate and complete documentation for 15-minute safety checks for two Residents (#5 & #6) of two residents reviewed for documentation related to 15-minute safety checks. Findings include: Resident #5 (R5) Review of R5's Electronic Medical Record (EMR) revealed diagnoses including Chronic Obstructive Pulmonary Disease (COPD), dependence of supplemental oxygen, heart failure, Type II diabetes, presence of artificial eye, and legal blindness. R5 had a Brief Interview for Mental Status (BIMS) score of 15 indicating R5 was cognitively intact. R5 was identified as a fall risk on 11/21/23 as indicated during review of their care plan. R5's care plan was updated on 8/14/24 after a fall with injury, to include 15-minute visual safety checks due to cognitive impairment, failure to use call light consistently, and frequent attempts to ambulate unassisted. R5's Current Care Record was updated to 15-minute checks Q (every) 2 hours. A review of R5's EMR tasks for 15 minute checks revealed 133 days of missing 2-hour charting and/or several entries at the exact same time, on the same date, from August 2024 to February 2025. Staff did not properly document whether the checks were completed. Resident #6 (R6) R6 was admitted to the facility on [DATE] with diagnoses including Parkinsonism, diabetes type II, generalized osteoarthritis, encephalopathy, motor and sensory neuropathy. R6 had a BIMS score of 15 indicating R6 was cognitively intact. R6's care plan implemented on 1/27/25, revealed : I am at risk for accidents, injuries, and falls r/t (related to) generalized weakness, diabetic neuropathy, Parkinsonism, impaired balance and mobility, Charcot-[NAME]-Tooth disease, and elevated ammonia levels. R6's care plan was updated on 3/5/25 post fall, to include: 15-minute visual safety checks with frequent reminders on call light use. R6's Current Care Record was updated to include: observe resident for visual safety check, offer frequent reminders on call light use every 15 minutes, charting Q2 hours. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's EMR tasks for 15 minute checks from implementation date of 3/5/25 through 3/11/25 indicated 5 days of inconsistencies in completing the required 15-minute safety checks. On 3/11/25, R6 was observed for a continuous period of 30 minutes revealed no staff completing the care planned 15-minute safety checks of R6, from 2:00 PM -2:30 PM. On 3/12/25 at 11:09 AM during an interview, the Director of Nursing (DON) stated the Q2 hour time frame for charting close supervision was to ensure staff were completing the 15-minute checks. When asked how the facility could ensure the checks were being completed if charting was only to be documented every 2 hours, the DON stated the documentation every two hours is the Certified Nursing Assistant's way of stating they had completed the 15-minute checks during that 2-hour time span. The DON explained the multiple exact times documented were due to staff charting at the end of their shifts and staff do not remember to change the time. When asked how the facility could determine 15-minute checks were being completed or if they were effective when staff are charting at the end of their shift, or only being required to chart in 2-hour increments, the DON did not provide an answer.