

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Health Campus of Jackson		STREET ADDRESS, CITY, STATE, ZIP CODE 703 Robinson Rd Jackson, MI 49203	

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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49103</p> <p>This citation pertains to Intakes MI00145676 and MI00145685.</p> <p>Based on interview and record review the facility failed to permit a resident to return to the facility after stabilization following emergency transport to the hospital for one resident (R214) of three residents reviewed.</p> <p>Findings include:</p> <p>Review of the electronic medical record (EMR) revealed that R214 was admitted to the facility 7/9/24 with a pertinent diagnosis of Unspecified Dementia, Severe, with Mood Disturbance (a condition that affects thinking, behavior, and the ability to perform everyday tasks). Review of the Admission Assessment titled Admission/Readmission assessment dated [DATE], reflected the finding that R214 had placed himself on the floor and was crawling around speaking to people . who are not there.</p> <p>On 9/5/24 at 9:07 AM during interview Unit Manager Licensed Practical Nurse (LPN) H recalled that resident was kind of sedated when he came (on admission) kind of out of it and explained that during the stay R214 went from 0 to 100 . R214 was described as having developed frightening behavior, screaming and threatening staff and R214's roommate. According to an EMR entry by Physician O dated 7/12/24 R214 was transferred to (an acute care hospital) d/t (due to) behaviors and safety concerns for other residents and himself. According to the EMR the transfer date was 7/11/24.</p> <p>On 9/4/24 at 12:58 PM interview with Case Manager Q an employee at the acute care hospital revealed that on 7/12/24 according to notes the nursing home had been contacted concerning R214's pending transfer back to the facility. R214 had been evaluated by psychiatry services and was ready to return. The facility declined to receive R214 even if his behavior had stabilized on medication. A statement in the note was that the facility would not take R214 back into the facility under any circumstances. There was not a name listed for the nursing home contact person; only a notation of Admissions.</p> <p>On 9/5/24 at 3:16 PM during an interview with the Nursing Home Administrator (NHA) K the refusal to permit R214's return to the facility was explained as a decision made by two people serving at that time as Regional Directors S and T. NHA K stated, We knew up front we would be cited for not taking him back. It's better to have a low-level tag than to have someone get hurt.</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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing home facility EMR did not reveal documentation from a physician stating a reason why R214 was not permitted to return to the facility.</p> <p>On 9/5/24 at 2:56 PM Physician O said during interview he had no involvement in a decision to not permit R214 to return to the facility and had been unaware of the decision and explained that admissions are handled through an admissions corporate team.</p> <p>The facility did not have a policy related to residents returning from the hospital.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954</p> <p>Based on interview and record review, the facility failed to provide a written reason for transfer/discharge for two residents (Resident #212, #214) of three reviewed for transfer/discharge, resulting in residents and/or responsible parties not being informed, in writing, of the reason for transfers/discharges. Findings include:</p> <p>Resident #212 (R212)</p> <p>Review of the medical record revealed that R212 was admitted to the facility on [DATE]. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/7/24 indicated that R212 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS).</p> <p>A Progress Note dated 6/16/24 revealed that R212 was being transferred to the hospital due to a change in condition. Review of the Electronic Medical Record showed no evidence of a bed hold or a transfer notice for R212.</p> <p>In an interview on 9/5/24 at 12:33 PM, Licensed Practical Nurse I R212s transfer was discussed. LPN I stated that when a resident is transferred out of the facility, the transfer notice and bed hold should be completed and be provided to the resident or the responsible party.</p> <p>In an interview on 9/5/24 at 2:14 PM, Director of Nursing (DON) B stated that she was assisting with R212 on 6/16/24 when it was identified that R212 was experiencing a change in condition. The decision was made to send R212 to an acute care hospital. DON B acknowledged that the expectation is to provide the resident with a transfer notice and a bed hold, and to document that the forms were signed. However, there was no evidence that the transfer notice and bed hold were provided by the time of the survey exit.</p> <p>49103</p> <p>Resident #214 (R214)</p> <p>Review of the medical record revealed that R214 was admitted to the facility on [DATE]. The Minimum Data Set (MDS) Cognitive Assessment with an Assessment Reference Date (ARD) of 7/9/24 was not completed in full. Review of the Admission Assessment titled Admission/Readmission assessment dated [DATE], reflected the finding that resident had placed himself on the floor and was crawling around speaking to people . who are not there.</p> <p>A Progress Note dated 7/9/24 revealed that R214 was being transferred to the hospital due to a change in condition. Review of the Electronic Medical Record showed no evidence of a bed hold or a transfer notice for R214.</p> <p>In an interview on 9/5/24 at 12:33 PM, Licensed Practical Nurse I R214's transfer was discussed. LPN I stated that when a resident is transferred out of the facility, the transfer notice and bed hold should be completed and be provided to the resident or the responsible party.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 9/5/24 at 2:14 PM, Director of Nursing (DON) acknowledged that the expectation for R214s transfer was to provide the resident with a transfer notice and a bed hold, and to document that the forms were signed. On 9/5/24 at 3:37 PM Regional Consultant A confirmed there was no bed hold documentation found for R214. Prior to survey exit there was no evidence provided to indicate the transfer notice was provided to the responsible party.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49103</p> <p>This citation pertains to Intake MI00145685</p> <p>Based on interview and record review the facility failed to administer medication as ordered for one resident (R214) of three residents reviewed potentially resulting in a relapse and escalation of psychologically disturbed behaviors.</p> <p>Findings Include:</p> <p>Review of the electronic medical record (EMR) revealed that R214 was admitted to the facility 7/9/24 with a pertinent diagnosis of Unspecified Dementia, Severe, with Mood Disturbance (a condition that affects thinking, behavior, and the ability to perform everyday tasks). Review of the Admission Assessment titled Admission/Readmission assessment dated [DATE], reflected the finding that resident had placed himself on the floor and was crawling around speaking to people . who are not there. Further review of the EMR revealed that one of the medications ordered for R214 was Ziprasidone 20 mg HCL (an atypical antipsychotic which rebalances dopamine and serotonin in the brain to improve thinking, mood, and behavior). Ziprasidone HCL was ordered to be given BID (two times per day). R214 had been taking this medication prior to admission to the facility.</p> <p>Review of the Medication Administration Record revealed that on the dates of 7/9/24 - 7/10/24 Ziprasidone HCL was unavailable at the facility. During this period documentation of R214's behavior showed a progression to a state of increased agitation.</p> <p>On 7/9/24 Licensed Practical Nurse (LPN) U documented the following: Resident (R214) observed crawling on the floor in his room throughout shift. Resident observed playing with carpet while crawling on the floor. Resident observed and heard speaking to himself/hallucinating while crawling on the floor in his room. Resident redirected with increased efforts. Resident unable to effectively communicate.</p> <p>On 7/10/24 at 12:35 AM LPN U documented that R214 was having outbursts of yelling and cursing. On 7/10/24 at 5:50 AM LPN U documented that R214 was . yelling out uncontrollably .</p> <p>On 7/11/24 at 8:31 AM Registered Nurse (RN) V documented that R214 was screaming most of the night . On 7/11/24 at 8:34 AM Registered Nurse (RN) V documented that R214 yelled I am going to kill. On 7/11/24 R214 was transferred to an acute care facility. According to an EMR entry by Physician O dated 7/12/24 R214 was transferred to (an acute care facility) d/t (due to) behaviors and safety concerns for other residents and himself.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/5/24 at 9:07 AM during interview Unit Manager Licensed Practical Nurse (LPN) H recalled that resident was kind of sedated when he came (on admission) kind of out of it and explained that during the stay R214 went from 0 to 100 . R214 was described as having developed frightening behavior, screaming and threatening staff and roommate. During interview with Unit Manager LPN H the medication administration record was reviewed. LPN H acknowledged two entries in Medication Administration notes entered 7/10/24 indicating that Ziprasidone was on order with pharmacy/not in backup medication cart. During interview LPN H was asked if the progressively agitated behavior R214 had displayed could have been related to having missed the medication doses of Ziprasidone. It could have. LPN H said. LPN H added she didn't know if an attempt had been made to drop ship the medication.</p> <p>On 9/5/24 an interview was held by phone with Consultant Pharmacist W who reviewed the pharmacy record of R214 for the dates R214 was a resident at the facility. Pharmacist W stated that the order for the medication sent from the facility was received 7/10/24 at 10:54 AM and the medication was delivered sometime after midnight on 7/11/24.</p> <p>On 9/5/24 at 2:56 PM Physician O stated during interview I was not notified he was not receiving medication when the unavailability of the Ziprasidone was discussed. When asked if the progression of agitated behavior could have been caused by the missed doses Physician O said there is a possibility and added, it was hard to say for sure, but it is a possibility it could have contributed.</p> <p>According to the National Alliance on Mental Illness website Ziprasidone should be continued without interruption and further states, Do not stop taking Ziprasidone or change your dose without talking with your health care provider first. For Ziprasidone to work properly, it should be taken every day with food as ordered by your health care provider. Missing doses of Ziprasidone may increase your risk of worsening (relapse) of your symptoms.</p>		