STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to provide a safe, clean, homelike environment for all facility residents. This deficient practice resulted in the potential for injury and dissatisfaction with the living environment. Findings include: During the initial screening of residents on 8/5/24 at approximately 12:30 p.m., the facility carpet in all hallways was observed stained, bleached in color, and with separated carpet tile seams. The carpeting had many brown, orange, and other stains that appeared to be uncleanable. Resident #15's (R15's) room was observed on 8/7/24 at 8:23 a.m., accompanied by Registered Nurse (RN) P, which showed the presence of a large gap (area for potential entrapment) at the foot of R15's bed. RN P estimated the gap between the bed mattress and the bed footboard was between five to six inches. The bed footboard had a strip of peeling, vinyl laminate, hanging from the footboard. The radiator covers on the heating unit directly under the right edge of R15's bed were off (did not cover) the metal fins that released heat from the radiator. The metal fins posed a danger of physical injury (cuts) and burns. During an observation and interview on 8/7/24 at 11:17 a.m., accompanied by RN S, found R23's room with a strong smell of urine. The vinyl flooring in the room had an open (split) seam in the middle of the room with raised edges which would allow for water and/or urine to seep under the open vinyl seam. When asked about the strong urine smell in R23's room, RN S said R23 did have a urinary catheter and did wear the same clothing for multiple days. When asked to observe the vinyl seam opening, RN S acknowledge it was present, with the potential for liquids to seep between the vinyl linoleum and the floor. RN S acknowledged the multiple carpet stains looked dirty, and not homelike. During and observation and interview on 8/7/24 at 11:25 a.m., accompanied by RN S, a large patio door in the dining room was found with opaque condensation between the windows, making vision out of the window cloudy and difficult. A spider web was clearly visible above and between the two, large patio windows. RN S confirmed the presence of window condensation in one of the large patio windows and spider webs at the top of the window. When asked about the appearance of multiple carpet stains, with orangish and brown discoloration outside of the dining room, RN S stated, It is terrible. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235552	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview of the dining room on 8/07/24 at 1:17 p.m., in the presence of Maintenance (Staff) Q, two broken cabinets (broken drawers, chipped wood and paint) were found in the dining room. Staff Q stated, I told them last week to throw those cabinets out. Staff Q looked at the clouded, patio window and stated, Yes the window needs to be replaced. Staff Q also acknowledged the spider webs above the clouded window and said the cleaner in the room would get it. During an observation and interview on 8/7/24 at approximately 1:20 p.m., Staff Q was asked for a tape measure. Staff Q measured the gap between the end of R15's mattress and the footboard on the bed. Staff Q said the gap between the footboard and the mattress was between 5 and 5.5 inches, which he acknowledged was outside of the acceptable measurement of 4 inches to prevent resident entrapment. Staff Q confirmed R15's radiator fins were uncovered with no radiator cover over the heating fins, posing a hazard. Staff Q acknowledge the vinyl veneer was coming off of the Residents footboard. Staff Q stated, Need a new footboard, need to work on radiator covers, gap in bed is between 5 and 5.5 inches between the footboard and the mattress. Further room observations with Staff Q found the following environmental concerns: 8/07/24 01:22 PM: room [ROOM NUMBER] - bedside table doesn't close, radiator cover off of fins posing hazard. 8/07/24 01:25 PM: room [ROOM NUMBER] - Dresser broken. 8/07/24 01:28 PM: room [ROOM NUMBER] - Right side of footboard broken completely off. Upon hearing the conversation between Staff Q and this Surveyor, R7 was lying in the bed and stated, It is about time. It has been like is (broken almost in half, with the right side missing) since I got here.! 8/07/24 01:30 PM: room [ROOM NUMBER]: No footboard on the bed. Headboard on backwards. 8/07/24 01:32 PM: Bathing Room door with chipped off paint. Dirty fan covered in brown lint and debris in shower room on North Hall. 8/07/24 1:34 PM: Red worn toilet seat between rooms [ROOM NUMBERS]. 8/07/24 1:36 PM: No footboard on bed in room [ROOM NUMBER] A. 8/07/24 1:40 PM: Mechanical lifts dirty, with visible debris on the foot plates, on North Hall. 8/07/24 1:44 PM: room [ROOM NUMBER] Separation in vinyl flooring seam, that is uncleanable. 8/07/24 1:46 PM: room [ROOM NUMBER] Dirty filter on air conditioner. Closet doors rusty and unhomelike. Staff Q said all the facility closet doors were like that, with visible rusting, chipping paint, and wheelchair scratches. Staff Q stated, All the closet doors need to be painted. 8/07/24 1:47 PM: room [ROOM NUMBER] - Carpet in room stained with black, bleached area and dirty. Appears unable to be thoroughly cleaned. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Mission Point Nsg & Phy Rehab Ctr of Hancock		STREET ADDRESS, CITY, STATE, ZIP CODE: 1400 Poplar St Hancock, MI 49930	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8/07/24 1:49 PM: room [ROOM NUMBER] - Needs paint by radiator - yellow by radiator, rest of room is grey. Staff Q stated, Every room is like that; no paint on top of the radiators with 4 to 5 inches of yellow in a grey room. 8/07/24 1:52 PM: South dirty laundry room air filter covered with thick, brown, dust and debris, located in a small closet-like room that had a foul-smelling odor. 8/07/24 1:58 PM: room [ROOM NUMBER] - Leaking faucet, won't shut off with a stream of water, no water-seal caulking at the base of toilet, and a rusty commode with missing rubber cover on the left, front leg support. During a telephone interview on 8/7/24 at 10:15 a.m., Anonymous U voiced the following concern related to a previous room R47 resided in: They did have her in a room that had a leaky ceiling. Water was leaking into her bed: room [ROOM NUMBER]. That was about a month ago. They got inspected about two years ago with a leaky roof. They moved her to three different rooms in a couple of weeks. Anonymous U said they had photos of the water leaking into the room, and would send photos via text message to this Surveyor, which they did. Observation of photographs provided by Anonymous U on 8/7/24 at 1:28 p.m., showed water leaking into the room from the window, a grey bucket on the floor, surrounded by white towels to collect water dropping from the ceiling, and water droplets visible on the ceiling in room [ROOM NUMBER], on June 28th. Review of the list of facility residents on the CMS-802 revealed no resident currently resided in room [ROOM NUMBER]. During an interview on 8/07/24 at approximately 2:00 p.m., Staff Q acknowledged he had toured the building, and he was aware of all the repairs and replacements that needed to be performed. Staff Q said they (administrative staff at the facility) had previously gotten quotes to replace the carpeting, but it had not been done. During an interview on 8/12/24 at approximately 5:45 p.m., the Nursing Home Administrator (NHA) expressed understanding of the concern that the facility did not provide a safe and homelike environment for the facility residents due to the state of disrepair and lack of aesthetic upkeep within the facility. The NHA said Maintenance Director C was no longer employed by the facility when it became apparent (during the course of the survey) that he had not been fulfilling his job responsibilities.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 40383 Based on interview and record review, the facility failed to provide written transfer notification to the resident and resident's representative for one Resident (R45) of two residents reviewed for transfers out of the facility. Findings include: Resident #45 (R45) On 8/4/24, R45 was transferred to the hospital with nausea/vomiting and uncontrolled pain. During an interview on 8/7/24 at 5:20 PM, the Regional Clinical Consultant Registered Nurse A stated the facility did not send written notifications to the resident or resident representatives and she had never heard of this. During an interview on 8/8/24 at 12:18 PM, the Nursing Home Administrator said they did complete a transfer form but it was not given or mailed to the resident or resident representative.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to provide wound care per comprehensive care plan, per physician orders and without proper infection control practices for one Resident (R47) out of 12 sample residents. This deficient practice resulted in the potential for delayed wound healing and potential for infection. Findings include: Review of the Minimum Data Set (MDS) assessment for R47, dated 7/25/24, revealed admission to the facility on [DATE] following a short-term hospital stay. R47 scored 13 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. R47 had unclear speech and was usually able to be understood and understand others. Active diagnoses upon admission included the following, in part: stroke, aphasia, hemiplegia (paralysis of one side of the body). R47 required Supervision or touching assistance, where the helper provided verbal cues and/or touching/steadying and/or contact guard assistance as the Resident rolled from side to side. Review of R47's Physician Order Summary, retrieved 8/5/24, revealed the following physician orders, in part: 1. Airborne isolation precautions ordered 7/29/24. (For COVID-19) 2. Right buttock dressing: Cleanse with NS (normal saline), dry, apply skin prep, cover with Optifoam dressing. Check every shift. Change DAILY and PRN if disrupted or soiled. Update MD if worsening. D/C (discontinue) when resolved, every shift. Start dated: 6/20/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/07/24 at 2:45 p.m., wound care was observed with Registered Nurse (RN) P who donned personal protective equipment (PPE) (gown, gloves, N95 face mask) and was ready to enter the room, reaching for the door handle. RN P did not don eye protection. The COVID-19 Airborne precaution signage and PPE instructions clearly stated eye protection was to be worn. This Surveyor pulled an unopened package of face shields from the tall PPE bin outside of R47's room and began to don the PPE required for entry. RN P asked, Do we have to wear eye protection when we are wearing glasses? This Surveyor said, Yes, due to the access of air on all sides of the glasses. This Surveyor donned a face shield, and RN P then grabbed a face shield to put on. RN P wore an N95 mask over his long protruding beard, which was not able to be covered by the N95 mask. RN P brought clean supplies into the room and dropped a box on the floor. RN P picked up the box from the dirty floor with his clean gloves. He closed the curtains, turned off the fan and proceed to lower R47's pants and pull-up style incontinence brief all with the same, now dirty gloves. No dressing was present on R47's bottom and barrier cream had been slathered on both the right and left buttocks. During an interview, at this same time, RN P was asked if the wound was supposed to be open to air. RN P said there should have been a dressing on, but sometimes they came off. When asked if he was notified that it had come off, so that a new dressing could be applied, RN P said he had not, and was not aware when the dressing from the previous day had been removed or displaced. RN P cleansed the wounds with normal saline and used sterile 4x4 gauze pads to remove most of the barrier cream. RN P applied skin prep around the right buttock cheek and applied a Mepilex dressing with the same dirty gloves. RN P then removed his gloves, did not perform hand hygiene, and donned clean gloves and assisted the resident in pulling up her pants and incontinence brief. RN P told R47 that he would be contacting the physician to update them on the new skin damage to the left buttock cheek. Review of R47's Progress Notes revealed the following entry: Effective Date: 06/20/2024 13:53 (1:53 p.m.) . Right buttock dressing: Cleanse with NS, dry, apply skin prep, cover with Optifoam dressing. Check every shift. Change QOD (every other day) and PRN (as needed) if disrupted or soiled. Update MD if worsening. D/C when resolved. Every shift. Dressing changed as ordered, area superficial re-opened, increased moisture, 0.8x0.8x0.01 blanchable red around, small amount serosanguineous (yellow with small amounts of blood) drainage with no odor, added air mattress, updated MD (physician). Signed by RN R. Review of R47's 8/1/24 Skin Sweep revealed the wound was intact MASD (moisture associated skin damage) to R (right) buttock area open to air and fragile, moisture barrier applied. During a telephone interview on 8/7/24 at 11:09 a.m., Anonymous U said they were present on 8/6/24 at approximately 6:30 p.m., when Certified Nurse Aide (CNA) V placed a wound dressing on R47's right buttock. Anonymous U asked if it was acceptable to have a CNA performing wound care in the facility? Anonymous U said they always thought that was outside of the scope of a CNA's practice. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/24 at 2:03 p.m., CNA V was asked if she had toileted R47 the previous evening (8/6/24). CNA V said R47 would ring the call light when she needed to use the commode. CNA V confirmed she had toileted R47 the previous evening, after dinner at about 6:30 p.m. When asked if she had placed a wound dressing on her bottom after toileting the Resident, CNA V stated, Yes. The nurse asked me to put a new foam dressing on her (right buttock wound). RN P (who worked day shift) had left the dressing for me to put on, but she never rang to use the commode until the next shift (evening shift). When asked how the wound looked, CNA V stated, It is pretty red, not where it is bleeding, but it is opening. I would call it sheering. Definitely skin breakage but not deep. CNA V understood it was outside the scope of her practice but because RN P had asked her to apply the dressing and left it in the room for her to apply, she complied with RN P's request. Review of the facility Wound Treatment Management and Documentation policy, revised 2/24, revealed the following, in part: Policy: 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 . 1. Wound treatments will be provided in accordance with physician orders . 6. Treatments will be documented on the Treatment Administration Record (by licensed nurses). 7. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include a. Lack of progression towards healing. b. Changes in the characteristics of the wound . Review of [Company Name] CNA Scope of Practice: Overview and FAQ (frequently asked questions) retrieved at [company name].com/facilities/resources/cna-scope-of-practice-overview-and-faq/ revealed the following, in part: What are Tasks That a CNA Cannot Do? . Perform open wound care. While CNAs should report changes in skin condition to a supervising nurse, they're not trained to assess, treat, or clean an open wound . During an interview on 8/8/24 at approximately 10:15 a.m., when asked when there would be an expectation for a CNA to apply a wound dressing, the Director of Nursing (DON) stated, Never. The DON continued and stated, I have educated them (nursing staff) when I first got here because that was the practice here. I have tried to change that. When asked if she would be disappointed if that was observed during the survey, the DON stated, I would be severely disappointed. She confirmed that application of a wound dressing was to be completed by the nurse, as the nurse was required to assess the wound and report any changes to the physician.

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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 35103

Based on interview and record review, the facility failed to provide adequate supervision to prevent a fall for one Resident (R50) of two residents reviewed for falls. This deficient practice resulted in a fall with injury (fractured hip), and a decline in condition. Findings include:

Review of the facility Investigation Summary revealed the following, in part: .R50 suffered a right hip fracture after an unwitnessed fall that occurred on [DATE] at approximately 8:15 PM. RN (Registered Nurse) caring for resident responded immediately after receiving a phone call at the nurse's station from [R50's] roommate . Resident was then transferred to [Acute Care Hospital] for imaging, d/t (due to) complaints of right hip pain . Resident was non-compliant with using her call light when needing assistance with ambulation while admitted to [Facility Name] . The Investigation Summary documented R50 scored 3 of 15 on the Brief Interview for Mental Status (BIMS), reflective of severe cognitive impairment, and diagnoses that included macular degeneration, falls, and acute respiratory failure with hypoxia.

Review of R50's Admission Record, revealed admission to the facility on [DATE], with an activated Durable Power of Attorney (DPOA). Diagnoses included the following, in part: acute respiratory failure with hypoxia (primary diagnosis), fall on same level, unspecified macular degeneration, unsteadiness on feet, other abnormalities of gait and mobility, repeated falls, and other symptoms and signs involving cognitive functions and awareness.

During a telephone interview on [DATE] at 10:54 a.m., R50's DPOA W was asked about their satisfaction with R50's care while in the facility. DPOA W stated, She fell at [Facility Name]. She broke her hip at [Facility Name]. She got COVID at [Facility Name], and she died . She cannot see. She has macular degeneration. She had been there (at the facility) 1.5 weeks. Once she was out (of the facility) I said she would not be going back there .Her vision was very poor. She was considered 100% blind. She could see peripheral vision, but she could not read or write or tell who was who - only by voice. If it was dark, she would not be able to see . On the 20th (of July) she went to the hospital from [Facility Name] . R50 was transferred to hospice and did not return to the facility.

Review of R50's Resident Care Plan, revealed the following care plan Interventions:

1. Focus: I have severe impaired cognitive function or impaired thought processes as evidenced by BIMS Score of 3 on [DATE]. Prior to admission, my diagnose are mild cognitive impairment, memory Impairment. Date Initiated: [DATE].

Interventions included: I have a DPOA in place due to impaired decision making . Date Initiated: [DATE]. Revision on [DATE].

2. Focus: I have impaired visual function r/t (related to) Macular Degeneration, cataracts. Date Initiated: [DATE]. Revision on: [DATE].

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. I have an ADL (activities of daily living): Self-Care Performance Deficit & Mobility deficit r/t sudden inability to ambulate secondary to mechanical fall at home, acute hypoxic respiratory failure, vision deficit, refusals/behaviors, cognitive loss, depression, risk for pain, malnutrition. Date Initiated: [DATE]. Revision on [DATE]. 4. I am at an increased risk for falls r/t incontinence, pain, neuropathy in BLE (bilateral lower extremities), muscle weakness, vision loss, hearing loss, cognitively impaired, new environment. Date Initiated: [DATE], Revision on [DATE]. Intervention added on [DATE]: Upon my return from the hospital, implement a toileting program and establish a frequent checks schedule. R50 never returned from the hospital. No mention of R50's legal blindness appeared anywhere in the care plan. Review of Witness Statements revealed two Certified Nurse Aides (CNAs) were on break in the break room, leaving one nurse and one aide on the halls. R50 was in a COVID-19 isolation room - with a COVID positive roommate. The room door remained closed beginning on [DATE], when R50's roommate tested positive for COVID-19. R50's roommate called on the telephone to get help from R50. During an interview on [DATE] at 12:16 p.m., R50's former roommate R4 was asked if she had a roommate that had a fall? R4 stated, Yes, she (R50) fell and broke her hip, and now she is dead. They (facility staff) had trouble getting to her because she was behind the door. I used my phone because she needed help immediately. She couldn't wait. Pressing the call light might not have had them coming to help immediately. R4 said she (R50) was behind the door, so when they tried to open the door, they couldn't move her easily. R4 confirmed R50 had fallen during the time that R4 was positive and in isolation for COVID-19 and the room door was required to be shut. Review of the Fall Reduction Policy, revised ,d+[DATE], revealed the following, in part: Policy: Our residents have the right to be free from falls, or to sustain no or minimal injury from falls . 1. The facility utilizes a standardized risk assessment for determining a resident's fall risk upon admission . 2. The nurse will initiate interventions on the resident baseline care plan, in accordance with the resident's identified risks. 3. Each identified resident risk factor and potential environmental hazards will be evaluated when developing the resident's comprehensive plan of care. A. Interventions will be monitored for effectiveness. B. The plan of care will be revised as needed . On [DATE] at approximately 4:00 p.m., an interview was conducted with the Nursing Home Administrator (NHA). Discussion of R50's lack of a toileting program and/or frequent checks to address any needs she may have while in the facility, were not implemented prior to her fall with injury. The NHA indicated the facility was aware of R50's macular degeneration, and noted vision loss. The NHA confirmed once the room door was closed due to COVID-19 isolation of R50's roommate, frequent checks for toileting and personal care needs were not added to and implement in R50's care plan, despite R50's recent admission, unfamiliarity with surroundings in the facility, severe cognitive impairment, and legal blindness. The NHA acknowledged these interventions may have been beneficial in preventing this fall. The NHA acknowledged frequent education to use the call light with severe cognitive impairment would likely not have been effective in ensuring the safety of R50.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 35103 Based on observation, interview, and record review, the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails to identify areas of potential entrapment for all facility residents. This deficient practice resulted in the potential for zones of entrapment to remain unidentified posing a risk to all 45 vulnerable facility residents. Findings include: Observation of the room for Resident #15 (R15) on 8/7/24 at 8:23 a.m., accompanied by Registered Nurse (RN) P, revealed the presence of a large gap (area for potential entrapment) at the foot of R15's bed. RN P estimated the gap between the bed mattress and the bed footboard to be between five to six inches. During an observation and interview on 8/7/24 at approximately 1:20 p.m., Staff Q was asked for a tape measure. Staff Q measured the gap between the end of R15's mattress and the footboard on the bed. Staff Q said the gap between the footboard and the mattress was between 5 and 5.5 inches, which he acknowledged was outside of the acceptable measurement of 4 inches to prevent resident entrapment. During an interview on 8/8/24 at 2:42 p.m., Maintenance Staff Q was asked for the documentation of bed measurements to ensure the bed rails and mattresses on beds fit appropriately. When asked for written documentation of the bed rail and mattress measurements, Maintenance Staff Q said they (facility) probably did not have any documentation of bed measurements. Staff Q said he had performed that task at his previous facility, but he didn't think they did that (bed rail or bed measurements) here. During an interview on 8/8/24 at approximately 4:00 p.m., RN R provided a list of facility Residents, by room number, showing all residents in the facility who had their beds against the wall and/or assist bars on their beds. Review of the [Facility Name] Devices 2024 lists, one for North Hall, and one for South Hall, revealed 11 Residents on each hall had assist bed rails attached to their beds, for a total of 22 Residents with assist bed rails in the facility. There were 19 Residents on North Hall, and 22 Residents on South Hall documented with bed against wall. During an interview on 8/8/24 at approximately 3:15 p.m., Maintenance Staff Q had reported that he had looked two places in the facility for the bed measurements but had not found any. Staff Q stated, I have one more place to look, then we can say that there are none (bed rail or bed measurements). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/24 at 4:10 p.m., Maintenance Staff Q indicated they were unable to be locate any bed rail/bed measurement documentation. The DON and RN R were also present at the nurse's station at this time, with the NHA. When asked if they had ever seen former Maintenance Director C perform bed measurements, both the DON and RN R said they had not. When asked if they had every witnessed or been aware of completion of measurements for five days following a new admission, especially one with assist bars, both said they had never witnessed that. When asked where Maintenance Staff Q was, the NHA stated, He is probably tearing that maintenance office apart looking for measurements, but he's probably not going to find any . It is extremely unlikely that he will find any measurements because I don't think they were done. When asked if the NHA had ever seen the former Maintenance Director C performing bed safety measurements, the NHA said they had not. During an interview on 8/12/24 at 10:04 a.m., when asked about documentation for bed measurements and assuring mattresses and beds are compatible as well as safety of bed rails, the NHA stated, [Staff Q] looked for them there and they are not there. I know for a fact they were not done. He (Maintenance Director C) knew he was supposed to do them (bed safety measurements). I understand your concern with that. During an interview on 8/12/24 at 4:36 p.m., RN R, the DON, and Regional Clinical Consultant A were present when asked when the Maintenance Director, prior to employment of Maintenance Director C, left employment with the facility. Human Resources Director H provided the information that former Maintenance Director left employment with Mission Point on 9/26/23. All present agreed, that because no bed or bed rail measurements were found to be available for review, it could be concluded that Maintenance Director C had not performed any bed rail or bed gap measurements since 9/26/23. Review of the facility Bed Maintenance and Inspections policy, implemented 1/11/21, revealed the following, in part: Policy: It is the policy of this facility to conduct regular inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify and avoid areas of possible entrapment . 1. The Maintenance Director, or designee is responsible for keeping records of bed inspections and maintenance. 2. A list of bed frames, mattresses, and bed rails will be maintained, including the manufacturer for each. The Maintenance Director shall be notified of any new equipment brought into the facility. 3. The Maintenance Director shall review each manufacturer's recommendations and requirements for maintenance and bed inspections and shall establish a maintenance and inspection schedule accordingly . 5. When bed rails and mattresses are used and purchased separately from the bed frame, the facility will ensure that the bed rails, mattress, and bed frame are compatible. 6. Bed frame, mattress, and bed rail inspections will be conducted upon each item entering the facility and then placed on a regularly scheduled inspection and maintenance cycle according to the manufacturer's recommendations, to include manufacturer's timeframe recommendations. 7. If bed equipment is found to be outside of the manufacturer's requirements for any reason, the facility will perform maintenance to the bed equipment or remove from use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49735 Based on interview and record review, the facility failed to ensure two Certified Nurse Aides (CNA) [L & N] had yearly competency training, including demonstration in skills and techniques necessary to care for the facility population. Findings include: During an interview on 8/7/24 at 11:39 a.m., the Director of Nursing (DON) stated, competency training is completed upon hire and annually, but I can't recall when last competencies were completed. The DON referred this surveyor to Human Resources/Business Office Manager H. During an interview on 8/7/24 at 11:47 a.m., the Human Resources/Business Office Manager H stated I do not have staff competencies. During an interview on 8/7/24 at 12:12 p.m., the DON stated, competencies are completed in May or June, but I do not know where they are. During an interview on 8/7/24 at 12:39 p.m., the Human Resource/Business Office Manager H stated, we are trying to find the competencies . I just don't have anything for you. During an interview on 8/12/24 at 1:03 p.m., the Nursing Home Administrator (NHA) stated, we do not have a policy on competency training. Review of Facility Assessment (FA) last updated 5/24 . read in part, all nursing staff complete a competency checklist .annually.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 49735 Based on interview and record review, the facility failed to complete a performance review for five of five Certified Nurse Aides (CNA's) [F, L, M, N, & O] at least once every 12 months. Findings include: Review of facility personnel records revealed the following: CNA F was hired on 11/30/22 with no performance review. CNA L was hired on 11/21/22 with no performance review. CNA M was hired on 4/12/16 with no performance review. CNA N was hired on 10/26/22 with no performance review. CNA O was hired on 3/14/23 with no performance review. During an interview on 8/7/24 at 11:47 a.m., the Human Resource/Business Office Manager H stated, I don't have the staff evaluations. During an interview on 8/7/24 at 12:39 p.m., the Human Resource/Business Office Manager H stated, we are trying to find them .I don't have anything to give you. During an interview on 8/12/24 at 1:03 p.m., the Nursing Home Administrator (NHA) stated, we do not have a policy on performance reviews for staff.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 49735 Based on interview and record review, the facility failed to enter the census (total number of residents) on the facility staffing information posting used to calculate appropriate levels of staffing. This deficient practice resulted in the potential for inaccurate staffing levels. Findings include: A review of the direct care staffing hours (Nursing Department Daily Staffing sheets) on 8/7/24 revealed no resident census information on 1/6/24, 1/7/24, 1/13/24, 1/14/24, 1/20/24, 1/21/24, 1/27/24, 1/28/24, 2/3/24, 2/4/24, 2/10/24, 2/11/24, 2/17/24, 2/18/24, 2/24/24, 2/25/24, 3/2/24, 3/3/24, 3/9/24, 3/10,24, 3/16/24, 3/17/24, 3/23/24, 3/24/24, 3/30/24, and 3/31/24. During an interview on 8/7/24 at 10:09 a.m., the Nursing Home Administrator (NHA) acknowledged the resident census information was not posted on the Nursing Department Daily Staffing sheets. The NHA stated, the sheets should have the census on those sheets .she didn't fill those out right. Review of facility policy titled Nurse Staffing Posting Information last revised dated 3/24 . read in part, the nurse staffing information . will contain the following information .facilities current resident census.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on observation, interview, and record review, the facility: - failed to ensure that one resident (R2) received food in the appropriate form as prescribed by a physician and - failed to ensure the appropriate nutritive content was served to 46 residents receiving meals from the dietary department. Findings include: During the lunch meal service on 8/6/24 at 12:03 PM, the dietary tray line was observed. The menu consisted of turkey casserole and corn. The turkey casserole contained diced turkey meat approximately 1/2 inch wide, 1/2 inch deep and in varying lengths from 3/4 inch to 1 1/2 inches . The Dietary Manager (Staff) B explained the casserole was substituted for fried chicken, which had not come in on the delivery truck. Staff B stated there were two residents who required mechanically altered food. Staff B said she did not grind the turkey but tried not to give (R2) any chunks. The tray card for R2 was reviewed and read in part, Diet order: 5-Minced and moist. *General . Alerts: All food chopped. The Electronic Medical Record (EMR) revealed R2 was admitted on [DATE] and had diagnoses including: Alzheimer's disease, dysphagia (difficulty swallowing), protein-calorie malnutrition and encounter for palliative care. The Physician's orders included, General diet, 5-Minced and moist texture, IDDSI 5 (International Dysphagia Diet Standardization Initiative Level 5), minced and moist small portions, soft diet ordered on 10/10/2023. The care plan for R2 included: I have the potential for a nutritional/hydration problem r/t (related to) history of weight loss, Alzheimer's disease, anxiety, schizophrenia, insomnia, OCD (obsessive compulsive disorder), depression, GERD (gastroesophageal reflux disease), malnutrition with interventions that included: My diet orders are: General, minced and moist texture, small portions. On 8/6/24 at approximately 3:00 PM, Staff B presented a diet manual copyrighted 2011. This manual did not contain the current IDDSI diet level 5 but only had dysphagia levels 1, 2, 3, and 4. During a telephone interview on 8/7/24 at 8:25 AM, the consulting Registered Dietitian (RD) D discussed the IDDSI 5 and stated minced and moist food should fit through the tines of a fork and diced pieces of turkey would not be appropriate for the level 5 diet. RD D stated she would be mailing an updated diet manual as the level 5 minced and moist diet was not defined in the facility's current diet manual. RD D agreed the meal for R2 was not served per physician's order. (continued on next page)

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	235552	A. Building B. Wing	08/12/2024

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/24 at approximately 3:00 PM, the turkey casserole recipe was reviewed with Staff B who stated the recipe was made for 50 residents (one steamtable pan) and approximately 1/4 of the pan had casserole left at the end of service. Staff B stated she had used a 5-pound bag of turkey in production of the casserole. With the 20- 25% left unserved, 3.75 - 4 pounds of the protein had been served to a census of 46 residents who received a meal tray. This was approximately 1.5 ounces (oz) of protein served to each resident. The recipe revealed the portion size should be 6 oz but only a 4 oz scoop was used. This resulted in less than the amount of protein being served to each resident based on their standard meal plan pattern. In an email received on 08-07-24 at 11:20 AM, RD D wrote, We plan for 1 oz of protein with breakfast, 3 oz with lunch and 2 oz with dinner as the standard meal plan pattern.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40383

Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety as evidenced by:

- Failing to ensure expired food was discarded.

- Failing to maintain three freezers in a sanitary condition.

- Failing to ensure the dietary ice machine was cleaned in a manner which prevented potential contamination of ice used by residents.

- Failing to ensure the facility dishwasher properly sanitized all items.

This deficient practice had the potential to result in food borne illness among any or all 46 residents in the facility who receive meals. Findings include:

On [DATE] at 12:15 PM, an initial tour of the kitchen was made with Dietary Manager (Staff) B. There was a gallon container of fruit salad in the walk-in refrigerator dated as opened [DATE] and a use by date of [DATE]. Staff B stated she would throw this out as it had expired. The walk-in refrigerator also contained an unlabeled undated gallon jug of juice which Staff B identified as cranberry juice. Staff B stated this should be labeled and dated with a use by date. An open container of apple juice and a commercially purchased supplement were also observed without a use by date. Staff B confirmed marking perishable opened items with a use by date was the expectation. A small container marked soup and a resident's first name was also in the walk-in refrigerator and was dated as produced ,d+[DATE] and had a use by date of ,d+[DATE]. This container of outdated soup had not been discarded.

During the initial tour, Staff B said the walk-in freezer was not in operation and parts had been ordered. There were 3 smaller freezers which contained frozen products. Each freezer was observed without a thermometer to monitor temperatures. The upright freezer had copious amounts of ice buildup. Staff B acknowledged the freezer needed to be defrosted. A package of frozen roast beef was engulfed in a large clear chunk of ice frozen to the outside of the packaging indicating evidence of thawing and refreezing. Temperature logs were requested and reviewed. The first four days of August had blanks which had not been fully filled in.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The initial tour continued and the Manitowoc ice machine, located in a room connected to the kitchen, was observed to have a mold like substance on the plastic deflector shield. Staff B stated, That does not look good. I will get maintenance to clean it. Staff B was queried on the cleaning schedule of the machine. Staff B said it was the maintenance department who cleaned the ice machine. A cleaning log was affixed to the side of the ice machine revealing a monthly cleaning in January, February, March and April of 2024. No further evidence of cleaning was recorded. Staff B stated this ice machine had been procured from another facility at the end of June. There was no record of cleaning since it had arrived. When asked if she had the user's manual for the machine which delineated the cleaning procedure, she pointed to a sheet taped to the side of the machine which was typed and had additional handwritten steps. Staff B again stated maintenance cleaned the machine. On [DATE] at 9:00 AM, the Director of Maintenance (Staff) C was asked if he had taken care of the ice machine. Staff C stated he did not know there was a problem with the ice machine. Staff C then inspected the ice machine and he rubbed the mold like substance on the plastic deflector with his fingers causing it to drip onto the ice. Staff C agreed it needed to be cleaned to remove what he thought looked like mold. On [DATE] at 9:05 AM, Staff C was observed spraying cleaner with bleach solution onto the deflector on the interior of the ice machine directly over the ice. The ice had not been removed. The cleaning procedure was reviewed and step one stated Remove ice from bin. It was suggested Staff C do this immediately, so no employee could inadvertently retrieve ice during the process. On [DATE] at approximately 10:00 AM, an interview with the Nursing Home Administrator (NHA) was conducted and she understood the ice machine had not been cleaned. She had instructed the facility to discontinue the use of facility ice and purchase ice until the ice machine could be disinfected per policy. On [DATE] at 8:53 AM, the cold-water dish machine was tested for adequate chlorine chemical sanitizing. Dietary Aide (Staff) E stated the white test strip should turn black and register 100 which would indicate optimal and sufficient chemical sanitization. After 6 cycles were tested with several test strips (even obtaining a brand new role of test strips), the strips continued to register 0 without a color change, indicating no sanitizer was detected. On [DATE] at 9:00 AM, Staff B tested the chlorine chemical sanitizing dish machine and again the test strip did not change color and registered 0. Staff B stated she would contact the vendor and proceed to manual dish washing with the three-compartment sink method. A record of the operation of the dish machine was requested and the Low - Temp Dish Machine Log was presented for August. The first four days of August were not completely filled in and contained no record of chemical sanitization or temperatures of the dish machine for breakfast or lunch on these days. The FDA Food Code 2013 states: ,d+[DATE].11 Safe, Unadulterated, and Honestly Presented. FOOD shall be safe, unADULTERATED, and, as specified under S ,d+[DATE].12, honestly presented. and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	,d+[DATE].11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts ,d+[DATE] and ,d+[DATE]. ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. and ,d+[DATE].11 Equipment Food-Contact Surfaces and Utensils. (A)EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: (E) Except when dry cleaning methods are used as specified under S ,d+[DATE].11, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cleaned: (1) At any time when contamination may have occurred; . (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. and ,d+[DATE].12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 49735 Based on interview and record review, the facility failed to complete a comprehensive facility assessment that included training that resulted in the potential for unidentified resources necessary to provide care and services to the resident population. Findings include: During an interview on 8/7/24 at 11:39 a.m., with the Director of Nursing (DON) revealed the competency /training list did not include training on ethics, communication, resident rights, infection control, abuse and neglect, or Quality Assurance Performance Improvement (QAPI). The DON was queried about the Facility Assessment to include training. The DON stated, staff receive education on [Facility Continuing Education Provider] and I am unaware of the training required on facility assessment. During an interview on 8/12/24 at 1:12 p.m., the Nursing Home Administrator (NHA) was queried regarding training for staff and if it would be in the Facility Assessment the NHA stated, I don't know about the trainings you brought up (QAPI, infection control, communication, resident rights, abuse, compliance, ethics, and behavioral health training) we use [Facility Continuing Education Provider] .and that is what we do for training. Review of the policy titled Facility Assessment last revised dated 7/23 . read in part, The facility assessment will, at a minimum, address or include . the facility resources including but not limited to .all personnel, including manager, staff (both employees and those who provide services under contract) and volunteers, as well as their education and training .related to resident care. Review of the Facility Assessment revealed no assessment or evaluation of the facility's training program to ensure any training needs were met for all new and existing staff and volunteers consistent with their expected roles.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 49735 Based on interview and record review, the facility failed to report Payroll Based Journal (PBJ) information to CMS (Centers for Medicare and Medicaid Services). This deficient practice resulted in inaccurate reporting of staffing levels with the potential to affect all 45 residents. Findings include: Review of the CMS PBJ Staffing Data Report FY (fiscal year) Quarter 2 2024 (January 1- March 31) revealed the metric Excessively Low Weekend Staffing Triggered with Submitted Weekend Staffing is excessively low with infraction dates being : 1/6/24, 1/7/24, 1/13/24, 1/14,24, 1/20/24, 1/21/24, 1/27/24, 1/28/24, 2/3/24, 2/4/24, 2/10/24, 2/11/24, 2/17/24, 2/18/24, 2/24/24, 2/25/24, 3/2/24, 3/3/24, 3/9/24, 3/10,24, 3/16/24, 3/17/24, 3/23/24, 3/24/24, 3/30/24, and 3/31/24. During an interview on 8/7/24 at 10:10 a.m., the Nursing Home Administrator (NHA) stated, I do not know what happened with the PBJ information, it probably wasn't entered right. Review of facility policy titled Payroll Based Journal last revised dated 6/24 . read in part, it is the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information including .resident census data . the facility will submit .no less frequently than quarterly .the Nursing Home Administrator (NHA) is responsible for reviewing validation reports and ensuring that any needed corrections are made before the quarterly deadline.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235552	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Hancock		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Poplar St Hancock, MI 49930	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 This citation has two deficient practice statements: Based on observation, interview, and record review, the facility failed to implement a comprehensive infection control program, as evidenced by the failure to complete the following during a COVID-19 outbreak: 1. Implement measures to contain the outbreak. 2. Complete infection surveillance, tracking, trending, and monthly summaries, 3. Implement effective Transmission Based Precautions (TBP) and ensure appropriate donning and doffing of personal protective equipment (PPE). This deficient practice resulted in immediate jeopardy when 40 Residents out of a total facility census of 45 residents contacted COVID-19, including one death (R102), 4 Resident (R102, R14, R11 and R45) hospitalization s, and sustained outbreak transmission. Findings include: The Immediate Jeopardy began on [DATE] when R102 had symptoms of COVID and was not tested until [DATE]. R102 was positive on [DATE] and sent to hospital on [DATE]. R102 died on [DATE]. Facility did not monitor or perform any surveillance which led to a further outbreak of COVID. The Nursing home Administrator (NHA) was notified of the Immediate Jeopardy on [DATE] at 2:52 p.m. At that time, a written plan of correction for removal was requested from the facility. The removal plan was accepted on [DATE]. The Surveyors confirmed by observation, interview and record review, the Immediate Jeopardy was removed on [DATE], but noncompliance remained at a potential for more than minimal harm due to sustained compliance that has not been verified by the State Agency. Resident #102 (R102) Review of R102's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: coronary artery disease, renal insufficiency, diabetes mellitus, depression, cirrhosis, and osteoporosis. R102 scored a 9 of 13 on the Brief Interview for Mental Status (BIMS) reflective of moderate cognitive impairment. Review of Nursing Progress Notes on the following dates: [DATE] revealed that R102 had increased issues with secretions, coughing, and sats (oxygen saturation) decreasing. [DATE] revealed R102 over the last two days complained of sore throat and has dry mouth, noted more difficulty swallowing. [DATE] revealed R102 had positive covid test. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 12:58 p.m., the Director of Nursing/Infection Preventionist (DON/IP) stated, R102 passed as a COVID death .she had symptoms of COVID on [DATE] but was not tested and I don't know why she wasn't tested . Review of transfer form from [Facility to Hospital] dated [DATE] revealed, R102 had covid Review of Nursing Progress Notes dated [DATE] revealed, R102 on droplet precautions, R102 lungs diminished with Rhonchi (coarse loud lung sounds). R102's arms flaccid mottling on lower extremities. R102's oxygen increased to 5 liters per nasal cannula. Review of Physician Progress note dated [DATE] revealed, R102 returned from hospital with COVID. R102 was not making eye contact . R102 is on comfort care. Review of Nursing Progress Note dated [DATE] revealed, R102 was absent of respiration and pulse. Review of Death Certificate date filed [DATE] revealed, R102 died of COVID exacerbating end stage condition and end stage cirrhosis with ascites. R102 resided on the South hall of the facility. Resident #11 (R11) Review of R11's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: anemia, coronary artery disease, heart failure, hypertension, diabetes mellitus, and cerebral vascular accident (CVA). R11 scored a 10 of 15 on the BIMS assessment reflective of moderate cognitive impairment. Review of Nursing Progress Note dated [DATE] revealed, R11 complained not feeling good this morning . when asked if [Resident] was short of breath (SOB) R11 stated yeah, audible expiratory wheezing. Left lung diminished throughout .congested cough .resident transferred to Emergency Department (ED) Review of discharge Summary from [name of hospital] dated [DATE] revealed that R11's chief complaint was shortness of breath .R11 tested positive for COVID. R11 resided on the South hall of the facility. Resident #14 (R14) Review of R14's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: anemia, coronary artery disease, heart failure, hypertension, diabetes mellitus, and respiratory failure. R14 scored a 11 of 15 on the BIMS assessment reflective of moderate cognitive impairment. Review of Nursing Progress Note dated [DATE] revealed, R14 hollered out from his bedroom . is having trouble breathing, call 911. Review of Progress Note dated [DATE] revealed, R14 was sent to [Hospital] Emergency Department (ED) via ambulance. Called the ED at 0125 for an update- resident is COVID positive. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R14 resided on the North hall of the facility. R14 died at hospital. Resident #45 (R45) Review of R45's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: anemia, pneumonia, orthostatic hypotension, diabetes mellitus, manic depression, and respiratory failure. R45 scored a 14 of 15 on the BIMS assessment reflective of intact cognition. Review of Nursing Progress Notes at the following dates and times: dated [DATE] at 3:33 p.m., revealed, R45 complained of feeling sick to his stomach had several large projectile emesis .R45 stated he still doesn't feel good. dated [DATE] at 4:49 p.m., R45 stated not feeling well, stomach is upset. No vomiting but .gagging occurring at times .R45 having nausea.dated [DATE] at 5:17 p.m., revealed, R45 vomited.dated [DATE] at 6:18 p.m., revealed, R45 continues to have emesis and moaning out in pain stating R45 does not feel good. Review of Situation, Background, Assessment, and Recommendation (SBAR) Summary for Providers [DATE] 6:37 p.m., revealed, R45 sent to emergency room (ER). Review of Nursing Progress Notes dated [DATE] at 2:09 a.m., revealed R45 returned to facility with diagnosis of COVID. R45 resided on the South hall of the facility. Observations by this Surveyor on the following dates and times revealed: [DATE] at 12:53 p.m., room [ROOM NUMBER] did not have signage regarding COVID for COVID positive resident. [DATE] at 9:05 a.m., room [ROOM NUMBER] door opened with resident on airborne contact precautions (COVID). Fan in hallway outside of room blowing air down the hallway. [DATE] at 9:39 a.m., Certified Nurse Aide (CNA) I observed in hallway with surgical mask under her nose. [DATE] at 10:53 a.m., Resident on airborne precautions due to COVID with door open. A box fan blowing air down the hall was in hallway just outside of residents open door. Signage on resident room door indicated to keep door closed. [DATE] at 10:55 a.m., Resident on airborne contact precautions due to COVID with room door wide open. [DATE] at 12:16 p.m., Dietary aide J pushing meal cart down hallway with surgical mask below her nose. [DATE] at 12:17 p.m., CNA Ientered room of Resident on droplet precautions without cleaning hands before entering room. CNA I did not wear eye protection or remove face protection before CNA I left the room as indicated by signage on door of room. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[DATE] at 1:48 p.m., CNA F charting in hallway with surgical mask pulled down below her mouth. During an interview on [DATE] at 8:46 a.m., the Director of Nursing (DON)/Infection Preventionist (IP) stated, I have not done any monitoring or surveillance for infection control .I have nothing done for the entire month of July .I have typed up a cheat sheet so you can see the staff and residents who have had COVID. A follow-up interview with the DON on [DATE] at 12:58 p.m., revealed, the outbreak started on [DATE] .we had a CNA with symptoms an [DATE] but there are no indications that she was tested .the CNA did test positive on [DATE] .that CNA worked all over the building . all the CNA's do, they are not scheduled on any particular wing, not during the outbreak, and not now .I believe this started our outbreak . I have not done any tracking or tracing of the COVID outbreak, so there is no line listing .I have not tracked employees or residents that have gotten COVID. On [DATE] at approximately 1:15 p.m., during a follow-up interview, the DON/IP acknowledged the Residents were still going out to smoke in groups throughout the outbreak, meals were offered in the dining room, and group activities were still occurring. The DON stated, we stopped activities and shut down the dining room on [DATE], but when dining started again, we had 15 residents that were positive for covid .we have had 40 residents out of 45 test positive for COVID .our last positive was on [DATE]. Review of the typed documentation for [DATE] COVID Outbreak provided by DON/IP revealed that between [DATE] and [DATE] a total of 12 residents were positive with COVID on one wing before facility closed the doors to the wing. On [DATE] residents on another wing were positive with COVID. The document did not indicate dining service in the dining room or activities were stopped. Review of facility policy titled COVID-19 Prevention, Response and Reporting date revised ,d+[DATE] . read in part, it is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections .the infection preventionist will assess facility risk associated with COVID-19 through surveillance activities of COVID-19 infection .present in the facility . signs of COVID .fever or chills, cough, shortness of breath, fatigue, muscles or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea .the facility will establish a process to identify and manage individuals with suspected or confirmed COVID .residents with suspected or confirmed COVID infection should be placed in a single person room with the door closed .residents should remain in their current location. The facility may consider designating entire units within the facility, with dedicated health care personnel to care for residents with COVID infections when the number of residents with COVID infection is high, limit transport and movement of the resident outside the room to medically essential purposes . The Infection Preventionist .will monitor and track COVID-19 related information to include . the number of residents and staff who exhibit signs and symptoms of COVID-19, the number of residents and staff who have suspected or confirmed COVID 19 and the date of confirmation .employee compliance with hand hygiene, employee compliance with standard and transmission-based precautions, and employee compliance with cleaning and disinfection policies and procedures. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of facility policy titled COVID-19 Antigen Testing date revised ,d+[DATE] . read in part, it is the policy of this facility to conduct antigen testing on symptomatic residents and staff, asymptomatic residents and staff as part of a COVID-19 outbreak response or testing of asymptomatic residents or staff who are known close contacts of persons with COVID-19 .antigen tests perform best when the person is tested within the first days of symptom onset when the viral load is generally highest. If an antigen test is positive .residents should be placed in Transmission Based Precautions .if the resident or staff is the first positive test for COVID-19 within the facility, an outbreak response should be initiated immediately. Review of facility policy titled Infection Outbreak Response and Investigation date revised ,d+[DATE] . read in part, the facility promptly responds to outbreaks of infectious diseases within the facility to stop transmission of pathogens and prevent additional infections .outbreak generally refers to the occurrence of more cases of a communicable disease than expected in a given area or among a specific group of people over a particular period of time. if a condition is rare or has serious health implications, an outbreak may involve only one case .the following triggers shall prompt an investigation as to whether an outbreak exists: a sudden cluster of infections on a unit .a single case of a rare or serious infection i.e COVID .symptomatic residents will be considered potentially infected .surveillance activities will increase to daily for the duration of the outbreak . Outbreak investigation: when the existence of an outbreak has been established an investigation will begin. The infection preventionist will be responsible for coordinating all investigation activities .A line list about each person affected by the outbreak will be maintained .a summary of the investigation will be documented and reported. Review of facility policy titled Personal Protective Equipment last revised ,d+[DATE] .read in part, this facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to resident, visitors, and other staff .Personal protective equipment .refers to .gloves, gowns, face protection . wear gowns to protects arms, exposed body areas, and clothing from contamination .wear a mask to protect the face from contamination with .body fluids. Review of facility policy titled Infection Prevention and Control Program revised ,d+[DATE] .read in part, 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 disease and infections .the designated infection preventionist is responsible for oversight of the program and serves as a consultant to .implement isolation precautions .surveillance, and epidemiological investigations of exposures of infectious diseases .a system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents .the infection preventionist serves a the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of facility policy titled Infection Surveillance last revised ,d+[DATE] .read in part, A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections .The DON .services as the leader in surveillance activities, maintains documentation of incidents, findings, and any correction actions made by the facility .surveillance activities will be monitored facility-wide and may be broken down by department or unit .monthly time periods will be used to capturing and reporting data, all residents infections will be tracked. Outbreaks will be investigated. Employee infections will be tracked. Data to be used in the surveillance activities include .documentation of signs and symptoms in the clinical record. The Immediate Jeopardy which began on [DATE] and was removed on [DATE] when the facility took the following actions to remove the immediacy. The Facility Removal Plan read: Issue Cited: The facility failed to investigate, perform surveillance, and implement preventative measures to mitigate an outbreak of Covid-19 resulting in 1 death multiple hospitalization s and sustained transmission in 40 of 45 residents. 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. o On [DATE], the DON reviewed the 24-hour report to ensure there were no unidentified residents exhibiting signs and symptoms to ensure all symptomatic residents were identified. o No previously unidentified symptomatic residents were found, so no additional residents need droplet precautions at this time. 2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. o On [DATE], all applicable facility COVID-19 policies and procedures were reviewed and deemed appropriate according to CDC recommendations. o On [DATE], the Regional Director of Clinical Operations reeducated the facility DON on the procedure for outbreak investigation, tracking, surveillance and the company COVID-19 policies. o Beginning on [DATE], the DON or designee provided education to all employees regarding the COVID 19 Prevention, Response and Reporting Policy, including the identification of COVID-19 illness, transmission-based precautions, source control and mitigating the spread of the virus. o Any staff who did not receive the education on [DATE] will not be permitted to work until the education has been received. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	o Beginning on [DATE], the Administrator or designee provided education to all housekeeping staff on cleaning high-touch areas such as light switches, call lights, doorknobs, and toilets/sinks to ensure sanitary conditions. o Any housekeeping staff who did not receive the education on [DATE] will not be permitted to work until the education has been received. o The employee call-off log includes surveillance for respiratory illness. Beginning [DATE], any staff call offs secondary to illness will be reported to the Infection Preventionist to ensure appropriate tracking. o The Infection Preventionist or designee is monitoring the 24-hour report to ensure that any resident with signs and symptoms of respiratory illness is immediately placed on transmission-based precautions (droplet precautions suspected or confirmed COVID-19). o Beginning on [DATE] the facility will limit transport and movement within the facility as much as able by: o Encouraging residents who have not tested positive with this outbreak to dine and/or smoke separately from those who are COVID positive and who recently recovered from COVID-19 (to clarify, avoid residents who tested positive within the last 30 days), o Utilizing closed hallway doors as physical barriers to reduce air flow and deter avoidable resident movement. o The facility will ensure passive screening of facility visitors with signage per the CDC's recommendation. o The facility Medical Director was notified by the facility of this Immediate Jeopardy on [DATE]. o On [DATE] the Director of Nursing notified all clinical staff of the immediate education required prior to the employee's next scheduled shift. No employee will work until they are able to demonstrate proper use of PPE and handwashing, as well as re-education on the COVID-19 Prevention, Response and Reporting. o On [DATE] the Director of Nursing called nine certified nursing assistants and seven nurses to the facility for re-education on the COVID-19 Prevention, Response and Reporting Policy. Clinical employees pending education on COVID-19 Prevention, Response and Reporting will not work until educated by the Director of Nursing or Unit Manager. o On [DATE] the Administrator observed the Director of Nursing and Unit Manager demonstrating donning and doffing protocol and handwashing with a total of 16 out of 31 clinical employees who were called back to the facility for immediate education. The Director of Nursing utilized the teach back method to educate employees on donning and doffing and handwashing. Immediate Jeopardy Removal Plan F-880 - Infection Prevention and Control (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	o On [DATE] the EVS (Environmental Services) Director educated all employees in the housekeeping and laundry departments on the policy and procedure required for deep cleaning high-touch areas, call lights, doorknobs, toilets/sinks and all cleaning requirements to control and prevent the spread of COVID-19. o On [DATE] the EVS Director completed a deep cleaning of the laundry department and all utility cleaning carts. o On [DATE] the Dietary Manager completed a full deep clean of the kitchen, utility room, all sinks, and touch point areas. o On [DATE] the Dietary Manager educated dietary staff on handwashing, by demonstration and deep cleaning requirements. Any staff who did not receive the training on [DATE] will not be permitted to work until the training has been received. o On [DATE], 1:1 observation of clinical staff performing cares has been initiated with no discrepancies found during random observations by clinical management. o On [DATE] the Administrator held an ad hoc QAPI meeting to address this plan. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: [DATE] 35103 On [DATE] at 12:30 p.m., Registered Nurse P was observed donning personal protective equipment (PPE) to enter Resident R17's COVID-19 isolation room. An airborne transmission-based precaution sign was posted on the door of R17's room, and a PPE bin was located outside of his room. A small, black fan was plugged in and operational under the wall monitor where staff electronically documented their task completions. A black, plastic garbage can was also positioned outside of the R17's room door, lined with a red, hazard plastic garbage bag liner. An interview subsequent to the observation was conducted. When asked why the garbage can was outside of R17's room, in the hallway, RN P stated, We were removing our PPE out in the hall, after we came out of the room. The garbage can was observed to contain N95 face masks, surgical masks, gloves and yellow gowns. No face shields were observed in the red, hazard plastic liner. On [DATE] at 2:45 p.m., Registered Nurse (RN) P was observed providing wound care and donned personal protective equipment (PPE) (gown, gloves, N95 face mask) and was ready to enter the room, reaching for the door handle. RN P did not don eye protection. The COVID-19/Airborne precaution sign and PPE instructions clearly stated eye protection was to be worn. When this Surveyor pulled the face shields from the tall PPE bin outside of R47's room, RN P asked, Do we have to wear eye protection when we are wearing glasses? This Surveyor said, Yes, due to the access of air on all sides of the glasses. This Surveyor donned a face shield, and RN P then grabbed a face shield to put on. RN P wore an N95 mask over his long protruding beard, which was not able to be covered by the N95 mask. Water management Based on observation, interview and record review the facility failed to implement measures to prevent the spread of infectious organisms in the facility by failing to: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Develop and implement a water management program. 2. Properly transport and sort linens to prevent cross contamination. Findings Include: During an interview on [DATE] at 8:24 a.m., the Maintenance Director C was asked to provide monitoring systems for the water management program, water temperature monitoring, and records of flushing unused pipes. Maintenance Director C stated, Oh God! I don't have any records .I have not kept any records for any of that .I have not written anything down. The Water Management Program the Maintenance Director C provided was a toolkit on how to develop a Water Management Plan. During an interview on [DATE] at 8:46 a.m., the Nursing Home Administrator (NHA) was queried about the Water Management Program and water temperature monitoring. The NHA stated, the [Maintenance Director] C has done none of that.During a follow-up interview on [DATE] at 10:15 a.m., the NHA stated, Temperature logs don't exist .the water management program will need some work. Review of the facility policy titled Legionella Surveillance last revised ,d+[DATE] . read in part, it is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections .Legionella surveillance is one component of the facility's water management plan for reducing the risk of Legionella .in the facility's water systems . primary prevention strategies: diagnostic testing . investigation for a facility source of Legionella, which may include culturing of facility water .physical controls . temperature controls. Review of facility policy titled Infection Prevention and Control Program last revised ,d+[DATE] .read in part, Water Management: A water management program has been established as part of the overall infection and prevention and control program. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. Linen During an observation on [DATE] at 7:51 a.m., Laundry Aide K transported uncovered laundry in a cart on a wing with Residents that have confirmed COVID. Review of facility policy titled Infection Prevention and Control Program last revised ,d+[DATE] .read in part, laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection . clean linen shall be delivered to resident care units on covered linen carts with covers down. During an interview on [DATE] at 8:58 a.m., Laundry Aide K stated, I do not wear a gown when sorting clothing, but I do wear gloves . I have never worn a gown to sort clothes and I have worked in the laundry for [AGE] years. Review of facility policy titled Handling Soiled Linen Origination date [DATE] .read in part, Proper personal protective equipment should always be worn when sorting soiled linens. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 49735 Based on interview and record review, the facility failed to implement, monitor, and document the antibiotic stewardship program. This deficient practice has the potential to affect all residents with exposure to unnecessary medications, antibiotic resistance, and infection. Findings include: During an interview on 8/7/24 at 12:58 p.m., the Director of Nursing/Infection Preventionist (DON/IP) stated, I do not have a current listing for antibiotic stewardship from June or July, I have not been tracing or monitoring the use of antibiotics. During an interview on 8/8/24 at 9:32 a.m., this surveyor queried the DON/IP to review the antibiotic stewardship binder for the past 3 months. The DON/IP stated, I have nothing written for antibiotics on a line listing . I haven't done any of it .we get a report from the pharmacy and look at that. During an interview on 8/8/24 at approximately 11:00 a.m., this surveyor queried the DON/IP to review a resident who received antibiotics. The DON/IP stated, I have not tracked anyone who has received antibiotics, I have nothing to show you regarding dosage, testing, or length of time the resident has been receiving antibiotics. Review of the monthly infection summary from July 2024 revealed there were no summary reports of infection data or antibiotic stewardship including resistance patterns, the antibiotics were not compared to resident infections, documented if the antibiotics were appropriate or effective, or a report to the Quality Assurance Performance Improvement (QAPI) meeting. Review of the facility policy titled Infection Prevention and Control Program date revised 12/19 . read in part, Antibiotic Stewardship: a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program. B. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. Review of facility policy titled Antibiotic Stewardship Program date revised 1/24 . read in part, the purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . infection preventionist coordinates all antibiotic stewardship activities, maintains documentation .monitoring antibiotic use .antibiotic orders . shall be reviewed for appropriateness . antibiotic use shall be measured by monthly prevalence . data obtained from antibiotic stewardship monitoring activities is discussed in the facility's (QAPI) meetings.

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NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Hancock		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Poplar St Hancock, MI 49930	

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 49735 Based on interview and record review, the facility failed to educate and offer COVID-19 vaccination for staff resulting in increased risk for COVID-19 infections and the potential spread of COVID-19 infection to other residents, staff, and visitors. Findings include: During an interview on 8/7/24 at 3:05 p.m., the Director of Nursing (DON) stated, there has not been any education about COVID-19 for staff or COVID-19 vaccine offered to staff. During an interview on 8/12/24 at 1:08 p.m., the Nursing Home Administrator (NHA) stated, we used to educate and offer education and the COVID-19 vaccine . it has not been offered .and not offered every month. During an interview on 8/12/24 at 2:34 p.m., Registered Nurse (RN) S stated, I have not been educated about COVID-19 or offered the COVID-19 vaccine the last almost two years that I have worked at this facility. Review of facility policy titled Employee Vaccinations last revised 10/23 . read in part, 1. vaccination offerings: [Facility] will provide . COVID-19 vaccinations .all healthcare providers (HCP) will be offered the COVID-19 vaccine per CDC guidelines. Review of facility policy titled COVID-19 Vaccination last revised 3/24 . read in part, the facility will educate and offer the COVID-19 vaccine to .staff and maintain documentation of such.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 35103 Based on observation, interview, and record review, the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails to identify areas of potential entrapment for all facility residents. This deficient practice resulted in the potential for risk of injury to all 47 vulnerable facility residents. Findings include: Observation of Resident R15's room on 8/7/24 at 8:23 a.m., accompanied by Registered Nurse (RN) P, showed the presence of a large gap (area for potential entrapment) at the foot of R15's bed. RN P estimated the gap between the bed mattress and the bed footboard to be between five to six inches. During an observation and interview on 8/7/24 at approximately 1:20 p.m., Staff Q was asked for a tape measure. Staff Q measured the gap between the end of R15's mattress and the footboard on the bed. Staff Q said the gap between the footboard and the mattress was between 5 and 5.5 inches, which he acknowledged was outside of the acceptable measurement of 4 inches to prevent resident entrapment. During an interview on 8/8/24 at 2:42 p.m., Maintenance Staff Q was asked for the documentation of bed measurements to ensure the bed rails and mattresses on beds fit appropriately. When asked for written documentation of the bed rail and mattress measurements, Maintenance Staff Q said they (facility) probably did not have any documentation of bed measurements. Staff Q said he had performed that task at his previous facility, but he didn't think they did that (bed rail or bed measurements) here. During an interview on 8/8/24 at approximately 4:00 p.m., RN R provided a list of facility residents, by room number, showing all residents in the facility who had their beds against the wall and/or assist bars on their beds. Review of the [Facility Name] Devices 2024 lists, one for North Hall, and one for South Hall, revealed 11 Residents on each hall had assist bed rails attached to their beds, for a total of 22 Residents with assist bed rails in the facility. There were 19 Residents on North Hall, and 22 Residents on South Hall documented with bed against wall. During an interview on 8/8/24 at approximately 3:15 p.m., Maintenance Staff Q had reported that he had looked two places in the facility for the bed measurements but had not found any. Staff Q stated, I have one more place to look, then we can say that there are none (bed rail or bed measurements). (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/8/24 at 4:10 p.m., Maintenance Staff Q was unable to be located regarding the unavailable bed rail/bed measurement documentation. The DON and RN R were also present at the nurse's station at this time, with the NHA. When asked if they had ever seen former Maintenance Director C perform bed measurements, both the DON and RN R said they had not. When asked if they had ever witnessed or been aware of completion of measurements for five days following a new admission, both said they had never witnessed that. When asked where Maintenance Staff Q was, the NHA stated, He is probably tearing that maintenance office apart looking for measurements, but he's probably not going to find any . It is extremely unlikely that he will find any measurements because I don't think they were done. When asked if the NHA had ever seen the former Maintenance Director C performing bed safety measurements, the NHA said they had not. During an interview on 8/12/24 at 10:04 a.m., when asked about documentation for bed measurements and assuring mattresses and beds are compatible as well as safety of bed rails, the NHA stated, [Staff Q] looked for them there and they are not there. I know for a fact they were not done. He (Maintenance Director C) knew he was supposed to do them (bed safety measurements). I understand your concern with that. During an interview on 8/12/24 at 4:36 p.m., RN R, the DON, and Regional Clinical Consultant A were present when asked when the Maintenance Director prior to employment of Maintenance Director C, left employment with the facility. Human Resources Director H provided information that the Maintenance Director prior to Maintenance Dircetor C left employment with Mission Point on 9/26/23. All present agreed, that because no bed or bed rail measurements were found to be available for review, it could be concluded that Maintenance Director C had not performed any bedrail or bed gap measurements since 9/26/23. Review of the facility Bed Maintenance and Inspections policy, implemented 1/11/21, revealed the following, in part: Policy: It is the policy of this facility to conduct regular inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify and avoid areas of possible entrapment . 1. The Maintenance Director, or designee is responsible for keeping records of bed inspections and maintenance. 2. A list of bed frames, mattresses, and bed rails will be maintained, including the manufacturer for each. The Maintenance Director shall be notified of any new equipment brought into the facility. 3. The Maintenance Director shall review each manufacturer's recommendations and requirements for maintenance and bed inspections and shall establish a maintenance and inspection schedule accordingly . 5. When bed rails and mattresses are used and purchased separately from the bed frame, the facility will ensure that the bed rails, mattress, and bed frame are compatible. 6. Bed frame, mattress, and bed rail inspections will be conducted upon each item entering the facility and then placed on a regularly scheduled inspection and maintenance cycle according to the manufacturer's recommendations, to include manufacturer's timeframe recommendations. 7. If bed equipment is found to be outside of the manufacturer's requirements for any reason, the facility will perform maintenance to the bed equipment or remove from use.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 49735 Based on interview and record review, the facility failed to ensure the provision of training on resident rights training for two of five staff reviewed for resident right training. This deficient practice had the potential of facility staff violating the rights of all 45 residents in the facility. Findings include: Review of [Vendor] Computer training logs on 8/7/24 at approximately 4:00 p.m., revealed the following staff had no resident rights training: Certified Nurse Aide (CNA) L was hired on 11/21/22 and CNA N was hired on 10/26/22 Review of Facility Assessment (FA) did not include a requirement for the provision of resident rights training for staff. Review of facility policy titled Resident Rights last revised .dated 2/24, read in part the facility will ensure that all direct care and indirect care staff members .are educated on the rights of residents.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 49735 Based on interview and record review, the facility failed to ensure the provision of training on Quality Assurance Performance Improvement (QAPI) training for one L of five staff reviewed for QAPI training. This deficient practice had the potential to result in unmet care needs due to an ineffective performance improvement program. Findings include: Review of [Vendor] Computer training logs on 8/7/24 at approximately 4:00 p.m., revealed the following staff had no QAPI training: Certified Nurse Aide (CNA) L was hired on 11/21/22. Review of Facility Assessment (FA) did not include a requirement for the provision of QAPI training for staff. Request for QAPI policy from this Surveyor. Facility did not provide QAPI policy prior to exit from facility on 8/12/24

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 49735 Based on interview and record review, the facility failed to ensure the provision of training on infection control for one of five staff reviewed for infection control training. This deficient practice had the potential for the spread of diseases and infectious processes to all 45 residents in the facility. Findings include: Review of [Vendor] Computer training logs on 8/7/24 at approximately 4:00 p.m., revealed the following staff had no infection control training: Certified Nurse Aide (CNA) O was hired on 3/14/23. Review of Facility Assessment (FA) did not include a requirement for the provision of infection control training for staff. Review of facility policy titled Infection Prevention and Control Program last revised .dated 12/19, read in part . all staff shall receive training .regarding the facility's infection prevention and control program.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49735 Based on interview and record review, the facility failed to ensure nurse aide training of no less than 12 hours per year for two Certified Nursing Assistants (CNA) L and N of five CNA's reviewed for nurse aide training hours. This deficient practice resulted in the potential for unmet resident care needs for all 45 residents in the facility. Findings include: During an interview on 8/7/24 at 11:47 a.m. Human Resource/Business office Manager H revealed the 12 hours of annual CNA training is based on the CNA's hire date. On 8/7/24 at approximately 12:30 p.m., a review of CNA L training log revealed L was hired on 11/21/22 and had only 10 hours of in-service training. A review of CNA N training log revealed that N was hired on 10/26/22 and had only 11.75 hours of in-service training. During an interview on 8/12/24 at 1:12 p.m., the Nursing Home Administrator (NHA) stated, there is no way we can communicate to the staff about completing any trainings or what they have to do for training .it is on the [Vendor] training and that is what we do for training. Review of facility policy titled Online Training System-[Vendor] Learning last revised . dated 9/26/17 read in part, Certified Nurse aides (CNAs) are required to complete 12 hours of in-service annually.