

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab of Superior Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 8380 Geddes Rd Ypsilanti, MI 48198	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>45038</p> <p>Based on observation, interview, and record review the facility failed to accurately complete a Minimum Data Set (MDS) assessment for one resident (#39) of 18 residents reviewed for accurate assessments.</p> <p>Findings Included:</p> <p>Resident #39 (R39)</p> <p>Review of the medical record revealed R39 was admitted to the facility 11/01/2023 with diagnoses that included end stage renal disease, hyperlipidemia (high fat content in blood), diabetes mellitus, congestive heart failure (CHF), legal blindness, hyperkalemia (high potassium), insomnia, dyspepsia (shortness of breath), constipation, protein-calorie malnutrition, renal dialysis, absence of right great toe, and anemia (low red blood cell count). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/08/2024, revealed R39 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. Section B-Hearing, Speech, and Vision of the MDS, with the same ARD, revealed b1000- Vision - Ability to see in adequate light (with glasses or other visual appliances) was documented as 1. Impaired.</p> <p>During observation and interview on 12/08/2024 at 01:31 p.m. R39 was observed lying down in bed. R39 explained that he could not see and was legally blind. R39 was observed attempting to consume his food that was provided on his lunch tray. During this time Certified Nurse Aide (CNA) N was observed to take R39's left hand and place it in his food that was located on his lunch tray and was heard to explain to R39 where his food was located after putting R39's hand in his food.</p> <p>In an interview on 12/09/2024 at 10:00 a.m. Licensed Practical Nurse (LPN) O explained that R39 was legally blind. LPN O explained that he is able to feed himself and sometimes required direction on where his food was located on his tray. LPN O explained staff guided his hand over his food and explained what type of food was present.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/09/2024 at 10:28 a.m. Minimum Data Set (MDS) Coordinator P explained that she was responsible to complete the Minimum Data Set's for all the Residents at the facilities. MDS Coordinator P confirmed that she had completed R39's MDS with the reference date of 11/08/2024. MDS Coordinator P also confirmed that she had completed section B-Hearing, Speech, and Vision of the MDS, with the same ARD, b1000- Vision - Ability to see in adequate light (with glasses or other visual appliances) and had documented that section as 1. Impaired. When asked to review the MDS manual for how to code this section for someone that is legally blind, MDS Coordinator P confirmed that code documented 1, impaired: if the resident sees large print, but not regular print in newspaper/books and that R39's MDS should have been documented as Code 4, severely impaired: if the resident has no vision, sees only light, colors or shapes, or does not appear to follow objects with eyes. MDS Coordinator P explained that she had coded R39's MDS inaccurately and explained that she was going to complete a corrected MDS for R39.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038</p> <p>Based on observation, interview, and record review the facility failed to coordinate and complete a level II screening for one (Resident #59) of one resident reviewed for Preadmission Screening/Annual Resident Review (PASARR).</p> <p>Findings Included:</p> <p>Resident #59 (R59)</p> <p>Review of the medical record revealed R59 was admitted to the facility 10/10/2023 with diagnoses that included rheumatoid arthritis, diabetes mellitus, atrial fibrillation, post-traumatic stress disorder (PTSD), atherosclerotic heart disease (plaque buildup in artery walls), dysphagia (difficulty swallowing), bipolar disorder, paranoid schizophrenia, insomnia, right bundle branch block (disorder of electrical activity affecting heart), chronic headache, vitamin D deficiency, polyarthritis (arthritis affecting greater than five bone joints), depression, anxiety, and osteoporosis (condition making bones weak and brittle). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/25/2024, revealed R59 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15.</p> <p>During observation and interview on 12/08/2024 at 03:01 p.m. R59 was observed lying in bed. R59 explained that he had Post Traumatic Stress Disorder (PTSD) because of the Vietnam War. R59 explained that he did not like to talk about the specifics of his diagnoses of PTSD.</p> <p>Review of R59's medical record demonstrated a 3877- Preadmission Screening (PAS) Annual Resident Review (ARR) completed 09/16/2023. The level II screen of the 3877 demonstrated 1.yes- the person has a current diagnosis of mental illness, 2. Yes the person has received treatment for mental illness., 3) yes the person has routinely received one or more prescribed antipsychotic or antidepressant medication within the last 14 days., 4. Yes - There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evident may include, but it not limited to suicidal ideations, hallucinations, delusions, serious difficulty interacting with others. R59's 3877 Preadmission Screen (PAS) Annual Resident Review (ARR) completed 09/16/2023 demonstrated If any answer to items 1-6 in Section II is Yes, send one copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH(Department of Community Health)-3878 if an exemption is requested. The nursing facility [NAME] retain the original in the patient record and provide a copy to the patient or legal representative.</p> <p>Review of R59's medical record did not demonstrate a completed CCH-3878 Level II.</p> <p>In an interview on 12/10/2024 at 12:21 p.m. Social Worker (SW) C verified that R59 did not have a level II DCH-3878 in his medical record. SW C explained that it was part of her duties to make sure that the DCH-3878 is completed for all residents that it is necessary. SW C could not explain why R59's DCH-3878 was not completed as required.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306</p> <p>Based on observation, interview and record review the facility failed to include Resident #181 care plan development and failed to update/revise individualized person-centered care plans to reflect changing care need for one Residents #39 for 2 of 18 reviewed.</p> <p>Findings include:</p> <p>Resident #181</p> <p>According to the clinical record Resident 181 (R181) was admitted to the facility on [DATE] with a diagnosis infective bursitis right elbow. Review of the Minimum Data Set (MDS) dated [DATE] reflected R181 scored 15 out of 15 (cognitively intact) on the Brief Interview Mental Status (BIMS).</p> <p>On 12/08/24 at 11:00 AM R 181 was observed ambulating around room and was well groomed. R181 reported being at the facility for intravenous antibiotic therapy (IVABT) and was independent with all activity of daily living R181 reported being at the facility over Thanksgiving and was becoming anxious as nobody has told him the stop date of the IVABT may have to stay for Christmas. When queried if the facility discussed a stop date at the care conference , R181 reported he didn't know what a care conference was, R181 elaborated there had no meeting with nursing, social work or any of the staff and he has been provided no information on length of stay nor has he been afforded the opportunity to have in put into the plan of care and discharge plan.</p> <p>On 12/10/24 at 12:20PM during an interview with Social Services Technician C reported she schedules a plan of care meeting with residents and or their family shortly after their admission. Social Services Technician C reported discharge planning and the plan of care are discussed those meetings. Social Services Technician C reviewed R181 medical record and reported R181's care conference had not been scheduled by mistake.</p> <p>45038</p> <p>Resident #39 (R39)</p> <p>Review of the medical record revealed R39 was admitted to the facility 11/01/2023 with diagnoses that included end stage renal disease, hyperlipidemia (high fat content in blood), diabetes mellitus, congestive heart failure (CHF), legal blindness, hyperkalemia (high potassium), insomnia, dyspepsia (shortness of breath), constipation, protein-calorie malnutrition, renal dialysis, absence of right great toe, and anemia (low red blood cell count). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/08/2024, revealed R39 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. Section B-Hearing, Speech, and Vision of the MDS, with the same ARD, revealed b1000- Vision - Ability to see in adequate light (with glasses or other visual appliances) was documented as 1. Impaired.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation and interview on 12/08/2024 at 01:31 p.m. R39 was observed lying down in bed. R39 explained that he could not see and was legally blind. R39 was observed attempting to consume his food that was provided on his lunch tray. During this time Certified Nurse Aide (CNA) N was observed to take R39's left hand and place it in his food that was located on his lunch tray and was heard to explain to R39 where his food was located after putting R39's hand in his food.</p> <p>Review of R39's plan of care demonstrated the problem statement, I have impaired visual function r/t (related to) blindness, which was initiated 02/29/2024. No interventions were listed as to how the staff could assist R39 in the location of items that he could not see related to his blindness. Review of R39's Kardex (documentation to assist direct care givers with needed care for a Resident) did not list that R39 was blind and did not list any interventions regarding his care for the diagnosis of legally blind.</p> <p>During observation and interview on 12/09/2024 at 09:56 a.m. R39 was observed lying down in bed. R39 explained that he was able to communicate with staff verbally. R39 denied using any communication board device and could not explain how staff would communicate to him regarding issues involving location of items he could not see because of his legal blindness.</p> <p>In an interview on 12/09/2024 at 10:00 a.m. Licensed Practical Nurse (LPN) O explained that R39 was legally blind. LPN O explained that he is able to feed himself and sometimes required direction on where his food was located on his tray. LPN O explained staff guided his hand over his food and explained what type of food was present. LPN O could not demonstrate any interventions to assist R39 with his blindness, list on his plan of care or on his Kardex.</p> <p>In an interview on 12/09/2024 at 10:28 a.m. Minimum Data Set (MDS) Coordinator P explained that she was responsible to complete the Minimum Data Set's for all the Residents at the facilities. MDS Coordinator P confirmed that she had completed R39's MDS with the reference date of 11/08/2024. MDS Coordinator P explained that once she completed a residents MDS that she would update the residents plan of care. MDS Coordinator P confirmed that R39's plan of care and Kardex did not list any interventions that should be used by staff to assist R39 with his blindness. MDS Coordinator P stated that the lack of interventions must have been an oversight on her part.</p> <p>In an interview on 12/09/2024 at 10:43 a.m. Director of Nursing (DON) B explained that it was her expectation that if a Resident was legally blind that the Resident should have a problem statement and interventions listed on their plan of care. DON B confirmed that R39 did not have interventions on his plan of care that would assist with his diagnosis of being legally blind. DON B could not explain why interventions were not present for R39's blindness.</p> <p>45135</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>45038</p> <p>Based on observation, interview, and record review the facility failed to provide alternative communication devices related to vision for one Resident (#39) that was legally blind out of one resident reviewed for activities of daily living abilities.</p> <p>Findings Included:</p> <p>Resident #39 (R39)</p> <p>Review of the medical record revealed R39 was admitted to the facility 11/01/2023 with diagnoses that included end stage renal disease, hyperlipidemia (high fat content in blood), diabetes mellitus, congestive heart failure (CHF), legal blindness, hyperkalemia (high potassium), insomnia, dyspepsia (shortness of breath), constipation, protein-calorie malnutrition, renal dialysis, absence of right great toe, and anemia (low red blood cell count). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/08/2024, revealed R39 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. Section B-Hearing, Speech, and Vision of the MDS, with the same ARD, revealed b1000- Vision - Ability to see in adequate light (with glasses or other visual appliances) was documented as 1. Impaired.</p> <p>During observation and interview on 12/08/2024 at 01:31 p.m. R39 was observed lying down in bed. R39 explained that he could not see and was legally blind. R39 was observed attempting to consume his food that was provided on his lunch tray. During this time Certified Nurse Aide (CNA) N was observed to take R39's left hand and place it in his food that was located on his lunch tray and was heard to explain to R39 where his food was located after putting R39's hand in his food.</p> <p>Review of R39's plan of care demonstrated the problem statement, I have impaired visual function r/t (related to) blindness, which was initiated 02/29/2024. No interventions were listed as to how the staff could assist R39 in the location of items that he could not see related to his blindness. Review of R39's Kardex (documentation to assist direct care givers with needed care for a Resident) did not list that R39 was blind and did not list any interventions regarding his care for the diagnosis of legally blind. Review of R39's plan of care entitled I have a communication problem revealed an intervention which stated Ensure availability and functioning of adaptive communication equipment message board.</p> <p>During observation and interview on 12/09/2024 at 09:56 a.m. R39 was observed lying down in bed. R39 explained that he was able to communicate with staff verbally. R39 denied using any communication board device and could not explain how staff would communicate to him regarding issues involving location of items he could not see because of his legal blindness.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/09/2024 at 10:00 a.m. Licensed Practical Nurse (LPN) O explained that R39 was legally blind. LPN O explained that he is able to feed himself and sometimes required direction on where his food was located on his tray. LPN O explained staff guided his hand over his food and explained what type of food was present. LPN O could not demonstrate any interventions to assist R39 with his blindness, list on his plan of care or on his Kardex. LPN O denied any type of communication device that was being used with R39.</p> <p>In an interview on 12/09/2024 at 10:28 a.m. Minimum Data Set (MDS) Coordinator P explained that she was responsible to complete the Minimum Data Set's for all the Residents at the facilities. MDS Coordinator P confirmed that she had completed R39's MDS with the reference date of 11/08/2024. MDS Coordinator P explained that once she completed a residents MDS that she would update the residents plan of care. MDS Coordinator P confirmed that R39's plan of care and Kardex did not list any interventions that should be used by staff to assist R39 with his blindness. MDS Coordinator P stated that the lack of interventions must have been an oversight on her part.</p> <p>In an interview on 12/09/2024 at 10:43 a.m. Director of Nursing (DON) B explained that it was her expectation that if a Resident was legally blind that the Resident should have a problem statement, and interventions listed on their plan of care. DON B confirmed that R39 did not have interventions on his plan of care that would assist with his diagnosis of being legally blind. DON B could not explain why interventions were not present for R39's blindness. DON B could not explain why a communication device was not in use as listed in R39's plan of care.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>45038</p> <p>Based on observation, interview, and record review the facility failed to provide Range of Motion (ROM) services to prevent the possibility of decreased ROM and mobility in one resident (#59) of one resident reviewed.</p> <p>Findings Included:</p> <p>Resident #59 (R59)</p> <p>Review of the medical record revealed R59 was admitted to the facility 10/10/2023 with diagnoses that included rheumatoid arthritis, diabetes mellitus, atrial fibrillation, post-traumatic stress disorder (PTSD), atherosclerotic heart disease (plaque build up in artery walls), dysphagia (difficulty swallowing), bipolar disorder, paranoid schizophrenia, insomnia, right bundle branch block (disorder of electrical activity affecting heart), chronic headache, vitamin D deficiency, polyarthritis (arthritis affecting greater than five bone joints), depression, anxiety, and osteoporosis (condition making bones weak and brittle). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/25/2024, revealed R59 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15.</p> <p>During observation and interview on 12/08/2024 at 02:57 p.m. R59 was observed lying down in bed. R59 explained that he had been received skilled therapy services but that those services had stopped. R59 denied that he had been receiving any Range of Motion (ROM) for any up his upper or lower extremities. R59 explained that he would like to continue some type of therapy services to increase his ROM.</p> <p>Review of R59's medical record revealed physician orders, written 10/23/2024, which stated, Daily skill care continues to be necessary for the following reason: PT(physical therapy)/OT(occupational therapy) 5 times a week for therapeutic exercise/activities neuromuscular reeducation, gait training, wheelchair training and self-care management .</p> <p>Review of R59's document entitled Physical Therapy PT Discharge Summary, with date of services 10/21/2024 to 11/08/2024 revealed discharge recommendations restorative program established/trained=Range of Motion Program and Range of Motion Program Established/trained: BLE (Bilateral Lower Extremities) ROM (Range of Motion) exs (exercise) in all available plan x15 and as tolerated.</p> <p>In an interview on 12/10/2024 at 03:05 p.m. the Director of Rehabilitation (DOR) Q explained that R59 had received Physical Therapy from the dates of 10/20/24 until 11/07/2024. DOR Q explained that therapy services were discontinued because R59 no longer qualified for those services and Physical Therapy had discharged R59 with recommendations to continue with a restorative program. DOR Q explained that R59 did not receive received a restorative program because one was not available at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/10/2024 at 03:30 Director of Nursing (DON) B explained that the facility did not have a restorative program for residents put that the Certified Nursing Aides CNA's performed Range of Motion (ROM) during activities of daily living (ADL) with the residents. DON B confirmed that R59 had not received ROM as requested from Physical Therapy at the time of discharge from therapy services. DON B explained that the specific task entitled CNA Maintenance Program: Passive ROM -During ADL care had not been activated prior to the date of 12/10/2024.</p> <p>In an interview on 12/10/2024 at 03:55 p.m. Certified Nursing Aide (CNA) E explained that Range of Motion is completed with residents that have that listed on their Task Care Record. CNA E explained that the task care record is where CNA's would document the care that is provided to the residents.</p> <p>Review of R 59's Task Care Record (location of Certified Aide Documentation) did not demonstrate any dates of completion for CNA Maintenance Program: Passive ROM -During ADL care, in the last thirty days.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306</p> <p>Based on observation, interview and record review the facility failed to prevent an elopement for one of one residents (R#74) reviewed for elopement.</p> <p>According to the clinical record including the Minimum Data Set (MDS) dated [DATE] reflected Resident # 74 (R74) was admitted to the facility on [DATE] with diagnoses of dementia, R74 scored 5 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS).</p> <p>Record review reflected R74 eloped from the facility on 07/09/2024 in the afternoon and was located approximately 100 yards from the building walking down a sidewalk. Further review of that facility reported incident reflected R74 eloped from the 200 hallway door.</p> <p>Record review completed on the certification survey reflected R74 eloped on 11/16/24 at approximately 4:40 PM. Review of the incident report reflected Certified Nursing Assistant (CNA) C was the first person to become aware of R74's elopement.</p> <p>On 12/10/24 11:56 AM during an interview with CNA C reported on 11/16/24 when she came back from her break she was notified by another resident that R74 exited the facility through the 200 hall door. CNA C stated she reported it immediately to Licensed Practical Nurse (LPN) R then went to the 200 hall door where there was a faint alarm sounding. When queried about the alarm, CNA C stated she could not hear the alarm until she was a few feet away from the 200 hall door. CNA C reported R74 was located behind the facility near the dumpster's.</p> <p>On 12/10/24 12:09 PM during a phone interview with Licensed Practical Nurse LPN R reported she was notified of R74's elopement from CNA C. LPN R stated she too went down the 200 hall where R74 resided and not until approximately 10 feet from the 200 hall door was the alarm audible.</p> <p>On 12/10/24 02:15 PM this surveyor pushed the delayed release bar on the 200 hall door, the door sounded an alarm sounded faintly and could not be heard at the end of the hall where the nurses station and television lounge area was. CNA C, CNA F and LPN G were all at the end of the 200 hall (near the nurses station) and when queried what they heard at the present time, they responded the television, a call light and other people talking. When queried if they could hear the push bar alarm at the opposite end of the 200 hall they all stated No. At this time the surveyor fully opened the 200 hall exit door which had a loud alarm that could easily be heard at the nurses station. CNA C, CNA F and LPN G all stated the louder alarm was not in place on 11/16/24.</p> <p>On 12/11/24 at 9:30 am during an interview with Maintenance Director D he reported on September 10th the alarm company was at the facility and installed a delayed egress alarm to the 200 hall exit door push bar, during that installation the alarm that was in place that would sound extremely loud if the door fully opened was disconnected. When Maintenance Director D was queried why the second alarm was not reconnected, Maintenance Director D stated he thought the alarm that sounded from the push/crash bar was loud enough.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab of Superior Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 8380 Geddes Rd Ypsilanti, MI 48198	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/11/24 11:06 AM during an interview with Nursing Home Administrator NHA A he reported he was not aware that the 200 alarm was disassembled until R74 had eloped on 11/16/24. NHA A stated the second alarm was reconnected on 11/16/24 after R74 was located and brought back into the facility.</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included .</p> <p>Element #1</p> <p>Resident #74 continues to reside within the facility. Skin asses assessment completed. R74 placed on one to one. Head count c facility; all residents accounted for. R74 physician and response emergency exit doors assessed by the Maintenance Director on 11/16/2024</p> <p>The Maintenance Director installed a secondary alarm on the emergency hall to provide an additional layer of protection in the event the door is op secondary alarm is loud and can be heard from the nursing station and to d keyed off. interventions/actions to correct the past noncompliance). The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p> <p>Element #2</p> <p>All residents that are determined to be elopement risk have the potential to be affected. The facility has completed elopement assessments on all current residents. Elopement books reviewed for accuracy and to ensure they are up to date. Any resident identified as an eloper risk will be reviewed and placed in the elopement book if needed, along with a wander guard bracelet to be applied, if needed.</p> <p>Element #3</p> <p>Facility policy (Elopement and Wandering Residents) reviewed and deemed appropriate. Facility staff provided with reeducation regarding following care plans and increasing supervision if needed. The IDT team will continue to review clinical alerts documentation regarding increase wandering and exit seeking during daily morning meetings. The Facility Maintenance Director given education to ensure facility exit doors function appropriately and if current alarms are not loud enough to ensure an additional alarm is installed to provide a sound that can be heard from the nurses station.</p> <p>Element #4</p> <p>The Director of Nursing /Designee will complete audits on residents that are at risk for elopement to ensure staff are following the care plan and providing increased supervision if needed related to wandering and/or exit seeking behavior every week x 4 weeks, then every month x 2 months. The results of the monitoring will be brought to the QAPI committee for review. Any concerns will have been addressed. However, any patterns identified and if needed an action plan will be written by the committee. The written action plan will be monitored weekly by the administrator until resolution.</p> <p>Element #5</p> <p>DON/Designee is responsible for compliance by 11/25/24</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45038</p> <p>Based on observation, interview, and record review the facility failed to follow pharmacy policy and acceptable clinical practice for medication usage and administration for one resident (#54) out of 83 current facility residents.</p> <p>Findings Included:</p> <p>Resident #54 (R54)</p> <p>Review of the medical record revealed R54 was admitted to the facility 06/30/2022 with diagnoses that included chronic obstructive pulmonary disease (COPD), stroke, protein-calorie malnutrition, hypertension, depression, attention-deficit hyperactivity disorder (ADHD), urinary incontinence, bilateral cataracts, dementia, alcohol abuse, and chronic respiratory failure. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/01/2024, revealed R54 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15.</p> <p>During observation and interview on 12/08/2024 at 12:50 p.m. R54 was observed lying in bed. An over the counter breathing inhaler was observed on the over bed table beside R54's bed. The inhaler was observed to be Primatene Mist. R54 explained that his wife had purchased the Primatene Mist inhaler for him and staff at the facility aware that he had the Primatene Mist. R54 explained that he used the Primatene Mist inhaler daily but could not tell how many inhalations or the frequency of those inhalations per day.</p> <p>Review of R54's medical record did not contain any current physician order for Primatene Mist.</p> <p>During an interview on 12/10/2024 The Director of Nursing (DON) B explained that all over the counter medication required a physician order which would include: the name of the medication, the route of the medication, the dosage of the medication, the route of administration, and the frequency of that medication. DON B confirmed that R54 did not have a physician order for the use of Primatene Mist. DON B confirmed that Primatene Mist was defined as an Over the Counter Medication and that Primatene Mist required a physician order.</p> <p>Review of policy entitled IB1: Non-Controlled Medication Order Documentation demonstrated a policy statement which stated, Medications are administered only upon the clear, completed, and signed order of a licensed prescriber. The same policy stated A. Elements of the Medication Order- 1). Medication orders specify the following: a. Name of medication</p> <p>b. Strength of medication, where indicated</p> <p>c. dose and dosage form</p> <p>d. frequency of administration</p> <p>e. route of administration</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>f. quantity or duration of therapy</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45038</p> <p>Based on observation, interview, and record review the facility failed to ensure proper medication storage of medications for one Resident (#54) out of 83 current residents residing at the facility.</p> <p>Findings Included:</p> <p>Resident #54 (R54)</p> <p>Review of the medical record revealed R54 was admitted to the facility 06/30/2022 with diagnoses that included chronic obstructive pulmonary disease (COPD), stroke, protein-calorie malnutrition, hypertension, depression, attention-deficit hyperactivity disorder (ADHD), urinary incontinence, bilateral cataracts, dementia, alcohol abuse, and chronic respiratory failure. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/01/2024, revealed R54 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15.</p> <p>During observation and interview on 12/08/2024 at 12:50 p.m. R54 was observed lying in bed. An over the counter breathing inhaler was observed on the over bed table beside R54's bed. Another inhaler was observed to be on the over bed table. The first inhaler was observed to be Primatene Mist. The second inhaler was observed to be Albuterol Sulfate. R54 explained that his wife had purchased the Primatene Mist inhaler for him and staff at the facility aware that he had the Primatene Mist. R54 explained that he used the Primatene Mist inhaler daily but could not tell how many inhalations or the frequency of those inhalations per day. R54 explained that the Albuterol Sulfate inhaler was used as a rescue inhaler when he was short of breath but could not explain how many times he used the medication.</p> <p>In an interview on 12/10/2024 at 08:8:46 a.m. Licensed Practical Nurse (LPN) M explained that residents were allowed to keep medication at their bedside if they had a physician's order and their plan of care specified that those medications could not be self-administered by the resident. LPN M could not demonstrate a physician's order to keep medication at R54's bedside or an order for R54 to self-administer any of his medication.</p> <p>Review of R54's medical record demonstrated a physician's order that stated, Albuterol Sulfate HFA (hydrofluoroalkane) Inhalation Aerosol Solution 108 (90 Base) MCG (micrograms) /ACT (actuation) 2 puff inhale orally every 6 hours as needed for SOB/Wheezing and no order for Primatene Mist. Review of R54's medical record did not demonstrate an evaluation for self-administration of medication. Review of R54's plan of care did not demonstrate a plan of care for self-administration of medication.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/10/2024 at 08:52 a.m. Director of Nursing (DON) B explained that residents could self-administer medication if a self-administration assessment was completed by the facility. DON B explained that residents would then be allowed to keep medication at their bed side, but that medication must be in a locked box. DON B also explained that a physician's order would also be written allowing the residents to self-administer medication and to keep medication at bedside. DON B also explained that the information would be included on the resident's plan of care. DON B could not demonstrate a self-administration assessment, a physician order for self-administration or any plan of care for self-administration of R54's medication that was in R54's medical record.</p> <p>Review of facility policy entitled Resident Self-Administration of Medication, implementation date 11/2012 and last revised 06/2023, revealed A resident may only self-administer medications after the facility's interdisciplinary team (IDT) has determined which medications may be self-administered safely. The same policy demonstrated Policy Explanation and Compliance Guideline which stated:</p> <ol style="list-style-type: none"> 1. Each resident who self-administers medication will have an assessment completed. 2. The IDT will determine if resident can safely self-administer medications 6. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident whose self-administers medication. The following conditions are met for bedside storage to occur: <ol style="list-style-type: none"> a. The manner of storage prevents access by other residents. b. The medications provided to the resident for bedside storage are kept in the original containers 11. The care plan must reflect resident self-administration and storage arrangements for such medications . <p>45135</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050</p> <p>Based on observations, interviews, and record reviews the facility failed to clean and maintain food service equipment effecting 83 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage.</p> <p>Findings include:</p> <p>On 12/09/24 at 09:25 A.M., A comprehensive tour of the food service was conducted with Dietary Manager H and Registered Dietician I. The following items were noted:</p> <p>Walk-In Freezer: The automatic door closer assembly was observed weak, allowing the door to not close completely. Registered Dietician I indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>The Victory one-door reach-in cooler door gasket was observed (worn, torn, missing). Dietary Manager H indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>Two fry pans (one 18-inch and one 14-inch) were observed (etched, scored, particulate). Dietary Manager H stated: I will just throw the pans away.</p> <p>The 2017 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened.</p> <p>Dry Storage Room: 2 of 2 overhead light assembly lens covers were observed with (8) dead insect carcasses resting upon the interior plastic lens cover surface.</p> <p>Food Production Kitchen: The overhead light assembly lens covers were observed with dead insect carcasses resting upon the interior plastic lens cover surface.</p> <p>The 2017 FDA Model Food Code section 6-501.12 states: (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing.</p> <p>Walk-In Freezer: The refrigeration unit was observed with ice [NAME] protruding from the Freon supply lines and unit cabinet. Dietary Manager H indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>The South Bend convection oven interior and exterior surfaces were observed heavily soiled with accumulated and encrusted food residue.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Vulcan stove/oven exterior was observed soiled with accumulated and encrusted food residue.</p> <p>The Legion tilt kettle exterior was observed soiled with accumulated and encrusted food residue.</p> <p>The Juice Machine was observed heavily soiled with accumulated and encrusted food residue. The interior surfaces were also observed soiled with accumulated and encrusted food residue. The (backsplash, undersplash, drip tray) were further observed soiled with accumulated and encrusted food residue.</p> <p>The Univex stand mixer was observed soiled with accumulated and encrusted food residue.</p> <p>Note: Dietary Manager H indicated she would have dietary staff thoroughly clean and sanitize the soiled food service equipment as soon as possible.</p> <p>The 2017 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.</p> <p>The drywall surface was observed (etched, scored, moist, particulate), adjacent to the Evolution steamer. The wall/floor vinyl coving strip was also observed loose-to-mount. The damaged wall/floor vinyl coving strip measured approximately 4-inches-wide by 36-inches-long. Dietary Manager H indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>The 2017 FDA Model Food Code section 6-501.11 states: PHYSICAL FACILITIES shall be maintained in good repair.</p> <p>Sub-Acute Nutrition Room: The Amana refrigerator interior door gasket was observed soiled with accumulated and encrusted food residue. The Amana refrigerator freezing compartment door gasket was also observed soiled with accumulated and encrusted food residue.</p> <p>Long-Term Care Nutrition Room: The Whirlpool refrigerator and freezing compartments were observed with accumulated and encrusted food residue. The door gaskets were also observed soiled with accumulated and encrusted food residue.</p> <p>Note: Dietary Manager H indicated she would have dietary staff thoroughly clean and sanitize the soiled food service equipment as soon as possible.</p> <p>The 2017 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/11/24 at 04:15 P.M., Record review of the Policy/Procedure entitled: Cleaning Equipment and Utensils dated 01/2024 revealed under Policy: Equipment and utensils will be properly cleaned and sanitized to prevent contamination. Record review of the Policy/Procedure entitled: Cleaning Equipment and Utensils dated 01/2024 further revealed under Purpose: Safe food handling and minimize the risk of cross-contamination.</p> <p>On 12/11/24 at 04:30 P.M., Record review of the Policy/Procedure entitled: Food Safety Requirements dated 01/2021 revealed under Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. Food will also be stored, prepared, and served in accordance with professional standards for food service safety.</p> <p>45135</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45038</p> <p>Based on observation, interview, and record review the facility failed to implement infection control practices to change oxygen tubing/nasal cannulas for one resident (#54) of three residents reviewed for oxygen usage.</p> <p>Findings included:</p> <p>Resident #54 (R54)</p> <p>Review of the medical record revealed R54 was admitted to the facility 06/30/2022 with diagnoses that included chronic obstructive pulmonary disease (COPD), stroke, protein-calorie malnutrition, hypertension, depression, attention-deficit hyperactivity disorder (ADHD), urinary incontinence, bilateral cataracts, dementia, alcohol abuse, and chronic respiratory failure. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/01/2024, revealed R54 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15.</p> <p>During observation and interview on 12/08/2024 at 12:47 p.m. R54 was observed lying in bed and an oxygen concentrator was observed beside his bed on the floor. It was observed that his nasal cannula was on the floor and that the oxygen tubing was not dated. R54 explained that he only wears his oxygen when he feels it is necessary.</p> <p>During observation and interview on 12/10/2024 at 09:27 a.m. R54 was observed lying in bed and his oxygen tubing was observed beside his bed on the floor. It was also observed that his oxygen tubing was not date. R54 could not explain how often the facility changed his oxygen tubing and responded, I have never see then change the oxygen tubing.</p> <p>In an interview on 12/10/2024 at 09:28 a.m. Licensed Practical Nurse (LPN) M explained that oxygen tubing is replaced once per week and that documentation of the oxygen tubing replacement was recorded on the residents Medication Administration Record (MAR).</p> <p>In an interview on 12/10/2024 at 09:31 a.m. Director of Nursing (DON) B explained that oxygen tubing is replaced weekly and as needed. DON B explained that an order is written to replace the oxygen tubing once per week on the midnight shift and completion of that order is record in the residents Medication Administration Record (MAR). DON B could not demonstrate an order for R54's oxygen tubing to be changed once per week or completion of oxygen tubing change on R54's MAR.</p> <p>Review of policy entitled Oxygen Administration and Concentrator Policy, implementation date of 05/2006 and last revised 06/2024, demonstrated Policy Explanation and Compliance Guidelines:</p> <p>4. Infection control measure included: .</p> <p>b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated and document in the electronic health record.</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45135</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab of Superior Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 8380 Geddes Rd Ypsilanti, MI 48198	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050</p> <p>Based on observations, interviews, and record reviews the facility failed to effectively clean and maintain the physical plant effecting 83 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased illumination.</p> <p>Findings include:</p> <p>On 12/09/24 at 10:48 A.M., One of two window sashes were observed drafty and leaking air, within resident room [ROOM NUMBER]. The drafty window sash was also observed to not shut completely, creating the cold air draft.</p> <p>On 12/09/24 at 12:13 P.M., The 300 Hall (Point Click Care Kiosk) chair backrest was observed covered with black duct tape. The inner backrest Styrofoam padding was also observed protruding from the black duct taped seams, creating a non-cleanable and non-sanitizable surface.</p> <p>On 12/09/24 at 12:20 P.M., The 300 Hall Shower Room spa tub wastewater connection line was observed detached, allowing wastewater to flow onto the flooring surface.</p> <p>On 12/09/24 at 12:42 P.M., Two base cabinet doors were observed missing, within the 100 Hall Shower Room. The two missing base cabinet doors were additionally observed resting within the hand sink basin base cabinetry. The wall/floor vinyl coving was further observed loose-to-mount, adjacent to the portable shower stall assembly. The two sections of loose-to-mount wall/floor vinyl coving measured approximately 3-foot-long and 4-foot-long respectively.</p> <p>On 12/09/24 at 02:26 P.M., An environmental tour of the facility Laundry Service was conducted with Environmental Services Manager D. The following items were noted:</p> <p>Clean Linen Room: 1 of 2 return-air-ventilation grills were observed heavily soiled with accumulated dust/dirt deposits. Environmental Services Manager D indicated he would have staff thoroughly clean and sanitize the soiled return-air-ventilation grill as soon as possible.</p> <p>Washer/Dryer Room: 2 of 2 desk fans were observed heavily soiled with accumulated dust/dirt deposits. The dryer rear access room was also observed soiled with accumulated dust/dirt deposits. Cobwebs were further observed near the wall/ceiling junctures, adjacent to the two commercial dryers. Environmental Services Manager D indicated he would have staff thoroughly clean the soiled desk fans and dryer rear access room as soon as possible.</p> <p>Soiled Laundry Room: The return-air-ventilation grill was observed heavily soiled with accumulated dust/dirt deposits. Environmental Services Manager D indicated he would have staff thoroughly clean and sanitize the return-air-ventilation grill as soon as possible.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/09/24 at 02:40 P.M., An interview was conducted with Environmental Services Manager D regarding the facility maintenance work order system. Environmental Services Manager D stated: We just started the TELS system a couple of months ago. Environmental Services Manager D further stated: We have not totally implemented the TELS program to date.</p> <p>On 12/09/24 at 02:45 P.M., A common area environmental tour was conducted with Environmental Services Manager D. The following items were noted:</p> <p>100 Hall/200 Hall Soiled Utility Room: 2 of 2 overhead light assemblies were observed with dead insect carcasses resting within the interior plastic protective lens cover. The waste caddy interior surface was also observed heavily soiled with accumulated dust/dirt/grime. Environmental Services Manager D indicated he would have staff thoroughly clean and sanitize the soiled waste caddy and overhead light assembly protective lens covers as soon as possible.</p> <p>100 Hall/200 Hall Clean Utility Room: Eight base cabinet doors were observed missing. Two landing strips were also observed soiled with accumulated soil and debris.</p> <p>300 Hall Soiled Utility Room: 2 of 2 overhead light assemblies were observed with dead insect carcasses resting within the interior plastic protective lens cover.</p> <p>300 Hall/400 Hall Clean Utility Room: 3 of 4 (48-inch-long) fluorescent overhead light bulbs were observed non-functional. Environmental Services Manager D indicated he would have staff replace the faulty light bulbs as soon as possible.</p> <p>300 Hall/400 Hall Nursing Station: The laminate flooring surface was observed (etched, scored, worn), adjacent to the printer. The damaged flooring surface measured approximately 4-inches-wide by 10-inches-long. Environmental Services Manager D indicated he would make necessary repairs as soon as possible.</p> <p>On 12/11/24 at 05:00 P.M., Record review of the Policy/Procedure entitled: Safe and Homelike Environment dated 01/11/2021 revealed under Policy: In accordance with resident's rights, the facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Record review of the Policy/Procedure entitled: Safe and Homelike Environment dated 01/11/2021 further revealed under Policy Explanation and Compliance Guidelines: (3) Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.</p>		