STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235664	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to develop a care plan to address resident's mood/behavior, psychotropic medication, and trauma informed care for one (R17) of 12 residents reviewed for care planning. Findings include: On 12/16/24 at 9:20 AM, R17 was observed laying in bed wearing a hospital gown and a thin cotton blanket over their legs. When asked simple questions, the resident began speaking but their speech was nonsensical at first and then R17 began stating Awesome, Awesome, Awesome and clapping their hands. Additional observations throughout the remainder of the survey revealed R17 self-propelling throughout the hallways in their wheelchair, and attempted to stand up and walking with staff. Review of the clinical record revealed R17 was admitted into the facility on [DATE], discharged to another nursing home on 6/27/24, and readmitted on [DATE] with diagnoses that included post-traumatic stress disorder - chronic. (It should be noted that the resident was discharged on [DATE] and readmitted from a sister facility in which staff were familiar and had access to the resident's historical psychosocial needs.) According to the admission Minimum Data Set (MDS) dated [DATE], R17 rarely/never makes self-understood and rarely/never understands others, scored 00/15 on their Brief Interview for Mental Status exam (BIMS) which indicated severe cognitive impairment, exhibited no hallucinations, no delusions, had wandering behaviors which occurred one to three days during this reference period of seven days which was not new, received routine antipsychotic medication. Review of the resident's care plans revealed there were none that identified the resident's specific targeted behaviors to identify what to monitor for in regard to the resident's use of psychotropic medication, or identified and addressed the specific details of the resident's PTSD potential triggers. There was a nutrition care plan that included the resident's PTSD diagnosis. Review of the resident's psych consultations included the following historical behaviors and potential interventions to utilize with the resident that were not identified and/or implemented into the care plans by the facility: (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/24 a consult with the Psychologist 'G' documented, in part, .admitted [DATE] from another nursing home, and I was following with her at her previous nursing home .is well-known to have significant behavioral and emotional disturbances associated with her dementia. She has displayed wandering, emotional liability, and frequently gets close in other resident's personal space which puts her at risk for physical conflict. She has recently been combative with staff, screaming and swearing at staff .her speech was disorganized and she was unable to meaningfully answer questions (which is her baseline). She had great emotional lability, literally laughing one moment and then crying the next .Therapeutic Intervention(s) attempted: Other: behavior management .She is well-known at her baseline to have significant aggression and impulsivity related to her dementia, and she does have a history of TBI (Traumatic Brain Injury) which can increase likelihood for severe/disorganized behaviors in dementia. Recommend staff try to provide a quieter, low-stimulation environment for her. Try to provide stability and routine in her care as much as possible, and she is likely still adjusting to her new environment as she has only been here for 2 weeks. She also tends to have high levels of physical energy, and would benefit from having clear spaces where she can propel in her wheelchair to release energy, may benefit from a busy box or similar items to occupy her . On 11/6/24 a consult with the Psych Physician Assistant (PA 'F') documented, in part, .seen today for a follow up to review medication and assess mood. She has a hx (history) of bipolar disorder, PTSD, traumatic brain injury, and dementia .She is currently prescribed .Seroquel 25 mg twice daily .She was previously seen by this writer in September at a different facility, where she was on a slightly higher dose of Seroquel . Progress notes from the past 14 days were reviewed, and there were no particular concerns regarding her mood or behavior documented in her chart .During today's visit .She appeared very confused and on edge at times, requiring redirection. When asked if she was doing okay, she responded absolutely but then mostly spoke randomly and nonsensically. Despite her confusion, she appeared calm with no significant evidence of psychosis, agitation, tearfulness, restlessness, or distress at today's visit .Post-traumatic stress disorder, chronic .(unchanged) .From previous clinician: Resident has an extensive history of both witnessing and experiencing abuse. Historically resident has experienced episode where she appeared to have been reliving witnessing her mother being strangled and sustaining neck injury .Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance .(unchanged) Plan: Continue soft redirection. Speak in simple sentences, slowly and clearly. Provide structure in the day. Promote non-pharmaceutical methods such as attending group activities and increasing sunlight exposure. Assess for thirst, hunger, pain .There have been some changes in her psychotropic regimen and dosage due to previous agitation. However, at this time, she appears without any significant evidence of mood instability, anxiety, agitation, or psychosis . On 12/16/24 at 9:30 AM, an interview was conducted with nursing staff assigned to R17. When asked if they were aware of any PTSD triggers for the resident, they reported they were not aware of any. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 3:40 PM, an interview was conducted with SW 'A'. When asked about their lack of trauma informed care assessment, or attempt to identify historical psychosocial needs, including potential PTSD triggers, SW 'A' reported that would be a different assessment and confirmed that had not been done for R17. When asked who was responsible for ensuring that information was identified and included on the resident's care plans, and informing staff of these specific needs, SW 'A' reported that would be social work and was unable to offer any further explanation. When asked how they became aware of recommendations identified by the consulting psych services, SW 'A' reported they usually checked out with them following their visits with the residents and confirmed that had not occurred. SW 'A' was requested to provide any additional documentation that may not have been available for review. On 12/17/24 at 10:14 AM, review of the additional documentation provided by the facility included the same information that had been reviewed on 12/16/24. On 12/18/24 at 8:30 AM, an interview was conducted with the Administrator. When asked about the documentation provided for review of R17's behaviors and the concern that the only identification of R17's PTSD was a reference to the diagnosis on a nutrition care plan and that the facility failed to thoroughly assess, identify and implement potential PTSD triggers, the Administrator acknowledged the concerns. According to the facility's policy titled, Trauma Informed Care dated 4/2024: .Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma .In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. According to the facility's policy titled, Psychotropic Medication Use dated 10/24/22: .Facility staff should take a holistic approach to behavior management that involves a thorough assessment of underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions .Staff should become familiar with the cultural, medical, and psychological information about the resident to identify potential environmental and other triggers to prevent or reduce behavioral symptoms and/or distress, types and the consequences of behaviors exhibited by the resident and interventions that may be indicated for a specific behavior type .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review, the facility failed to ensure complete and accurate medication orders and clarify ambiguous orders with the physician for one (R16) of one resident reviewed for professional standards. Findings include: Review of the clinical record revealed R16 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: diabetes, kidney disease and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R16 was cognitively intact. Review of a Consultant Pharmacist's Medication Regimen Review dated 10/16/24 recommendation for nursing read in part, .Patient had an order for the Insulin Lispro 7 units SubQ (subcutaneous) TID (three times a day) with meals on discharge records but they are not present in (electronic medical record). Please clarify with prescriber if these therapies should continue and add orders if deemed appropriate . It was signed and marked Completed 10/16/24. Review of R16's physician orders revealed an active order dated 10/16/24 that read, GIVE 7 UNITS SUBCUTANEOUSLY WITH MEALS CALL MD (medical doctor) IF BS (blood sugar) < (less than) AND > (greater than) 40 .with meals. It should be noted there was no medication indicated to be administered. Review of R16's Medication Administration Records (MAR's) for October 2024, November 2024 and December 2024 revealed three times a day, the order for 7 units subcutaneous with meals was being marked off as given by the nursing staff. On 12/16/24 at 3:42 PM, Registered Nurse (RN) J, R16's assigned nurse, was interviewed and asked what medication was being given to R16 three times a day. RN J explained R16 had another order for a sliding scale of Lispro Insulin, so he would give an extra 7 units of the Lispro along with the sliding scale amount. RN J was asked if it was allowed to assume what medication the order was for. RN J explained nurses should never assume, and that he would call the doctor to clarify the order. On 12/16/24 at 3:42 PM, the Director of Nursing (DON) was interviewed and informed for two months, a physician order with no medication was being documented as given three times a day for R16. The DON explained she would look into the matter. The DON was asked if a nurse could assume what medication to give if it was not specified. The DON explained if an order was not clear, it should be clarified with the doctor. On 12/16/24 at 4:15 PM, the DON explained when R16 was readmitted into the facility on [DATE], the order for Lispro Insulin was put in with a sliding scale and the 7 units, but on 10/16/24 the orders were separated, and the order for the 7 units was entered incorrect. When asked why no nurse had clarified the incorrect order for two months, the DON had no answer. Review of facility job descriptions titled, Charge Nurse RN revised 12/18/17 and Charge Nurse LPN (Licensed Practical Nurse) revised 4/27/20 both read in part, .Administer medications to residents according to the Public Health Code, Nursing Department policies, and standards and procedures and as prescribed by the physician; notify appropriate clinical and/or nursing personnel of medication contraindications .

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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. 48680 This citation is pertains to Intake #MI00145426. Based on observation, interview, and record review, the facility failed to provide adequate supervision and implement elopement policies for one (R8) of one residents reviewed for elopement, resulting in a cognitively impaired resident being let out of a secured back door to the facility, unsupervised. R8 was found by the police, about two miles away from the facility. Findings include: On 6/11/24 the Facility reported an investigation that alleged R8 eloped from the facility, was found by police, and sent to the hospital for further evaluation. On 12/17/24 at 9:30 am, R8 was interviewed and they were asked did they remember leaving the facility in June and if so, why did they leave. R8 replied, Yes, I remember leaving the facility because they were trying to shock my heart and I got mad so I went through the back doors. I put the code in and left. I walked to 14 Mile and Southfield Road and picked a random house, it was green, and asked them if they could call the police for me. The residents of that home called the police for me and then the police arrived and asked me if I would like to go to my sister's house or to a mental hospital. I told the officer's, the hospital. They dropped me off at [local hospital]. The next morning the Administrator came to talk to me and told me if I ever get upset or angry like that just to come and talk to him and we can figure it out I haven't left since then or tried to leave I usually go and talk to him if I feel down. On 12/17/24 at 11:10 AM an interview was held with the administrator about the resident leaving, he explained that R8 sometimes gets in a mood where he thinks people are trying to harm him. On this night it was one of those times. R8 had his mind made up,put the code into the door and went out the back. The police department called to notify the facility that they had picked R8 up and taken them to the hospital and when R8 returned the next day, the administrator had a conversation with R8 and told him to remember to let the facility know their feelings because we are here to help. The administrator further stated that R8 has not eloped since then and the staff have been trained and re-educated on how to handle elopements. The administrator also stated that they change the passcode to the doors more often since residents do tend to pick up on the codes. There was no additional information provided by the exit of the survey.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to ensure Urostomy (an abdominal wall opening that allows urine to leave the body through a stoma) Care and Monitoring were completed for one resident (R18) of one resident reviewed for ostomy care. Findings include: On 12/16/24 at approximately 9:15 a.m., R18 was observed in their room, laying in their bed. R18 was observed to have a Urostomy bag protruding from underneath their shirt. R18 was observed to have small brown and wet spots covering their bed sheets. R18 was asked if the staff are helping with emptying their Urostomy bag and they reported that they are most of the time but have had to wait a few times and sometimes nobody empties it. R18 was asked how often they change the bag and assess the site for any infection and they reported they did not know. On 12/16/24 the medical record for R18 was reviewed and revealed the following: R18 was initially admitted to the facility on [DATE] and had diagnoses including: Hydronephrosis with renal and ureteral calculous obstruction. A review of R18's MDS (minimum data set) with an ARD (assessment reference date) of 11/23/24 revealed R18 needed setup/clean up assistance with toileting hygiene. A review of R18's careplan revealed the following: Focus-I have renal insufficiency 2/2 (secondary to) DX (diagnosis): Kidney disease CKD stage 4 severe with urostomy in place to help support my urinary function. I may need urostomy care- I sometimes believe I can do it myself Date Initiated: 10/02/2024 . A Physicians evaluation dated 11/22/24 revealed the following: Z93.6 OTHER ARTIFICIAL OPENINGS OF URINARY TRACT STATUS -History of recurrent UTIs (Urinary tract infections) with urostomy as well as asymptomatic bacteruria. Encourage participation with care and importance of hygiene. Monitor for s/sx (signs/symptoms) of infection. Urostomy care q (every) shift per facility policy. Further review of the electronic medical record revealed (EMR) no Physician orders were in place that directed the staff on assessing/monitoring the site and provide ostomy care. On 12/17/24 at approximately 1:07 p.m., the Director of Nursing (DON) was asked if R18 had any Physician orders for the directed care and monitoring of R18's Urostomy and they reported they did not see any Physician orders in the record. On 12/17/24 at approximately 1:18 p.m., Nurse J was asked what Physician orders were in place for the care and monitoring of R18's Urostomy and they indicated that they did not see any orders and would have to contact the Physician. Nurse J reported that orders should be in the record for monitoring the site and emptying the bag. Nurse J indicated that R18's Urostomy was in the careplan but they would have to get some Physician orders so they can document their assessment of the site and care being completed. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at approximately 1:22 p.m., during a follow-up conversation with Nurse J, Nurse J reported they had put Physician orders in R18's record for the care of their Urostomy. Nurse J was asked why their were no current orders and indicated they did not know but they were supposed to have them. On 12/18/24 a request to review the facility's policy/procedures on ostomy care was requested but none was provided by the end of the survey.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure that a resident diagnosed with Post Traumatic Stress Disorder (PTSD) received care and services that accounted for experiences and identified and implemented interventions to mitigate triggers for one (R17) of one resident reviewed for trauma informed care, resulting in the potential for exposure to trauma triggers and re-traumatization. Findings include: Review of the clinical record revealed R17 was admitted into the facility on [DATE], discharged to another nursing home on 6/27/24, and readmitted on [DATE] with diagnoses that included post-traumatic stress disorder - chronic. (It should be noted that the resident was discharged on [DATE] and readmitted from a sister facility in which staff were familiar and had access to the resident's historical psychosocial needs.) According to the admission Minimum Data Set (MDS) dated [DATE], R17 rarely/never makes self-understood and rarely/never understands others, scored 00/15 on their Brief Interview for Mental Status exam (BIMS) which indicated severe cognitive impairment, exhibited no hallucinations, no delusions, had wandering behaviors which occurred one to three days during this reference period of seven days which was not new and received routine antipsychotic medication. Review of the available documentation in the resident's clinical record revealed no identified triggers, or social service assessment, care plans, and Behavior Management Program Review and Symptoms Analysis dated 11/7/24, signed as completed on 11/11/24 by Social Worker (SW 'A') revealed no identification of R17's PTSD, or potential triggers. Review of the care plans revealed a mention of R17's PTSD diagnoses that was included on a nutrition care plan. There were no specific details about potential trauma triggers. Review of the resident's psych consultations included the following identified PTSD concerns with recommendations that were not identified and/or implemented by the facility staff: On 11/6/24 a consult with the Psych Physician Assistant (PA 'F') documented, in part, .She has a hx (history) of bipolar disorder, PTSD, traumatic brain injury, and dementia .During today's visit .She appeared very confused and on edge at times, requiring redirection. When asked if she was doing okay, she responded absolutely but then mostly spoke randomly and nonsensically. Despite her confusion, she appeared calm with no significant evidence of psychosis, agitation, tearfulness, restlessness, or distress at today's visit . Post-traumatic stress disorder, chronic .(unchanged) .From previous clinician: Resident has an extensive history of both witnessing and experiencing abuse. Historically resident has experienced episode where she appeared to have been reliving witnessing her mother being strangled and sustaining neck injury .Plan: Continue soft redirection. Speak in simple sentences, slowly and clearly. Provide structure in the day. Promote non-pharmaceutical methods such as attending group activities and increasing sunlight exposure. Assess for thirst, hunger, pain . (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 9:30 AM, an interview was conducted with nursing staff assigned to R17. When asked if they were aware of any PTSD triggers for the resident, they reported they were not aware of any. On 12/16/24 at 3:40 PM, an interview was conducted with SW 'A'. When asked about their lack of trauma informed care assessment, or attempt to identify historical psychosocial needs, including potential PTSD triggers, SW 'A' reported that would be a different assessment and confirmed that had not been done for R17. When asked who was responsible for ensuring that information was identified and included on the resident's care plans, and informing staff of these specific needs, SW 'A' reported that would be social work and was unable to offer any further explanation. When asked how they became aware of recommendations identified by the consulting psych services, SW 'A' reported they usually checked out with them following their visits with the residents and confirmed that had not occurred. SW 'A' was requested to provide any additional documentation that may not have been available for review. On 12/17/24 at 10:14 AM, review of the additional documentation provided by the facility included the same information that had been reviewed on 12/16/24. On 12/18/24 at 8:30 AM, an interview was conducted with the Administrator. When asked about the documentation provided for review of R17's behaviors and the concern that the only identification of R17's PTSD was a reference to the diagnosis on a nutrition care plan and that the facility failed to thoroughly assess, identify and implement potential PTSD triggers, the Administrator acknowledged the concerns. According to the facility's policy titled, Trauma Informed Care dated 4/2024: .The facility will work to facilitate the principles of trauma informed care which include .Collaboration - an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care .The facility will use a multi-pronged approach to identifying a resident's history of traumas .This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others .The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family .and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions .The facility will identify triggers which may re-traumatize residents with a history of trauma .Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma .In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00145538. Based on interview, and record review, the facility failed to ensure all controlled substances were accounted for and accurately documented for one (R226) of five residents whose medications were reviewed, resulting in the unaccountability of the resident's controlled medications and the potential for diversion. Findings include: Review of complaints reported to the State Agency included allegations that R226's medications, including controlled medications were not properly managed at the time of discharge to another nursing facility. Review of the clinical record revealed R226 was admitted into the facility on [DATE] and discharged due to facility depopulation on 7/5/24 to a sister nursing home. As of this review, the resident did not return. Diagnoses included: Parkinson's disease without dyskinesia, polyneuropathy, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, other chronic pain, and post-traumatic stress disorder chronic. According to the Minimum Data Set (MDS) assessment dated [DATE], R226 had moderately impaired cognition, and received scheduled pain medication and non-medication intervention for pain, and received an anti-anxiety medication. Review of the physician orders included: Xanax Tablet 0.25 MG (Milligrams) (Alprazolam - an antianxiety medication) Give 0.25 mg by mouth two times a day for anxiety. This medication was started on 1/30/2023 and discontinued upon discharge on 7/5/24. Morphine Sulfate Oral Solution 20 MG/5ML (Milliliters) (Morphine Sulfate - a narcotic pain medication) Give 0.25 ml by mouth every three hours as needed for pain. This medication was started on 3/31/23 and discontinued upon discharge on 7/5/24. Further review of the clinical record revealed there were no controlled substance proof-of-use records (documentation the facility utilized for accountability of controlled medications) for R226's Xanax from 6/26/24 - 7/5/24, and there was no documentation for the Morphine Sulfate. Review of the Medication Administration Records (MARs) in the resident's electronic medical record (EMR) revealed: There were no documented administrations of Morphine Sulfate from January 2024 to July 2024 (however the order remained in place through 7/5/24). (continued on next page)

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	235664	A. Building B. Wing	12/18/2024

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Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The July MAR documented R226 was administered Xanax tablet 0.25 MG BID (at 9:00 AM and 9:00 PM) from 7/1/24 - 7/4/24, and at 9:00 AM on 7/5/24 (day of discharge). The Nurse assigned to R226 at the time of the resident's discharge on 7/5/24 was Nurse 'C'. Further review of the progress notes included: An entry on 7/5/24 at 10:43 AM by the current Director of Nursing (DON) read, Pt (patient) discharged to [name of other nursing facility] transported by her son [name redacted] with all belongings and medications. A late entry on 7/8/24 at 2:05 PM for 7/5/24 at 2:04 PM by Nurse 'O' read, Clarification, patient discharged to [name of sister nursing facility]. Review of the available controlled substance proof-of-use forms scanned into the EMR revealed the last record for the Xanax was from 6/25/24. There were none for the Morphine Sulfate. On 12/17/24 at 12:57 PM, an interview was conducted with the Administrator. When asked about the facility's process for depopulation and transfers to other nursing facilities, and whether medications were sent with the residents, the Administrator reported their facility utilized a checklist on a spreadsheet and further reported it was not their practice to send residents with medications. The Administrator was asked specifically how R226 transferred to the other facility and they reported their son had transported the resident per his choice. They were not at the facility on the resident's day of discharge due to a scheduled day off, and deferred to the nursing staff for further information regarding medication. On 12/17/24 at 2:39 PM, the facility was requested to provide the controlled substance records, including any destruction records for R226 for both the Xanax and Morphine Sulfate medications. There was no additional documentation of any controlled substance records provided by the end of the survey. On 12/18/24 at 8:15 AM, review of the documentation provided by the facility did not reveal any documentation for R226 as requested on 12/17/4. On 12/18/24 at 8:40 AM, an interview was conducted with the DON. When asked what they could recall about R226's medications at the time of their discharge and if the resident's medications were sent with them, the DON reported they were here that day and the nurse was [Name of Nurse 'C']. The DON reported the resident's son was given the medications. When asked if that was their process to release medications to the son, including controlled substances, the DON reported that was. The DON further reported, they recalled it was chaotic then, and they didn't recall specifics, so they had reviewed the documentation and saw they had actually made the note for R226. The DON reported their notes reflected Nurse 'C' was the one that discharged R226 and they put that in the documentation that medications were given to the son. The DON further reported they had called Nurse 'C' (following this surveyor's request for controlled substance records) and stated When I called [name of Nurse 'C'] She said she gave him everything. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked about the lack of accountability of the controlled medications (Xanax and Morphine Sulfate), the DON reported they weren't sure if that was ever at the facility. The DON confirmed the order was current through discharge on 7/5/24 but was unable to recall if the medication had ever been at the facility. The DON was requested to provide any documentation of the facility and/or resident's records from pharmacy regarding receipts of medication, including destruction, or if the medication was returned to the pharmacy, including any further controlled substance records for the Xanax from 6/26/24 - 7/5/24. There was no further documentation provided by the end of the survey. On 12/18/24 at 9:00 AM, during an interview with the Administrator, it was reported the facility had identified a past non-compliance (PNC) regarding controlled substances. They were requested to provide documentation for review. Review of the documentation provided for the facility's PNC revealed they did not have documentation to provide for accountability of the controlled substances, the PNC provided was for a separate concern in October 2024 (three months following R226's discharge) that addressed medication errors related to administration of controlled substances and did not address/identify concerns with accountability of controlled medication. On 12/18/24 at 9:10 AM, the facility was requested to provide policies which addressed Controlled Substances (including all aspects from delivery, to discharge/discontinuation). There was no policy provided for review by the end of the survey. On 12/18/24 at 9:18 AM, a phone interview was conducted with the Administrator (Staff 'D') at R226's current facility they were transferred to on 7/5/24. The Administrator reported the DON was currently not at the facility, and they were requested to provide documentation or further information regarding the medications R226 arrived to their facility with, including any controlled substance records. The Administrator reported they would have someone follow-up. On 12/18/24 at 9:39 AM, a phone interview was conducted with the DON (Staff 'E') at R226's current facility. When asked to review the resident's status upon admission to their facility on 7/5/24, the DON reported they reviewed the admission documentation at the time of R226's arrival and there was no indication the resident arrived with any medication. The DON further reported that would definitely be documented if they had arrived with medication. On 12/18/24 at 9:57 AM, the facility was requested via email to provide the phone number for Nurse 'C' as they no longer were employed at this facility. On 12/18/24 at 10:05 AM, a phone interview was attempted with Nurse 'C' and a message was left to return the call. There was no response by the end of the survey. On 12/18/24 at 11:32 AM, an interview was conducted with the Administrator and Director of Quality and Reimbursement (Staff 'P'). Both confirmed R226 had been discharged with medications from this facility, but they did not have any documentation to provide for accountability of the controlled substances. They were informed that the PNC provided identified non-compliance with medication errors and did not address accountability of controlled medications and acknowledged the concerns.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to ensure residents prescribed psychotropic medication had adequate documentation to support continued use, as well as identify and monitor resident specific targeted behaviors and implement non-pharmacological approaches for two (R17 and R126) of five residents reviewed for unnecessary medication. Findings include: R126 On 12/16/24 the medical record for R126 was reviewed and revealed the following: R126 was initially admitted to the facility on [DATE] and had diagnoses including Depression and repeated falls. A review of R126's Physician orders revealed the following orders for psychotropic medications: Order date 12/14/24-ALPRAZolam Tablet 0.25 MG *Controlled Drug* Give 0.25 mg by mouth every 8 hours as needed for Anxiety for 14 Days Order date 12/12/24-Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for depression A review of R126's December 2024 MAR (medication administration record) revealed R126 was administered their PRN (as needed) alprazolam on 12/17 and 12/18. No non-pharmacological interventions were noted as being attempted prior to their administration. Further review of R126's medical record did not reveal any system for monitoring of adverse side effects of R126's psychotropic medications or any resident specific targeted behaviors that R126's medications were treating or any individualized non-pharmacological interventions to attempt prior to administration of their PRN Alprazolam. On 12/18/24 at approximately 9:40 a.m., Social Worker A (SW A) was interviewed regarding R126's non-pharmacological interventions to attempt prior to administering their alprazolam and they reviewed the record and indicated there were none. SW A was asked if it was standard practice to attempt non-pharmacological interventions when PRN's are administered and they indicated that it was. SW A was asked to identify the targeted behaviors that R126's sertraline and alprazolam were seeking to reduce and and they indicated there were none identified. 30675 R17 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 9:20 AM, R17 was observed laying in bed wearing a hospital gown and a thin cotton blanket over their legs. When asked simple questions, the resident began speaking but their speech was nonsensical at first and the R17 began stating Awesome, Awesome, Awesome and clapping their hands. Additional observations throughout the remainder of the survey revealed R17 self-propelling throughout the hallways in their wheelchair, and attempted to stand up and walking with staff. Review of the clinical record revealed R17 was admitted into the facility on [DATE], discharged to another nursing home on 6/27/24, and readmitted on [DATE] with diagnoses that include: adjustment disorder with anxiety, mild cognitive impairment of uncertain or unknown etiology, dementia in other diseases classified elsewhere, severe, with other behavioral disturbance, with psychotic disturbance, personal history of traumatic brain injury, bipolar disorder current episode manic with current episode mixed, severe, with psychotic features, psychotic disorder with delusions due to known physiological condition, bipolar disorder current episode depressed, moderate, anxiety disorder, and post-traumatic stress disorder chronic. (It should be noted that the resident was discharged on [DATE] and readmitted from a sister facility in which staff were familiar and had access to the resident's historical psychosocial needs.) According to the admission Minimum Data Set (MDS) dated [DATE], R17 rarely/never makes self-understood and rarely/never understands others, scored 00/15 on their Brief Interview for Mental Status exam (BIMS) which indicated severe cognitive impairment, exhibited no hallucinations, no delusions, had wandering behaviors which occurred one to three days during this reference period of seven days which was not new, and received routine antipsychotic medication. The medication section N0450 A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent? was inaccurately coded 0. No which automatically excluded the remaining questions which pertained to Gradual Dose Reduction (GDR). Review of R17's current psychotropic medications included: Seroquel (an antipsychotic medication) Oral Tablet 25 MG (Milligrams) Give 1 tablet by mouth two times a day for bipolar, psychosis. (The Seroquel medication was not newly prescribed, and R17 had received this medication during their previous stay in the facility from 5/1/24 - 6/27/24, as well as during their stay at a sister facility from 6/27/24 - 10/24/24.) Review of the Behavior Management Program Review and Symptom Analysis dated 11/7/24, signed as completed on 11/11/24 by Social Worker (SW 'A') revealed this assessment documented only the date of the most recent PHQ-9 (Mood evaluation) and BIMS score. The section of this behavior analysis for Behavior Assessment including type of behavior; quantity; frequency; interventions; possible root cause; identified patterns/comments and the mood symptoms sections were all left blank (incomplete). The section for Psychoactive Medications and IDT (Interdisciplinary Team) review documented: .Medication & Dose Seroquel 25 mg .For anti-psychotic .Diagnosis bipolar disorder .Date of Last GDR (left blank) .Date Medication was First started: 10/24/2024 (date of facility readmission) .Review of Behaviors/IDT review of Care Plan .[R17] is alert to self. She does wander the hallways. She picks up wet floor signs. She is followed by [Contracted Psych Group] for medication management. Medications and behaviors are care planned. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an additional Behavior Management Program Review and Symptom Analysis dated 5/16/24 documented the same as above, except for Date Medication was First started, it was noted as 5/1/24 (initial admitted). This behavior analysis contained the same blank/incomplete sections as mentioned above. Additionally, the section for the review of behaviors/IDT review of care plan was left blank (incomplete). There were no details of any identified GDR's attempted for the resident's use of Seroquel medication. Review of the resident's psych consultations included the following historical behavior and potential interventions that were not identified and/or implemented by the facility: On 11/4/24 a consult with the Psychologist 'G' documented, in part, .admitted [DATE] from another nursing home, and I was following with her at her previous nursing home .is well-known to have significant behavioral and emotional disturbances associated with her dementia. She has displayed wandering, emotional lability, and frequently gets close in other resident's personal space which puts her at risk for physical conflict. She has recently been combative with staff, screaming and swearing at staff .her speech was disorganized and she was unable to meaningfully answer questions (which is her baseline). Se had great emotional lability, literally laughing one moment and then crying the next .Therapeutic Intervention(s) attempted: Other: behavior management .She is well-known at her baseline to have significant aggression and impulsivity related to her dementia, and she does have a history of TBI (Traumatic Brain Injury) which can increase likelihood for severe/disorganized behaviors in dementia. Recommend staff try to provide a quieter, low-stimulation environment for her. Try to provide stability and routine in her care as much as possible, and she is likely still adjusting to her new environment as she has only been here for 2 weeks. She also tends to have high levels of physical energy, and would benefit from having clear spaces where she can propel in her wheelchair to release energy, may benefit from a busy box or similar items to occupy her . On 11/6/24 a consult with the Psych Physician Assistant (PA 'F') documented, in part, .seen today for a follow up to review medication and assess mood. She has a hx (history) of bipolar disorder, PTSD, traumatic brain injury, and dementia .She is currently prescribed .Seroquel 25 mg twice daily .She was previously seen by this writer in September at a different facility, where she was on a slightly higher dose of Seroquel . Progress notes from the past 14 days were reviewed, and there were no particular concerns regarding her mood or behavior documented in her chart .During today's visit .She appeared very confused and on edge at times, requiring redirection. When asked if she was doing okay, she responded absolutely but then mostly spoke randomly and nonsensically. Despite her confusion, she appeared calm with no significant evidence of psychosis, agitation, tearfulness, restlessness, or distress at today's visit .Post-traumatic stress disorder, chronic .(unchanged) .From previous clinician: Resident has an extensive history of both witnessing and experiencing abuse. Historically resident has experienced episode where she appeared to have been reliving witnessing her mother being strangled and sustaining neck injury .Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance .(unchanged) Plan: Continue soft redirection. Speak in simple sentences, slowly and clearly. Provide structure in the day. Promote non-pharmaceutical methods such as attending group activities and increasing sunlight exposure. Assess for thirst, hunger, pain .There have been some changes in her psychotropic regimen and dosage due to previous agitation. However, at this time, she appears without any significant evidence of mood instability, anxiety, agitation, or psychosis . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's mood/behavior care plans revealed there were no resident-specific targeted behaviors to identify what to monitor for, or resident-specific interventions/approaches that had been identified by both contracted psych providers, as mentioned above. Additionally, this information was not utilized as part of the facility's behavior management program review. On 12/16/24 at 3:40 PM, an interview was conducted with SW 'A'. When asked to explain their process of completing social service assessments including residents that have known behaviors and receive psychotropic medication, SW 'A' reported they would look and see if the diagnoses are appropriate for the medications they are taking and will make a referral to [name of contracted psych services] if that was applicable. When asked if they should also be identifying resident-specific behaviors, and potential trauma triggers as well as making sure the medications had the correct diagnoses, SW 'A' reported they should be, but was unable to explain why they had not for R17. SW 'A' further reported if SW 'A' or staff noticed a behavior, they'd try to talk to the family to see if it occurred before. SW 'A' reported R17 came from one of their sister facilities. When asked why their behavior assessments reflected R17 started the antipsychotic medication on the date of admission, when that had been reflected as inaccurate according to the psych consultations, SW 'A' reported they just used the date of admission. When asked about their lack of attempt to identify historical psychosocial needs, including potential PTSD triggers and who was responsible for ensuring that information was identified and included on the resident's care plans, SW 'A' acknowledged the lack of documentation and reported they were now using revised assessments that were more detailed. When asked why this had not been completed with R17, SW 'A' was unable to offer any further explanation. When asked who was involved in the behavior management reviews, SW 'A' reported they did that assessment when the resident first arrives at the facility and then if any behaviors occur, then they are made a part of the behavior management program. When asked why the behaviors were left blank/incomplete, SW 'A' reported that was because the resident hadn't displayed any. When asked why it was mentioned in the psych consultations as staff reporting some resident behaviors, SW 'A' reported they did not get that information. When asked about the lack of trauma informed care assessment, SW 'A' reported that would be a different assessment to identify what the triggers are and confirmed that had not been completed for R17. When asked how they became aware of recommendations identified by the consulting psych services, SW 'A' reported they usually checked out with them following their visits with the residents and confirmed that had not occurred. SW 'A' was requested to provide any additional documentation that may not have been available for review. On 12/17/24 at 10:14 AM, review of the additional documentation provided by the facility included the same information that had been reviewed on 12/16/24. On 12/17/24 at 9:45 AM, an interview was conducted with the MDS Nurse 'B'. When asked about their inaccurate completion of the MDS section N0450 which affected the lack of identified GDR information, they confirmed that had been incorrectly marked and would complete a modification. On 12/17/24 at 1:15 PM, an interview was conducted with the Administrator to review the concerns and to review the details of these concerns with R17's lack of behavior management and use of psychotropic medication. They reported social work had only reported concerns with GDR. The Administrator was informed of the concerns discussed in detail with SW 'A' on 12/16/24. According to the facility's policy titled, Psychotropic Medication Use dated 10/24/22: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors . Facility staff should take a holistic approach to behavior management that involves a thorough assessment of underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions .Staff should become familiar with the cultural, medical, and psychological information about the resident to identify potential environmental and other triggers to prevent or reduce behavioral symptoms and/or distress, types and the consequences of behaviors exhibited by the resident and interventions that may be indicated for a specific behavior type .Psychotropic medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use .Antipsychotics used to treat BPSD (Behavioral or Psychological Symptoms of Dementia) must receive gradual dose reduction and behavioral interventions, unless contraindicated .Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication for organic mental syndrome with agitated or psychotic behavior(s). Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39592 Based on interview and record review, the facility failed to ensure a current accurate surveillance that identified antibiotic use, this had the ability to effect all 29 residents that resided in the facility, including R13. Findings include: On 12/17/24 at 3:34 PM, review of the facility's Infection Control Surveillance binder revealed no data provided for December 2024. On 12/18/24 at 9:26 AM, review of the surveillance binder with the Director of Nursing (DON), who served as the Infection Preventionist, and Licensed Practical Nurse (LPN) M, who was assisting with Infection Control. LPN M was asked for documentation of surveillance for December 2024. LPN M provided a MONTHLY INFECTION CONTROL LOG (LINE LIST) dated 12/2024 that had two entries, on the first line it was documented R13 had a UTI (urinary tract infection) with an onset date of 12/16/24 and was getting an oral antibiotic with a start date of 12/16/24. On the second line, it was documented a resident had cellulitis and was receiving an antibiotic with an onset date of 12/17/24. Review of R13's December 2024 Medication Administration Record (MAR) revealed an order that read, Cipro Oral Tablet 500 MG (milligrams) .Give 1 tablet by mouth two times a day for Chronic UTI's for 5 Days - Start Date - 12/16/24. Continued Review of R13's December 2024 MAR revealed another order for an antibiotic that read, Cefpodixime Proxetil Oral Tablet 200 MG . Give 1 tablet by mouth every 12 hours for UTI for 3 Days - Start Date - 12/03/24. The DON and LPN M were asked about R13 receiving an antibiotic from 12/3/24 through 12/6/24 that was not on the line listing. The DON explained it should have been put on the line listing and directed LPN M to write it. LPN M was then observed to write on the third line that R13 had a UTI with an onset date of 12/3/24. The DON was asked when should it be documented on the line listing if a resident had an infection that needed antibiotics. The DON explained it should be documented at the time of the occurrence. The DON and LPN M were asked if there were any other infections with antibiotics that should have been placed on the line listing. No answer was given. Review of a facility policy titled, Infection Prevention and Control Program revised 1/2024 read in part, .A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards .An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 39592 Based on interview and record review, the facility failed to maintain an effective Antibiotic Stewardship program that included consistent implementation of protocols for appropriate antibiotic administration and ensured that infection criteria was met, this had the ability to affect multiple residents, including R375 and R13, that were prescribed and administered antibiotics while residing at the facility. Findings include: On 12/18/24 at 9:26 AM, review of the surveillance binder with the Director of Nursing (DON), who served as the Infection Preventionist, and Licensed Practical Nurse (LPN) M, who was assisting with Infection Control revealed: R375 was documented in May 2024 as having a urinary tract infection (UTI), no organism was identified and was on an antibiotic with a start date of 5/16/24. An Infection Report V2 dated 5/16/24 for R375 documented criteria for a UTI without a urinary catheter required a culture and sensitivity (C&S) test be performed on a urinalysis (UA) that showed bacterial organisms. Nothing was checked on the report to meet the criteria. The DON and LPN M were asked if a UA/C&S was obtained prior to the start of R375 taking antibiotics. A lab report with a collection date of 5/16/24 documented no bacteria were detected in R375's urine. R375's May 2024 Medication Administration Record (MAR) documented Bactrim DS Tablet 800-160 MG (milligrams) . Give 1 tablet by mouth every 12 hours for UTI for 5 Days was given 5/17/24 through 5/22/24. R13 was documented in December 2024 as having a UTI, no organism was identified and was on an antibiotic with a start date of 12/17/24. The DON and LPN M were asked if a UA/C&S was obtained prior to the start of R13 taking antibiotics. The DON explained R13 had refused to give a urine sample because they wanted to go smoke. The DON was asked if R13 had been asked after returning from smoking, or at a time more convenient for R13. The DON explained they would try again to get the sample. The DON was asked if R13 had already started on the antibiotic. The DON explained it had been started. When asked what would be the purpose of getting a urine sample after antibiotics were started, the DON had no answer. R13's December 2024 MAR documented Cipro Oral Tablet 500 MG . Give 1 tablet by mouth two times a day for Chronic UTI's for 5 Days - Start Date - 12/16/24. On 12/16/24 at 9:12 AM, an Entrance Conference Worksheet was provided that included a request for the facility's Antibiotic Stewardship Policy. On 12/18/24 at approximately 10:30 AM, the Administrator was again asked for the Antibiotic Stewardship Policy. None was received prior to the end of the survey.