STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235214	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clawson	535 N Main Clawson, MI 48017

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation pertains to Intake MI00145934 Based on observation, interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when failing to report a black eye of unknown source and failed to report information accurately regarding an ankle fracture to the State Agency (SA) for two (R405 and R403) of three residents reviewed for injuries of unknown source. Findings include: Review of a facility policy titled, Abuse, Neglect and Exploitation revised 6/2023 read in part, .Possible indicators of abuse include, but are not limited to: .2. Physical marks such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident's body 3. Physical injury of a resident, of unknown source . Investigations may include but not limited to: .6. Providing complete and thorough documentation of the investigation . R405 On 8/12/24 at 11:21 AM, R405 was observed sitting in a chair in the hallway. R405's left eye appeared to have reddish to purple bruising (indicating a fresh bruise) from the inner corner spreading to the outer corner under the eye. Review of the clinical record revealed R405 was admitted into the facility on [DATE] with diagnoses that included: dementia, traumatic brain injury and psychotic disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R405 scored 2/15 on the Brief Interview for Mental Status (BIMS) exam, indicating severely impaired cognition. Review of progress notes revealed: A Nursing Note dated 8/11/24 at 4:10 PM by Licensed Practical Nurse (LPN) P read in part, .while in dinning [sic] room resident reported that (their) eye was hurting (them). upon assessment I noticed that under (their) left eye (they) had a [NAME] [sic], (they) said it [sic] hurt and that (they) wanted to lay down. I gave pain medication as ordered for reported pain. resident in bed resting, will reassess for pain. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Note dated 8/11/24 at 7:00 PM by LPN P read in part, reassessed resident for pain, resident in bed with eyes open, no noted distress, will continue to monitor pt (patient) for pain . This was an unseen incident. I will report to oncoming nurse. A Nursing Note dated 8/11/24 at 8:13 PM by Registered Nurse (RN) O read in part, Another nurse on this shift noted bruising beneath resident's eye and notified administrator and writer. Upon receiving this information, I performed a thorough assessment of the resident's R (right - it should be noted the bruising was to R405's left eye). Red/purple bruising and pain noted. Using cognitively impaired pain scale, the resident exhibited signs of pain to R [sic] outer side of bruising rated 7/10. Writer spoke with administrator and supervisor . A Practitioner Note dated 8/12/24 at 12:39 PM read in part, .seen for left eye ecchymosis (bruising) . Left facial bruising/left eye ecchymosis . On 8/13/24 at 8:24 AM, R405 was observed lying in bed eating breakfast. R405 was asked how the reddish/purple bruising to their left eye happened. R405 explained they did not know. When asked if the eye hurt, R405 agreed the eye was painful. On 8/13/24 at 11:08 AM, a phone call was made to LPN P and a message left for a return call. On 8/13/24 at 1:35 PM, the Administrator, who served as the Abuse Coordinator, was interviewed and asked if she had reported R405's black eye to the SA. The Administrator explained it had not been reported. When asked the timeframe to report an injury of unknown source to the SA, the Administrator explained it was within two hours. The Administrator was asked if LPN P should have notified her when the bruising was first noticed. The Administrator agreed she should have been informed as soon as the bruising was discovered. When asked why it was not reported to the SA when she was informed of the bruising, the Administrator explained she had wanted to get more information before deciding to report the bruising. On 8/13/24 at 2:02 PM, LPN P was interviewed by phone and asked when she first noticed R405's black eye. LPN P explained there was no bruising to R405's all day, then at approximately 4:00 PM, R405 was seen in the dining room blinking and rubbing their eye, upon examination it appeared reddish. LPN P was asked if she had started an Incident and Accident report and/or notified the Administrator. LPN P explained she had endorsed it to the midnight nurse. LPN P was asked if she had noticed the bruising around 4:00 PM and the midnight shift did not start until 7:00 PM, why she waited to endorse reporting the incident to the next nurse. LPN P had no answer. 41415 R403 Review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) documented a bruise identified on R403's right ankle. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility five day investigation summary report submitted to the SA, documented in part . On Thursday, July 18, 2024, at approximately 10:30 am, Cena (later identified as Certified Nursing Assistant - CNA N) reported a bruise on (R403's name) right ankle. Upon interview of (CNA N name), she states . went into (R403's name) room to do ROM (range of motion) and she started crying. (R403's name) was touching her right hip so when I went to turn to look at her hip I noticed the bruise on her ankle . Upon assessment of her environment in the room her wheelchair did not have foot pedals on it, which could have contributed to bruising to prevent her from dragging feet . This report was submitted to the SA on 7/25/24. The facility requested a desk review for this investigation. An onsite investigation was conducted to investigate the injury of unknown origin. On 8/12/24 at 11:39 AM, staff members were observed transferring R403 into their wheelchair via a hoyer lift. A gray leg boot was observed on the right lower leg and foot. Staff applied the wheelchairs right leg rest and placed R403's leg on the leg rest. An interview was attempted with R403, however unsuccessful due to the resident's cognitive level. Review of the medical record revealed R403 was initially admitted to the facility in 2008 and readmitted on [DATE], with diagnoses that included: dementia, spastic hemiplegia affecting right dominant side and nondisplaced fracture of medial malleolus of right tibia (7/26/24). R403 was documented to have severely impaired cognition. Review of a Nurse Practitioner (NP) note dated 7/18/24 at 9:58 AM, documented in part . CNA (certified nursing assistant- later identified as CNA N) reported bruising to the right foot/ankle this morning while she was doing ROM (range of motion) exercise. No reports found about recent injury or fall. There is also a non blanchable 1x1 diameter to right ankle. 1+ edema noted as well . Contusion of right foot . of right ankle, initial encounter . Unknown origin . ER (emergency room) to do x-ray . Review of the hospital documentation noted the following: A Physician consultation dated 7/19/24 at 10:49 AM, documented in part . Per ED (emergency department), noticed a bruise over right ankle but no known falls per daughter . X-ray of right ankle demonstrates oblique lucency <sic> in the distal fibular diaphysis, concerning for possible age-indeterminate fracture . Pt (patient) is admitted . orthopedics consulted . Review of the progress notes revealed the resident was readmitted back to the facility on [DATE] and noted in part . Right ankle broken below knee . boot on right foot upon arrival . Per a nursing note documented at 8:47 PM. Although the facility was aware of the resident's right ankle fracture, the facility failed to inform the SA of the injury and submitted an investigation which only noted the identified bruise found to the right ankle. Per the medical record due to increased pain and swelling the resident was sent back out to the hospital on 7/25/24. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital documentation dated 7/25/24, documented and Ankle Fracture . Diagnosis Closed nondisplaced fracture of medial malleolus of right tibia, initial encounter . The resident was discharged back to the facility on the same day. The facility again failed to update and notify the SA of the identified injury. On 8/12/24 the Administrator was interviewed and asked why they failed to submit accurate details of the injury identified to the SA. The Administrator stated they were not aware of the fracture for R403 as the hospital did not include it in the paperwork. The hospital documents provided to the facility was reviewed with the Administrator and noted the documentation of the fracture, as well as the nurses note of the resident's readmission to the facility that documented the fracture. No further explanation or documentation was provided by the end of the survey.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00145315. Based on interview and record review the facility failed to ensure the required documentation for the transfer of one (R401) of one resident reviewed for a facility transfer, was noted in the medical record. Findings include: Review of a complaint submitted to the State Agency (SA) documented in part . we chose to move (R401) to a BETTER rehab facility so that she could actually receive care . and BE SAFE . We had to stand with (Facility name) staff at the main desk to ensure that they actually faxed documents over to (another facility name) for the transfer . That took about 2 hours for them to confirm that the documents did actually send. If we hadn't been present daily at (facility name) to monitor (R401) she would have wound back up in the hospital due to lack of care . Review of the medical record revealed R401 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, acute kidney failure, hypertension, atrial fibrillation and severe sepsis. R401 required staff assistance for all Activities of Daily Living (ADLs). The resident was discharged five days later. Review of the medical record revealed no documentation for the basis for the transfer or documentation from the physician of a discharge or why the transfer of R401 to another facility was necessary. Further review of the medical record revealed no documentation of a discharge summary to have been completed and provided to the receiving facility to ensure a safe transition of care. There was no documentation of transportation services ordered for the transfer. Review of a facility titled policy Transfer and Discharge . revised 7/24 documented in part, . Obtain physician orders for transfer or discharge and instructions or precautions for ongoing care . A member of the interdisciplinary team completes relevant sections of the Discharge Summary . A post discharge plan of care that is developed with the participation of the resident . will assist the resident to adjust to his or her new living environment . Assist with transportation arrangements to the new facility . Supporting documentation shall include evidence of . a discharge plan . Review of a progress note documented by the Previous Director of Nursing (PDON) R on 6/10/23 at 12:09 PM, noted in part . Resident up in wheelchair family here for care conference. Writer received call that (another facility name) accepted resident family excited about transfer. Resident med (medication) list explained all belonging packed and therapy transferred resident to family car. Writer called the facility to ensure transition was smooth. Med list faxed to unit with all medication usage. A Practitioner progress note dated 6/10/24 at 10:46 AM, noted the resident was examined, assessed and consulted with the medical practitioner, however there was no documentation of the resident's discharge or transfer noted. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 2:28 PM, the Administrator was asked to provide all grievances and incident and accident (I&A) reports for the resident for their five day inpatient stay at the facility. At 2:50 PM, the Administrator stated they had no grievances or I&As for R401. On 8/12/24 at 2:57 PM, the Social Worker (SW) B was interviewed and asked if they could recall any concerns or why the resident transferred from the facility after only five days at their facility and SW B stated they could not recall. SW B stated Unit Manager (UM) A talked to R401's family a lot. SW B was asked if they knew why a discharge and/or transfer plan was not formulated, documented or provided by the Interdisciplinary team for R401's transfer and SW B could not recall. On 8/12/24 at 3:20 PM, UM A was interviewed and asked if they knew of any concerns made by or on the behalf of R401 and if they knew the reason why the family transferred the resident after only five days of being at their facility. UM A stated they had not spoken to the family themselves. UM A stated they were informed by the Previous Director of Nursing (PDON) R of the family concerns of the call bell response time (being too long). On 8/13/24 at 9:44 AM, PDON R was interviewed and asked if they can recall any concerns regarding R401's care or the reason R401's family transferred them from the facility after being inpatient for five days at the facility. PDON R stated they believed R401's nephew was very upset and didn't know if it was going to work at the facility. PDON R stated the nephew of R401 had concerns of confused residents walking into the room of R401. When asked why the Physician did not consult the resident for a discharge or transfer, why there was no discharge papers in the medical record and why transportation was not set up for the resident, PDON R replied they were unsure. On 8/13/24 at 9:56 AM, the (interim) Director of Nursing (DON) was interviewed and asked the facility's protocol in transferring a resident to another facility. The DON stated the doctor would consult with the resident and complete the orders. The DON then stated discharge paperwork should be scanned in the resident's chart. The DON was asked why the facility failed to ensure the required documentation for R401's discharge/transfer was implemented in the medical record and asked why the facility failed to arrange transportation services for the transfer. The DON stated they would look into it and follow back up. At 11:28 AM, the DON returned and stated they were unable to find discharge orders, recap of stay and could not find any documentation by the physician team regarding the transfer. The DON stated there were no transportation arrangements made and they reviewed the record and read the resident was transferred by the family in their personal car. No further explanation or documentation was provided by the end of the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00145315. Based on interview and record reviews the facility failed to ensure a medication ordered by the physician was obtained and administered for one (R401) of three residents reviewed for quality of care. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns of R401's care upon admission to the facility. Review of the medical record revealed R401 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, acute kidney failure, hypertension, atrial fibrillation and severe sepsis. R401 required staff assistance for all Activities of Daily Living (ADLs). The resident was transferred to another facility five days later. Review of the hospital documents provided to the facility upon admission noted an order for Acetylcysteine (Mucomyst 10%) 200 Milligrams (mg) Nebulized Inhalation twice a day. Review of the physician orders implemented at the facility noted on 6/6/24, Acetylcysteine 200 mg/ml (milliliters) inhale orally two times a day for Acute respiratory insufficiency. Review of the June 2024 Medication Administration Record (MAR) documented the first dose administered on 6/7/24 and the last dose on 6/10/24. Review of a nursing note documented the medication was not available, despite multiple nurses signing that they administered the medication. On 8/13/24 at 11:28 AM, the interim Director of Nursing (DON) was asked why R401's medication was not ordered on 6/5/24 the day they admitted and why it was not administered as ordered by the physician. The DON stated they would look into it and follow back up. At 12:48 PM, the DON stated they reviewed the record and saw the admitting nurse did not implement the order the day of admission. The DON stated the practitioner ordered the medication the next day on 6/6/24. The DON was asked to provide the pharmacy receipt of the medication to have been delivered for R401 and the DON stated they had already called the pharmacy and asked. The DON stated the pharmacy said they never delivered the medication. No further explanation or documentation was provided by the end of the survey.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00145934. Based on observation, interviews and record reviews the facility failed to implement interventions to prevent injury for one (R403) of three residents reviewed for an injury of unknown origin, resulting in pain and a right subtle nondisplaced medial malleolus (break of the tibia, at the inside of the lower leg) fracture. Findings include: Review of a Facility Reported Incident (FRI) submitted to the State Agency documented a bruise identified on R403's right ankle. An onsite investigation was conducted to investigate the injury of unknown origin. Review of a facility five day investigation summary report submitted to the SA, documented in part . On Thursday, July 18, 2024, at approximately 10:30 am, Cena (later identified as Certified Nursing Assistant - CNA N) reported a bruise on (R403's name) right ankle. Upon interview of (CNA N name), she states . went into (R403's name) room to do ROM (range of motion) and she started crying. (R403's name) was touching her right hip so when I went to turn to look at her hip I noticed the bruise on her ankle . Upon assessment of her environment in the room her wheelchair did not have foot pedals on it, which could have contributed to bruising to prevent her from dragging feet . Additionally, (R403's name) has an order to wear a Prafo boot daily . However, the Prafo boot was unable to be located and had not been worn prior to this event. The facility did order another Prafo boot on 7/22/24 . Staff will be re-educated to ensure foot pedals are on wheelchair to prevent her foot from dragging . On 8/12/24 at 11:39 AM, staff members were observed transferring R403 into their wheelchair via a hoyer lift. A gray leg boot was observed on the right lower leg and foot. Staff applied the wheelchairs right leg rest and placed R403's leg on the leg rest. An interview was attempted with R403, however unsuccessful due to the resident's cognitive level. Review of the medical record revealed R403 was initially admitted to the facility in 2008 and readmitted on [DATE], with diagnoses that included: dementia, spastic hemiplegia affecting right dominant side and nondisplaced fracture of medial malleolus of right tibia (7/26/24). Review of Nurse Practitioner (NP) note dated 7/18/24 at 9:58 AM, documented in part . CNA (certified nursing assistant- later identified as CNA N) reported bruising to the right foot/ankle this morning while she was doing ROM (range of motion) exercise. No reports found about recent injury or fall. There is also a non blanchable 1x1 diameter to right ankle. 1+ edema noted as well . Contusion of right foot . of right ankle, initial encounter . Unknown origin . ER (emergency room) to do x-ray . Review of the hospital documentation noted the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Physician consultation dated 7/19/24 at 10:49 AM, documented in part . Per ED (emergency department), noticed a bruise over right ankle but no known falls per daughter . X-ray of right ankle demonstrates oblique lucency <sic> in the distal fibular diaphysis, concerning for possible age-indeterminate fracture . Pt is admitted . orthopedics consulted . Review of the progress notes revealed the resident was readmitted back to the facility on [DATE] with a . Right ankle broken below knee . boot on right foot upon arrival . Per a nursing note documented at 8:47 PM. A Nursing note dated 7/25/24 at 4:27 PM, documented in part . resident is being sent out to the hospital for MRI (Magnetic resonance imaging) due to redness with swelling with pain of an 8 on a grimace pain scale . PRN (as needed) medication and schedule pain medication was giving to resident, but pain did not subside. Right ankle is warm to touching <sic> with swelling . Review of the hospital documentation dated 7/25/24, documented an Ankle Fracture . Diagnosis Closed nondisplaced fracture of medial malleolus of right tibia, initial encounter . The resident was discharged back to the facility on the same day. Review of the care plans documented the following: . I require assist with adls (activities of daily living) due to confusion, and decreased mobility. I have limited physical mobility r/t (related to) contracture to right UE (upper extremity) flexion and right-side weakness from a prior stroke . Apply right pressure relief ankle foot orthosis (PRAFO) boot as tolerated with daily care . 10/11/2022 . Right Pressure relief ankle foot orthosis. PRAFO boot . 10/24/23 After the identified injury an intervention . Ensure my feet are up and not dragging on the ground when I am up in w/c (wheelchair) . 07/24/2024 On 8/12/24 at 2 PM, CNA N was interviewed and asked about 7/18/24 and them notifying the NP of R403's right foot. CNA N stated they were familiar with R403 and had been assigned to them multiple times. CNA N stated they went into the room with another CNA to perform range of motions with the resident. CNA N stated . (R403) was in so much pain, she grabbed my hand and hit her leg . CNA N again stated that R403 was in so much pain the day of 7/18/24, so they did not perform the range of motion exercises with them. They informed the staff of their observations. CNA N was asked if they ever seen or have observed a boot applied to R403's foot prior to the incident and CNA N stated No, the staff have never put a boot on R403 prior to the incident. When asked if they ensured the right leg foot rest were applied to the resident's wheelchair, CNA N stated No, either way she would drag it if we did (referring to the resident's right foot). The facility's education document provided by the Administrator was reviewed with CNA N. CNA N was asked why they had not attended the education on the Resident Devices/Foot Pedal and CNA N was not sure why they were not educated. Review of the Resident Devices/Foot Pedal in-service provided by the Administrator was compared to the facility's staff list, multiple staff were identified to have not been educated on the deficient practice. The Inservice date was completed on 7/26/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	This indicated the facility staff failed to follow proper protocol of applying leg rest to wheelchairs when applicable, failed to implement the resident specific interventions of the utilization of a right foot boot and failed to educate all staff on the deficient practice. On 8/12/24 the Administrator who also serves as the facility's Abuse Coordinator was interviewed and asked why the staff were not ensuring the wheelchair foot pedals and right foot boot interventions were not implemented as documented in the resident's care plans. The Administrator stated they were recently hired as the Administrator for the facility and during the investigation they found the resident's foot pedal was not applied to the wheelchair and they did not have a boot for the resident as documented in their care plan. The Administrator stated the staff was re-educated. The Administrator was asked why all staff had not been educated on the identified deficient practice and the Administrator stated they would look into it and follow back up. No further explanation or documentation was provided by the end of the survey.