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	10/26/2023

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure resident dignity for four residents (R#'s 17, 28, 44, and 93) of four residents reviewed for dignity, three additional residents (R2, R49, and R58) and several members who participated in the group meeting who wished to remain anonymous. Findings include: R28 On 10/24/23 at 8:47 AM, upon entry to the building, R28 was observed being pushed into the shower room on the shower chair. R28 was nude, with a bedsheet covering only their genital area. The sheet was askew and R28's bare buttocks could be observed on the shower chair. R44 and R93 On 10/24/23 from 3:05 PM to 3:30 PM, R44 was overheard to be loudly and repeatedly yelling out I need help. At that, time, at least six staff members were observed clustered around the nursing station. Nurse 'N' was observed to walk past R44's room and did acknowledge R44. At 3:20 PM, Nurse 'P' was observed to pass by R44's room. At approximately 3:25 PM, R93 exited their room to the hallway and said, I am sick of all his (expletive) yelling. Nurse 'N' intercepted R93 and Nurse Aide 'Q' finally entered R44's room to attend to his yelling out. After Nurse 'N' calmed R93, he said to the surveyor, He (R44) is one of our yellers. 32568 R2 and R49 (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/23 from 11:45 AM until 12:25 PM, multiple residents were observed seated in the Bay Dining Room. No staff were present or observed engaging with the residents. R2 and R49 were observed with their backs to the television which was on. Multiple residents were in the dining room at that time. At that time, the Administrator asked Certified Nursing Assistant (CNA) 'U' to enter the dining room to supervise the residents. At that time, R49 was turned around to face the television, but there was no verbal interaction from CNA 'U'. From 12:25 PM until approximately 12:35 PM, CNA 'U' did not speak to or interact with the residents and stood in the room. At 12:35 PM, the Administrator entered the dining room and instructed CNA 'U' to talk with the residents and ensure they were engaged while waiting for lunch. The residents' lunch arrived in the Bay Dining Room at approximately 12:40 PM. Review of R2's clinical record revealed R2 was admitted into the facility on [DATE] with diagnoses that included: colon cancer, human immunodeficiency virus (HIV), and dementia. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R2 had severely impaired cognition. Review of R49's clinical record revealed R49 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: conversion disorder with seizures and dementia. Review of an MDS assessment dated [DATE] revealed R48 had moderately impaired cognition. R58 On 10/24/23 at approximately 12:35 PM, R58 was observed in the main dining room eating lunch. R58 had a plate of food on their lap and was shoveling it into their mouth using their hands. Food was observed on the floor, on R58's face and hands, and clothing. One staff member was observed in the dining room and did not offer assistance to R58. On 10/25/23 at 12:05 PM, R58 was observed seated at a table with a staff member. The staff member assisted R58 with eating their food and R58 was receptive to the assistance. Review of R58's clinical record revealed R58 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Alzheimer's Disease, legal blindness, and schizophrenia. Review of a MDS assessment dated [DATE] revealed R58 had severely impaired cognition, no behaviors, and required supervision (oversight, encouragement, or cueing) from one staff member for eating. Review of R58's care plans and Kardex revealed they required one person assist for eating. 39592 R17 On 10/24/23 at 10:39 AM, R17 was observed lying in bed. R17 was asked about care at the facility. R17 explained about two weeks before, they asked a CNA to turn them. The CNA was very rude, and said mean things to them and turned them too quickly, it hurt their neck. R17 was asked who the CNA was. R17 explained they did not remember her name, but had told the Director of Nursing (DON) and it had been investigated. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed R17 was admitted into the facility on [DATE] with diagnoses that included: stroke with paralysis, diabetes and heart failure. According to the MDS assessment dated [DATE], R17 was cognitively intact and was dependent on staff for most activities of daily living (ADL's). On 10/26/23 at 11:24 AM, Unit Manager (UM) H was interviewed and asked about the incident between R17 and CNA J. UM H explained R17 told her about the incident on Monday 10/16/23, R17 told her on Friday 10/13/23 a CNA had been rude to them and that she needed more training. On 10/26/23 at 11:50 AM, the DON was interviewed and asked about the incident between R17 and a CNA. The DON explained after she talked to R17 and he described the CNA they determined it had been CNA J, she was suspended and has since been terminated due to her attitude with residents and staff. 38271 On 10/25/23 at approximately 11:13 a.m., during the anonymous group meeting, the residents were queried if the facility staff were treating them with dignity and respect. Four residents indicated that the facility staff do not announce themselves before coming into the room and do not use the privacy curtain. One resident reported that the CNA's had entered their bathroom while they were on the toilet without knocking on the door and emptied another residents urinal in the sink. On 10/25/23 at approximately 11:28 a.m., One resident reported that the facility staff have their cell phone on their persons and that staff are having phone conversations by using the device ear pieces when providing care to them. .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 34208 Based on observation, interview and record review the facility failed to ensure fresh water was provided and water was within reach for eight residents (R#'s 32, 12, 90, 56, 75, 13, 37, 16, and 44) of 87 residents reviewed for accommodation of needs. Findings include: A review of a facility provided policy titled, Hydration revised 1/2021 was conducted and read, The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health . On 10/24/23 at 9:25 AM and 11:44 AM, R32 was observed in bed, no drinking water was observed in their room, within reach. On 10/24/23 at 9:28 AM, R12 was observed in their bed, no drinking water was observed in their room, within reach. On 10/24/23 at 10:16 AM, R90 was observed in their bed. A foam cup of water was on their bedside table and it was noted to be dated 10/23/23 for the day (7A-3P) shift. On 10/24/23 at 10:19 AM and 3:07 PM, R56 was observed in their bed. An empty foam cup for water was on their bedside table and it was noted to be dated 10/23/23 for the day shift. On 10/24/23 at 10:28 AM, R75 was observed in their bed. A foam cup of water was on their bedside table and it was noted to be dated 10/23/23 for the day shift. On 10/24/23 at 10:37 AM, R13 was observed in their bed, they shook their empty foam water cup and said they had put the call light on and had been waiting since 6 AM for fresh water. On 10/24/23 at 11:45 AM, R37 was observed sitting on the side of their bed. A foam cup of water was observed to be dated 10/23/23 for the day shift. On 10/24/23 at 11:47 AM, R16 was observed sitting in their room in their wheelchair, no drinking water was observed in their room, within reach. On 10/24/23 at 3:09 PM, R44 was observed in their bed, no drinking water was observed at their bedside. On 10/26/23 at 12:08 PM, an interview was conducted with the facility's Director of Nursing. They indicated fresh water should be provided every shift and the cups should have a date and time on them.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview, and record review, the facility failed to ensure the residents right to private and confidential mail delivery for one resident (R48) of one residents reviewed for private communications, resulting in resident mail being opened by the facility prior to delivery to the resident. Findings include: On 10/25/23 at approximately 11:31 a.m., R48 was queried if the facility was respecting their rights including their privacy and they reported the business office had opened their mail without their permission. On 10/25/23 at approximately 2:25 p.m., during a follow-up conversation with R48, R48 was observed in their room, sitting on their bed. R48 was queried regarding their concern that their mail was coming to them already opened by the facility and they had spoken with business office manager L (BOM L) about receiving their mail opened. R48 provided an opened document that had to do with their Medicaid and indicated that it had came to them opened and they had let the Administrator know about it. On 10/25/23 the medical record for R48 was reviewed and revealed the following: R48 was initially admitted to the facility on [DATE] and had diagnoses including mood disorder and panic disorder. A review of R48's MDS (minimum data set) with an ARD (assessment reference date) of 8/29/23 revealed R48 was independent with most of their activities of daily living. R48's BIMS score (brief interview of mental status) was 15 indicating intact cognition. On 10/25/23 at approximately 2:28 p.m., Business office Manager L was queried regarding R48's mail being delivered to them already opened. BOM L indicated that the mail was opened by the business office and was R48's medicaid insurance paperwork. BOM L was queried if it was the facility practice to open resident mail that is addressed to them before it is delivered to them and they reported that they knew they should not open mail but when it was from from the State such as a redetermination that might need to be addressed, they do open it otherwise they were worried that the business office would not be aware of it. On 10/26/23 a facility document titled Mail was reviewed and revealed the following: Policy Statement . Residents are allowed to communicate privately with individuals of their choice and may send and receive their personal mail unopened unless otherwise advised by the Attending Physician and documented in the residents ' medical records .Policy Interpretation and Implementation: Mail will be delivered to the resident unopened unless otherwise indicated by the Attending Physician and documented in the resident ' s medical record. Staff members of this facility will not open mail for the resident unless the resident requests them to do so. Such request will be documented in the chart (i.e., on the resident ' s plan of care) .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22960 This citation pertains to Intake Number(s): MI00138819 and MI00139774. Based on observation, interview, and record review, the facility failed to provide a clean, comfortable, homelike environment for multiple residents (including R5, R23, R88, R35, R93,R18, R54, R17) in multiple resident rooms and hallways throughout the facility. Findings include: On 10/24/23 at 10:30 AM, the sink in the bathroom for room [ROOM NUMBER] was observed with an approximately 3 inch by 3 inch hole in the sink basin, with heavily rusted out edges. In addition, there was a strong urine odor in the bathroom. On 10/24/23 at 10:35 AM, the call light string in the bathroom for room [ROOM NUMBER] was observed to be short and did not extend down far enough to be accessible for a resident on the floor. In addition, the sink vanity particle board was warped and pulling away from the sink basin, leaving a large gap at the rear of the sink. On 10/24/23 at 10:40 AM, the bathroom for room [ROOM NUMBER] was observed. The grout around the toilet base was stained black, there was missing cove base molding, and the sink laminate top was split and separating from the front edge of the sink vanity. In addition, the bathroom ceiling vent cover was coated with dust. On 10/24/23 at 10:45 AM, R 5 was observed in room [ROOM NUMBER]. The vinyl covering on 5's wheelchair arms was observed to be heavily cracked and missing in spots, and was no longer smooth and easily cleanable. 32568 On 10/24/23 at 10:19 AM, R23 was observed lying in bed. When queried about the care and services in the facility, R23 reported their room was not cleaned regularly. R23's room was observed to be cluttered with personal items. The closet did not have a door and personal items were scattered on the bottom of the closet and on the floor. R23's was facing the wall and explained they would prefer to face the other way, but that was where the television was (on the wall). A bed sheet with a large, dried, yellow stain was observed on the floor near the closet. R23 reported it was removed from their bed after it was soiled with urine two days ago. R23 explained, the Certified Nursing Assistants (CNAs) were responsible for changing bed linens and they were supposed to put soiled linens in bags. On 10/24/23 at 12:15 PM, R23's room remained cluttered. The soiled bed sheet remained on the floor near the closet and it appeared that the floor was mopped around it. On 10/24/23 at 12:17 PM, an interview was conducted with CNA 'U'. When queried about who was responsible for removing soiled and dirty bed linens from residents' rooms, CNA 'U' reported the CNAs were responsible. When queried about the dirty bed sheet on R23's floor, CNA 'U' stated, I didn't see it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/23 at 10:50 AM, R23 was observed lying flat on their back in bed. R23 reported the head board to the bed was loose and therefore it prevented them from grabbing on to it to assist with turning. The head board was observed with two missing screws on one side and was loose upon grabbing onto it. On 10/25/23 at approximately 11:00 AM, an interview was conducted with Assistant Maintenance Supervisor 'T' and Maintenance Staff 'V'. When queried, Assistant Maintenance Supervisor 'T' and Maintenance Staff 'V' reported they were not aware of any repairs needed to R23's head board. They observed it and reported it needed to be replaced. R23 reported it had been loose for a few weeks. Review of R23's clinical record revealed R23 was admitted into the facility on [DATE] and readmitted on [DATE]. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R23 had intact cognition, required extensive physical assistance from staff for bed mobility, and was frequently incontinent of urine. 34208 On 10/24/23 at 8:40 AM, a resident who wished to remain anonymous was interviewed regarding the facility's cleanliness. They said, The place ain't very clean. They continued to say the staff let people walk around in soiled clothing and it made for offensive odors throughout the facility. On 10/24/23 at 9:33 AM, a fan in room [ROOM NUMBER]-A was observed to have a large accumulation of dust on the blades and front of the fan. On 10/24/23 at 9:59 AM, a brownish colored liquid puddle was on the floor outside room [ROOM NUMBER]. Multiple staff members were observed to be walking over, through, and around the puddle making no attempt to wipe it from the floor. At 10:33 AM, it was observed a wet floor sign had been placed over the puddle. Nurse 'P' was observed to see the puddle and say they were going to get housekeeping to clean up the puddle, despite a linen cart with towels parked near the stain. On 10/24/23 at 11:37 AM, a soiled blanket not contained in a sack was observed on the floor outside the dirty linen room on the [NAME] unit. On 10/24/23 at 11:38 AM, it was observed room [ROOM NUMBER]-A and 111-B still had their breakfast trays at the bedside. On 10/24/23 at 11:38 AM, a resident who wished to remain anonymous said the bed sheets were always stained. They stated, It gives me the willys. It was observed the sheets did have scattered light brown stains. On 10/24/23 at 11:40 AM, the made bed in room [ROOM NUMBER]-B was observed to have a white e bedspread with multiple faded brown stains. On 10/24/23 at 12:20 PM, an observation of the dining room on the Gold unit was conducted. The floor and tables were observed with multiple areas of dried food stains and crumbs. The ice machine room was observed to have paper and garbage debris strewn about the floor. 38271 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R18 On 10/25/23 at approximately 10:28 a.m., R18 was observed in their room, laying in their bed. R18 was observed in bed shivering stating they were cold. R18 was observed to have holes in their blanket. R18 was queried regarding the holes in the blanket and they stated they're all like this. R54 On 10/24/23 at approximately 12:07 p.m., R54 was observed in their room, laying in their bed. R54 was queried if they had any concerns and they reported their window has been in disrepair for a long time and was not closing at the top and was letting cold air come in. At that time, an observation of R54's window was made and it was observed to be cracked at the top, unable to be closed. R35 On 10/25/23 at approximately 1:48 p.m., R35 was observed in their room, up in their wheelchair sitting in the dark. R35 was queried regarding the light in their room and they reported their overbed light had not worked in a month. At that time, R35's light was observed to be non functioning without a chain to turn it on. R35's roommate (R88) reported that they felt it was unfair that the midnight Nurse turns on their overbed light when addressing concerns for R35 and the light wakes them up in the night. R93 On 10/25/23 at approximately 1:51 p.m., R93 was observed in their room, up in their wheelchair. R93's bathroom was observed to not contain any working lighting. R93 reported that the staff gave them a flashlight to use when going to the bathroom. R93 reported the flashlight is not good lighting and they shouldn't have to use the flashlight when using the bathroom. On 10/25/23 at approximately 1:53 p.m., Nurse Manager N (NM N) was queried regarding the flashlight that residents had to use to go to the bathroom. NM N reported they were not aware of the light being out and that the residents in the room should not have to use a flashlight when going to the bathroom and they would get it fixed. 39592 R17 On 10/24/23 at 9:16 AM, during observation of medication administration, Licensed Practical Nurse (LPN) C picked up food debris that was on R17's overbed table. LPN C also was observed to peel a wrapper off the overbed table that was adhered to the top of the table. On 10/24/23 at 10:39 AM, R17 was observed lying in bed. R17's gown was observed to be heavily soiled along with the linens on the bed under R17. When asked about their gown, R17 explained whenever they ask for a new gown, the Certified Nursing Assistants (CNA's) tell them they do not have any the bed was not changed frequently . and there were never any washcloths.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 34208 Based on interview and record review, the facility failed to document and address resident grievances for one resident (R90) of one resident reviewed for grievance resolution, resulting in verbalized complaints and frustration. Findings include: On 10/24/23 at 10:21 AM, R90 said they were frustrated with not having a working television set for at least two weeks. They were asked if they had reported the broken television and said they reported it to the Assistant Maintenance Supervisor. They were asked if they were offered the opportunity to fill out a grievance form and said they were not. On 10/24/23 at approximately 3:00 PM, and 10/25/23 at 1:20 PM, a request was made for any grievances for R90, none were received by the end of the survey. On 10/25/23 at 1:58 PM, an interview was conducted with the facility's Assistant Maintenance Director. They were asked if they were aware of R90's broken television and said R90 had spoke to them several times about it. They said they explained to R90 that it was a satellite issue and they were not sure when it was going to be fixed. They were asked why R90 could not have one of the a wi-fi equipped televisions that were stacked in the conference room and they said the wi-fi signal wasn't strong enough. They were then asked why R90's roommate's television worked, and they had no explanation. Finally, the Assistant Director was asked if they filled out a grievance form for R90 and said they had not. On 10/25/23 at 2:15 PM, an interview was conducted with the facility's Administrator regarding R90's complaints about their television. The Administrator said they had no knowledge of the issue. On 10/25/23 at approximately 3:15 PM, Maintenance Staff were observed in R90's room replacing their television set. A review of a facility provided policy titled, Resident and Family Grievances revised 12/20 was conducted and read, .Procedure .b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated resident assistance form .c. forward the grievance from to the Grievance Officer as soon as practice .

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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** 38271 Based on interview and record review the facility failed to report an allegation of abuse to the State Agency for two residents (R93 and R252) of 15 residents reviewed for abuse/neglect/mistreatment. Findings include: R252 On 10/26/23 the medical record for R252 was reviewed and revealed the following: R252 was initially admitted to the facility on [DATE] and had diagnoses including adjustment disorder and chronic pain syndrome. A review of R252's MDS (minimum data set) with an ARD (assessment reference date) of 10/11/23 revealed R252 was independent with most of their activities of daily living. R252's BIMS score (brief interview for mental status) was 15 indicating intact cognition. A Nursing progress note dated 10/15/23 revealed the following: Approx. (approximately) 1330 writer was charting at east nurse's station heard verbal altercation down east hallway. While walking down hallway to see where altercation occurring, writer was approached by resident's roommate [R93] stating, 'Resident hit me in my back with cane. I was sitting with my back toward roommate eating my lunch, roommate rolled up to my w/c and bumped it with roommate's w/c (wheelchair). I didn't think anything about it until roommate did it again and started yelling and cursing stating ,Move the f*** out my way!' 'I stood up with my back toward my bed, my roommate stood up and pushed me and then hit me in my mouth. Roommate than start turning around I thought roommate was about to swing again to hit me, so I swung my cane and hit roommate on the back of shoulder.' Head to Toe assessment was done no physical or visual findings were noticed at this time. BLE (bilateral lower extremity) and BUE (bilateral upper extremity) POM (passive range of motion) & AROM (active range of motion) done no pain note during before or after. Vital signs wnl (within normal limits) 128/84(B/P) 94(HR) 98.2(Temp) 20(Resp) 100%(POx). Resident was immediately separated roommate [R93] was moved to new room. All responsible parties notified of altercation. On 10/26/23 2:36 p.m., the facility Administrator was queried pertaining to the progress note dated 10/15/23 in R252's medical record. The Administrator indicated that they were unaware of the incident but will have to look into it and do an investigation. The Administrator was queried if anyone had reported the incident to the State Agency for review and they indicated that nobody had because they were not aware of it. On 10/26/23 at approximately 2:40 p.m., R252 was observed in their room up in their wheelchair. R252 was queried regarding the altercation noted in their medical record on 10/15/23 and they reported that their old roommate stood up and pushed them on their bed and then punched them in their mouth. R252 Stated their roommate was moved out shortly afterwards and they have not had any issues since. On 10/26/23 at approximately 2:58 p.m. Nurse O was queried regarding their progress note on 10/15/23 in R252's medical record. Nurse O reported they heard yelling in the hallway but did not see the altercation just what R252 had told them. Nurse O reported they told all responsible parties and administration about the altercation and that they ended up moving R93 to the other side of the facility. (continued on next page)

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	235664	A. Building B. Wing	10/26/2023

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/23 a facility document titled Abuse, Neglect and Exploitation was reviewed and revealed the following: Reporting/Response .1. The facility will implement the following: 2. Reported of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. , law enforcement) within specified timeframe's: a. Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involved abuse and do not result in serious bodily injury .

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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** 39592 Based on observation, interview and record review, the facility failed to develop comprehensive care plans which addressed activities based on resident preferences for three (R's 17, 82 and 90) of five residents reviewed for care planning. Findings include: R17 On 10/24/23 at 10:39 AM, R17 was observed lying in bed. When asked about activities at the facility, R17 pointed at the television and said it was his only entertainment, no one asked him to go anywhere or do anything. Review of the clinical record revealed R17 was admitted into the facility on [DATE] with diagnoses that included: stroke with paralysis, diabetes and heart failure. According to the Minimum Data Set (MDS) assessment dated [DATE], R17 was cognitively intact and was dependent on staff for most activities of daily living (ADL's). Review of R17's comprehensive care plan revealed no activity care plan, no activity goals or interventions. On 10/25/23 at 11:29 AM, the Activity Director was interviewed and asked who initiated activity care plans. The Activity Director explained they were initiated by the Activity Department. When informed R17 had no activity care plan, the Activity Director explained all residents should have an activity care plan. 34208 R82 On 10/25/23 at 10:52 AM, a review of R82's clinical record was conducted and revealed they admitted to the facility on [DATE] with diagnoses that included: stroke, heart failure, tracheostomy, feeding tube, hemiplegia, and diabetes. R82's most recent MDS assessment dated [DATE] indicated R82 had severe cognitive impairment, was non-ambulatory, and required extensive to total assistance from one to two staff members for all activities of daily living. A review of R82's care plans was conducted and revealed no care plan for activities. R90 On 10/26/23 at 8:40 AM, a review of R90's clinical record was conducted and revealed they admitted to the facility on [DATE] and was most recently admitted on [DATE]. R90's diagnoses included: diabetes, peripheral neuropathy, psychoactive substance abuse, and depression. R90's most recent MDS assessment dated [DATE] indicated they had intact cognition. A review of R90's care plans revealed no care planning for activities.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on interview and record review, the facility failed to ensure care conferences were conducted regularly for one (R62) of 18 residents reviewed for care planning. Findings include: Review of R62's clinical record revealed R62 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: heart failure and Parkinson's Disease. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R62 had moderately impaired cognition and required extensive physical assist for bed mobility and toilet use and limited assistance with transfers. On 10/25/23 at 2:34 PM, an interview was conducted with Social Services Director (SSD) 'Y'. SSD 'Y' explained that resident care conferences were documented in the progress notes under care conference summary. Review of R62's Care Conference Summary progress notes revealed the last documented care conference was on 10/28/22. On 10/25/23 at 2:44 PM, an interview was conducted with SSD 'Y'. When queried about how often care conferences were conducted, SSD 'Y' reported they were held quarterly to coincide with the required MDS assessments. When queried about why R62 had no documented care conferences since 10/28/22, a year prior to the current date, SSD 'Y' reported Social Services Technician (SST) 'Z' sent emails out to coordinate with R62's resident representative and at times he was not available, but that should be documented. SSD 'Y' reported she would look into it. On 10/25/23 at 3:50 PM, the Administrator reported that SST 'Z' followed up with him and reported the last time she sent an email to schedule a care conference with R62's representative was 10/24/23, but they should have been scheduled quarterly and any attempts to schedule should have been documented. Review of a facility policy titled, Care Planning, revised on 6/2023, revealed nothing regarding the facility's care conference policies and procedures.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview, and record review, the facility failed to ensure a meaningful program of activities for four residents (R's 17, 28, 82 and 90) of five residents reviewed for activities. Findings include: Review of a facility policy titled, Activities revised 1/2001 read in part, .Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging, and usefulness. b. Promote or enhance physical activity. c. Promote or enhance cognition. d. Promote or enhance emotional health. e. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence. f. Reflect resident's interests. g. Reflect cultural and religious interests f. the residents. h. Reflect choices of the residents . R17 On 10/24/23 at 10:39 AM, R17 was observed lying in bed. When asked about activities at the facility, R17 pointed at the television and said it was his only entertainment, no one asked him to go anywhere or do anything. R17's roommate said sometimes they would come in and ask him if he wanted to go to an activity. R17 said they never asked him if he wanted to go. Review of the clinical record revealed R17 was admitted into the facility on [DATE] with diagnoses that included: stroke with paralysis, diabetes and heart failure. According to the Minimum Data Set (MDS) assessment dated [DATE], R17 was cognitively intact and was dependent on staff for most activities of daily living (ADL's). Review of R17's 30 Day Look Back had a task for 1:1 Activity PRN (as needed). There were only two check marks, indicating it was done, for Resident Focused Conversation on 10/10/23 and 10/24/23. On 10/25/23 at 11:29 AM, the Activity Director was interviewed and asked where one to one (1:1) activities were documented. The Activity Director explained they were documented either in Tasks or progress notes. When asked how often 1:1 activities should be documented, the Activity Director explained they tried to get to each resident two times a week. The Activity Director was informed of only two documented activities for R17. The Activity Director explained they sometimes wrote in progress notes as well. Review of R17's progress notes revealed no documentation in an Activity Progress Note, Activity Participation Summary or Activity Participation Note. 34208 R28 On 10/24/23 at approximately at 10:54 AM, 1:45 PM and 4:15 PM, R28 was observed in their bed, but not responsive to attempts at verbal communication. It was noted there was no television, radio, or other stimulation provided for R28. It was further noted that during the survey from 10/24/23 thru 10/26/23, R28 was not observed out of their bed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/26/23 at 8:47 AM, a review of R28's clinical record was conducted and revealed they admitted to the facility on [DATE] and most recently readmitted on [DATE]. R28's diagnoses included: epilepsy, developmental disorders, dysphagia, failure to thrive, schizophrenia, adjustment disorder, delusional disorders, contractures, and presence of a feeding-tube. R28's MDS assessment dated [DATE] indicated R28 had severe cognitive impairment, was non-ambulatory, and required extensive to total assist for all activities of daily living. A review of R28's Activity Task in the electronic medical record was conducted on 10/25/23 at 11:05 AM. It was revealed there were only two group activities documented for a 30 day look-back period, and there were no one-on-one activities documented. R82 It was observed through the dates of the survey from 10/24/23 thru 10/26/23, R82 was not observed out of their bed. On 10/25/23 at 10:52 AM a review of R82's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: stroke, heart failure, hemiplegia, diabetes, presence of a tracheostomy, and presence of a feeding tube. R82's most recent MDS assessment dated [DATE] revealed they had severe cognitive impairment and required extensive to total assist from one to two staff members for all activities of daily living. R82's care plans were reviewed and did not reveal a care plan for activities. On 10/25/23 at 11:01 AM, a review of R82's Activity Task in the electronic medical record was conducted for a 30-day look back period. Documentation revealed R82 had only one documented one-on-one activity. R90 On 10/24/23 at 10:21 AM, R90 said the facility didn't have activities that interested them. They said they were out and about in the facility a lot and didn't see much going on, especially for people that were, stuck in their beds. R90 complained about activities, not much to do around here, especially for the people that don't get out of bed. On 10/26/23 at 12:08 PM, an interview was conducted with the facility's Activity Director. They were asked how their department documented activities and said they should be documenting in the resident's electronic medical record under the Activity task. They were asked if they were involved with care planning for activities and said they were. At that time, they were made aware R82 had no activity care plan. They were also made aware of the frequency R28 and R82 had documented activities and said their staff must not have documented.

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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** 34208 This citation pertains to intake #MI00139774. Based on interview and record review, the facility failed to address a change of condition and ensure a timely transfer to the emergency department after a fall for one resident, (R247) of one resident reviewed for transfer the the emergency room . Findings include: On 10/26/23 at approximately 1:00 PM, a review of a complaint to the State Agency was reviewed and indicated the local Police department responded to the facility on [DATE]. The complaint further read, ' . dispatched .to (facility name) for a male fall victim with a head injury .spoke with (Nurse 'W) who stated she started her shift at 1900 hours (7PM), and the injury had already happened and had not been reported. She discovered the patient had apparently fallen out of his bed and hit his head causing a large laceration .(Nurse 'W') .called (Unit Manager 'X') who informed her to call (Ambulance Company) not 911 .We received the initial call @ 1025pm when the incident took place prior to 7 pm according to the reporting party . revealed the local Police department responded to the On 10/26/23 at 1:43 PM, the facility's Administrator was requested to provide an an incident/accident report or any investigations into an incident for R247 that occurred on 9/11/23. No documentation was provided by the end of the survey. On 10/26/23 at 2:53 PM, a review of R247's closed clinical record was conducted and revealed they admitted to the facility on [DATE] with diagnoses that included: early onset Alzheimer's disease, anxiety disorder, seizures, depression, psychotic disorder, and repeated falls. R247's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed R247 had severe cognitive impairment, was non-ambulatory and required extensive to total assistance from one to two staff members for most activities of daily living. A review of a progress note entered into the record by Nurse 'W' dated 9/12/23 at 2:14 AM read, At 8:22 PM writer was called to room by nurse's assistant <sic> writer observed a laceration that had a small amount of blood around the area that was approximately 1-2 inches long to the right side of the forehead. Writer cleaned area with normal saline covered with dry dressing and applied an ice pack, resident was given scheduled pain medication per order .Doctor was notified and writer received a verbal order to transfer resident to the hospital for stitches. The unit manager and all other responsible parties were notified. (Ambulance Company) was called and told writer they would be arriving shortly. Approximately ten minutes later two (City) police officers arrived and assessed the resident andquestioned <sic> writer and roommate about what happened. (Ambulance Company) arrived shortly after, and resident left the facility at 11:04 PM. A review of a physician's note entered into the record on 9/11/23 at 9:20 PM was conducted and read, .Note Text: Patient was seen by video conferencing-with help of the nurse on duty/telehealth services rendered . Patient fell -and hit his head to the floor apparently/sustained a laceration to the right side of the forehead/Temple area with some bleeding no loss of consciousness no seizure activity .Long laceration on the right side of the forehead noted with blood using from the margins -small hematoma also noted . Assessment and plan .skin laceration to the right forehead .skin laceration would need closure and therefore patient needs to be transferred to the hospital ER (emergency room) . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/23 at 1:57 PM, an interview was conducted with Unit Manager 'X' regarding the incident R247 experienced on 9/11/23. Unit Manager 'X' said they did not recall the incident, but if a resident sustained a laceration they would call 911 and have the resident transferred. On 10/26/23 at 2:35 PM, an interview was conducted with Nurse 'W' regarding the incident. They said they came on duty and got report at 7 PM on 9/11/23, but they did not remember who they took shift report from. They said a while later a nurse aide told them R247 was bleeding from their forehead. When asked what caused the bleeding, Nurse 'W' said the aide told them R247 had fallen earlier in the day. They said they notified Unit Manager 'X', called a transportation company, and had R247 transferred to the emergency room . They were asked about the police reporting to the facility and said they did not know how they were alerted and why they showed up. They were also asked why they did not call 911, and instead called a private transportation company, delaying R247's transfer to the emergency room , they said they called a private company because R247 was, at his baseline and they didn't think they needed to call 911. On 10/26/23 at approximately 2:50 PM, the Director of Nursing was asked about the incident and said they had no knowledge. A review of a facility provided policy titled, Change of Condition revised 6/2023 was conducted, but did not address assessment and treatment for a change of condition.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review the facility failed to ensure splints/braces were applied for one resident (R18) of two residents reviewed for positioning/mobility. Findings include: On 10/24/23 at approximately 10:27 a.m., R18 was observed in their room, laying in their bed. R18 was observed to have a hand splint on their dresser. R18 was queried if anyone had applied the splint and they indicted nobody does and everyone forgets. On 10/26/23 at approximately 10:28 a.m. R18 was observed in their room, laying in their bed. R18 was observed to not have their splint on. R18's splint was still observed on top of their dresser in same position as the observation on 10/24/23. R18 was queried regarding their splint and they reported they need it and that nobody has puts it on and they cannot get it on themselves. On 10/25/23 the medical record was reviewed and revealed the following: R18 was initially admitted to the facility on [DATE] and had diagnoses including Osteoarthritis, Hemiplegia and Hemiparesis affecting left non-dominant side and paralytic syndrome. A review of R18's MDS (minimum data set) with an ARD (Assessment reference date) of 7/20/23 revealed R18 needed extensive assistance from staff with their activities of daily living. R18's BIMS (brief interview for mental status) score was 13 indicating intact cognition. An Occupational Therapy Discharge Summary dated 9/6/23 revealed the following: Apply left resting hand splint as tolerated daily. A review of R18's careplan revealed the following: Focus-I have an ADL (activity of daily living) Self Care Performance Deficit 2/2 Hx (history) of CVA (stroke) w/left sided weakness apply left resting hand splint as tolerated daily .Date Initiated: 07/14/2023 . A review of R18's Physician orders revealed no orders to administer their left resting hand splint. Further review of R18's CNA (Certified Nursing Assistant) task documentation revealed no documentation that R18's left resting hand splint had been applied daily per R18's plan of care. On 10/26/23 at approximately 11:16 a.m., R18's assigned CNA, CNAR was queried regarding the application of R18's left resting hand splint. They reported they had not been trained on it. CNA R was observed checking their computer screen for their assigned tasks and they reported the splint was not on the task screen so they would never have known to put it on. On 10/26/23 at approximately 11:36 a.m., Therapy Director S (TD S) was interviewed pertaining to R18's left hand resting hand splint. They reported that it should be on daily 4-6 hours as tolerated. TD S indicated that it should have been placed on the CNA task schedule but that they would have to look and see what happened. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/23 at approximately 11:47 a.m., Therapy Director S reported that R18's left resting hand splint should have been added to the CNA tasks so they would know when to apply it but it was not. They reported that it would have to bee added and they would discuss with Nursing to ensure that it was added to the CNA task's for R18.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure catheter care for one resident (R21) of one resident reviewed for catheter care. Findings include: A request for a policy on catheter care was requested via e-mail on 10/26/23 at 12:35 PM, however; it was not provided by the end of the survey. On 10/24/23 at 9:43 AM, R21 was lying in their bed. It was observed they had a urinary catheter and the drainage bag. It was observed the drainage bag did not have a dignity bag and the bag and tubing were observed in contact with the floor. It was further observed the catheter tubing had a build-up of white sentiment. On 10/25/23 at 12:00 PM, a review of R21's clinical record revealed they most recently readmitted to the facility on [DATE] with diagnoses that included: moderate protein calorie malnutrition, adult failure to thrive, anxiety disorder, major depressive disorder, diabetes, and dementia. R21's most recent Minimum Data Set assessment dated [DATE] revealed R21 had moderately impaired cognition, was not ambulatory, and required extensive to total assist from one to two staff members for activities of daily living. Continued review of R21's record revealed no orders or treatment administration record documentation that indicated R21 was receiving care of their urinary catheter care for August, September, and October 2023. On 10/25/23 at 2:20 PM, an interview was conducted with the facility's Director of Nursing regarding catheter care. They indicated there should be a physician's order and signed off documentation that indicated catheter care was provided every shift.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services for a feeding tube for one resident (R82) of three residents reviewed for feeding tubes. Findings include: A review of a facility provided policy titled, Care and Treatment of Feeding Tubes revised 6/2023 was conducted and read, Policy: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . On 10/24/23 at 9:33 AM, R82 was observed in their bed, with tube feeding being delivered via pump. A foam cup dated 10/22/23 contained a large, undated flush syringe submerged in water. An observation of R82's feeding tube site on their abdomen revealed an undated gauze with dried reddish, brown drainage. On 10/24/23 at 3:15 PM, the large flush syringe remained submerged in the cup of water dated 10/22/23. On 10/25/23 at 8:19 AM, an observation of R82's feeding tube site on their abdomen revealed an undated gauze with reddish, brown drainage. On 10/25/23 at 10:52 AM, a review of R82's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: stroke, hemiplegia, diabetes, heart failure, and presence of a tracheostomy, and feeding tube. R82's most recent Minimum Data Set assessment dated [DATE] indicated R82 had severely impaired cognition, was non-ambulatory, and required extensive to total assistance from one to two staff members for activities of daily living. Continued review of R82's clinical record revealed no orders or signed off treatment record for feeding tube site assessment or care until 10/22/23. A review of the August and September 2023 treatment administration records were reviewed and did not document any feeding tube assessment or care. On 10/25/23 at 2:20 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding feeding tube assessment, site care, and documentation. They indicated there should be a physician's order and it should be documented as completed per physician's order on the treatment administration record.

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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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure treatment and services for a tracheostomy for one resident (R82) of one resident reviewed for tracheostomy care. Findings include: A review of a facility provided policy titled, Tracheostomy Care revised 4/2023 was conducted and read, .4. Procedure: Licensed nurse or respiratory care personnel will perform trach care twice daily unless otherwise indicated by a physician order .5. Documentation a) Date, time, initials and any abnormalities b) All subjective and objective data c) Trach, condition of peristomal tissue, excessive or purulent or fetid trach secretions . On 10/24/23 at 9:33 AM, R82 was observed in their bed. They were observed to have a sterile tracheostomy care and cleaning kit and an open cup of sterile water on their bedside table. 10/24/23 at 11:45 AM and 3:15 PM, the open sterile tracheostomy care kit (the open kit exposed the sterile items within the kit to become contaminated) and sterile water remained on the bedside table. On 10/25/23 at 10:32 AM, a review of R82's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: stroke, hemiplegia, diabetes, heart failure, and presence of a tracheostomy, and feeding tube. R82's most recent Minimum Data Set assessment dated [DATE] indicated R82 had severely impaired cognition, was non-ambulatory, and required extensive to total assistance from one to two staff members for activities of daily living. Continued review of R82's clinical record revealed no orders or signed off treatment administration record documentation for routine tracheostomy care for September or October 2023. On 10/25/23 at 2:20 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding routine tracheostomy assessment and care. They indicated there should be a physician's order for tracheostomy care every shift and it should be documented on the treatment administration record.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39592 This citation pertains to Intakes MI00138819 and MI00139871. Based on interview, and record review, the facility failed to ensure there was sufficient nursing staff to provide care and services to the residents. This had the ability to affect all residents in the facility. Findings include: Review of the facility's Payroll Based Journal (PBJ) Report revealed excessively low weekend staffing for the Second Quarter of the Fiscal Year, January 1, 2023-March 31, 2023. Review of the Daily Staffing Sheet revealed: 1/7/23 (Sunday) the census was 63 and from 7:00 AM-7:00 PM there were only two nurses for the whole facility. 3/4/23 (Saturday) the census was 65 and from 3:00 PM-11:00 PM there were only three Certified Nursing Assistants (CNA's) for the whole facility. 3/5/23 (Sunday) the census was 63 and from 3:00 PM-7:00 AM there were only three CNA's for the whole facility. 3/18/23 (Saturday) the census was 65 and from 11:00 PM-7:00 AM there were only three CNA's for the whole facility. 3/19/23 (Sunday) the census was 65 and from 11:00 PM-7:00 AM there were only three CNA's for the whole facility. 3/25/23 (Saturday) the census was 67 and from 11:00 PM-7:00 AM there were only three CNA's for the whole facility. On 10/26/23 at 2:05 PM, the Administrator was interviewed and asked if there had been any issues with staffing levels. The Administrator agreed there had been staffing shortages. The Administrator was asked if the residents had voiced complaints during the low staffing levels about services not being provided. The Administrator explained the residents had complained they were not getting ice water, getting changed timely and about the (delayed) call light response times. 38271 On 10/25/23 at approximately 11:17 a.m., during the anonymous group meeting, One resident indicated that the staffing levels for the weekends were slim and that the facility has had lots of call offs (staff not reporting to work). They reported that it was worse before the new managers started in the last few months and that they could not get their call light answered or help getting dressed in the morning. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Two residents in the group meeting reported that they could not get their bed sheets changed because they did not have enough CNA's (Certified Nursing Assistants). A review of the resident council minutes revealed the following meetings had noted staffing concerns: 1/30/23-Med passing is too late .the aides are inconsistent w (with) care: slow to answer, bad attitudes in regards to performing work duties . 5/23/23-Medication not being administered on time .6/5/23-Medication being administered too late .Received medication for bedtime at 1:00 AM .All agreed-not enough CNA or nurses on weekends/midnights . On 10/26/23 a request was made for a policy/procedures on maintaining adequate staffing levels but none was provided before the end of the survey.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review the facility failed to ensure pharmacy recommendations were timely identified, responded to and implemented for four (R's 5, 21, 44 & 65) of five residents reviewed for a medication regimen review. Findings include: Review of a facility policy titled, Medication Regimen Review revised 3/2022 read in part, .Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication . Written communication from the pharmacist shall become a permanent part of the resident's medical record . R5 Review of the clinical record revealed R5 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: diabetes, atrial flutter and paranoid schizophrenia. The most recent Minimum Data Set (MDS) assessment dated [DATE] revealed R5 had intact cognition and required the assistance of staff for most activities of daily living (ADL's). A review of the Pharmacist's monthly medication regimen reviews in progress notes revealed irregularities were found on 7/5/23 and 8/5/23. On 10/25/23 at 9:11 AM, the Director of Nursing (DON) was interviewed and asked to provide documentation of what the irregularity were for R5, and what the physician's response to the pharmacist recommendations were. On 10/25/23 at 12:12 PM, the DON explained there was no documentation of the recommendations or physician response. 34208 R21 On 10/25/23 at 1:34 PM, a review of R21's medication regimen reviews from the consultant pharmacist were reviewed. It was revealed the consultant pharmacist had made recommendations in February 2023 and May 2023. On 10/25/23 at 4:03 PM, a request for the pharmacist's recommendations and the physician's response to the recommendations for R21 was made, however; none were received by the end of the survey. R44 On 10/25/23 at 3:39 PM, a review of R44's medication regimen reviews from the consultant pharmacist were reviewed. It was revealed the consultant pharmacist had made recommendations in February August 2022 and December 2022. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/23 at 4:03 PM, a request for the pharmacist's recommendations and the physician's response to the recommendations for R21 was made, however; none were received by the end of the survey. 38271 R65 On 10/26/23 the medical record for R65 was reviewed and revealed the following: R65 was initially admitted to the facility on [DATE] and had diagnoses including Chronic obstructive pulmonary disease and Major depressive disorder. A review of R65's MDS (minimum data set) with an ARD (assessment reference date) of 9/26/23 revealed R65 needed supervision for most of their activities of daily living. R65's BIMS score (brief interview for mental status) was 15 indicating intact cognition. A review of R65's monthly medication regimen (MMR) revealed the pharmacist had noted irregularities that needed to be reviewed by the Physician for July, August and October 2023. The pharmacist reports documenting what the irregularities were and the Physician documentation of the clinical rationale for agreeing or disagreeing with the pharmacist recommendations were not available in R65's record for review. On 10/26/23 at approximately 9:25 a.m., the Director of Nursing (DON) was queried pertaining to the irregularities identified by the Pharmacy for the months of October, August and July of 2023. The DON Stated that they did not have the pharmacist reports nor did they have the Physician consultation reports that documented their clinical rationale and they had to contact the pharmacist to get them and have the doctor review them. The Director of Nursing indicated they were new to the facility and that the Pharmacist reviews with the Physician follow up were not being completed and they were starting to work on the getting the process fixed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 34208 Based on observation, interview, and record review, the facility failed to ensure appropriate medication storage for two of two medication rooms Findings include: On 10/24/23 at 10:02 AM, a plastic wash basin was observed on a bedside table in the [NAME] Unit hallway. Inside the basin was a bottle of Milk of Magnesia. On 10/25/23 at 4:30 PM, an observation of the East Unit medication room was conducted with Unit Manager 'N'. It was observed the medication refrigerator in the room contained two plastic grocery sacks of resident's personal foods (all undated) including cheeses, condiments, and left-over tacos. The fridge also contained a vial of Influenza (Flu) vaccine with an expiration date of 6/2023. Nurse 'N' said food was not to be stored with medications. On 10/26/23 at 9:10 AM, the medication storage area on the [NAME] Unit was conducted with Unit Manager 'N' It is noted this area is not kept locked but did contain cabinets and refrigerators equipped with locks for medication storage. During the observation, six bags of intravenous (IV) antibiotic medications were observed on the counter, not secured in a locked cabinet. It was further observed the refrigerator pad lock was locked, however the key was left in the pad lock. The refrigerator was unlocked and a glass tumbler of a green, milky substance was stored in the rack of the refrigerator door. At that time, Unit Manager 'N' took the tumbler and disposed of it in the garbage. Unit Manager 'N' further said the IV antibiotics should have been stored in the East Unit medication room, as it had a door and lock. A review of a facility provided policy titled, MEDICATION STORAGE IN THE FACILITY dated June 2019 was reviewed and read, .Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .G. Outdated, contaminated, or deteriorated medications .are immediately removed from the medication supply .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 10/24/23 during an initial tour of the kitchen between 8:40 AM-9:15 AM, the following items were observed: In the [NAME] reach-in cooler, there was an opened, undated bottle of lemon vinaigrette dressing, and a black mold-like substance on the door gaskets. According to the 2017 FDA Food Code section 3-501.17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. According to the 2017 FDA Food Code section 4-602.13 Nonfood-Contact Surfaces, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. The Vulcan oven was observed with the right side door hanging open. Staff stated that the door has been broken for a while, and that they have to push a cart up against it to keep it closed. In addition, the steamer and the ventilation hood were observed to be non-functional. According to the 2017 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment, (A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 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. There was a wet, wiping cloth stored on the counter top. According to the 2017 FDA Food Code, Section 3-304.14 Wiping Cloths, Use Limitation, .(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114; The drainboard for the clean side of the dish machine was observed to be soiled with food debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food code section 4-501.14 Warewashing Equipment, Cleaning Frequency, A warewashing machine; the compartments of sinks, basins, or other receptacles used for washing and rinsing equipment, utensils, or raw foods, or laundering wiping cloths; and drainboards or other equipment used to substitute for drainboards as specified under S 4-301.13 shall be cleaned: (A) Before use; (B) Throughout the day at a frequency necessary to prevent recontamination of equipment and utensils and to ensure that the equipment performs its intended function; and (C) If used, at least every 24 hours. The floor under the soiled side of the dish machine was observed with a thick layer of a green and black slimy substance. In addition, the white tile wall under the soiled drain board was stained with large globs of a black mold like substance, and the white tile grout was stained black. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean. The ceiling ventilation cover in the dry storage room was coated with dust. According to the 2017 FDA Food Code section 6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition, (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials.

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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. 34208 This citation pertains to intake #MI00139279 This citation has three deficient practices Deficient Practice #1 Based on interview and record review the facility failed to establish a comprehensive infection control program that identified resident infections, calculated monthly infection rates, tracked and trended infections, utilized laboratory and pharmaceutical data, and ensured departmental surveillance and staff education on infection control. This deficient practice had the potential to affect all 87 residents who resided in the facility. Findings include: On 10/26/23 at 12:05 PM, a review of the facility provided infection control program was conducted. At that time, the facility's Director of Nursing (DON)/Infection Control Preventionist said they took over infection control when they started employment at the facility in September 2023. They said they would not be able to provide any infection control data prior to September 2023. The binder provided was reviewed and contained no monthly data including: monthly summaries, calculated infection control rates, line listings, mapping, pharmacy reports, laboratory reports, departmental surveillance, or staff education. On 10/26/23 at approximately 2:30 PM, the facility's Administrator was interviewed about the facility's infection control program and readily admitted they did not currently have one. A review of a facility provided policy titled, Infection Surveillance revised 12/202 was conducted and read, Policy: A system of infection surveillance serves as a core activity of the facility ' s infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections . Deficient Practice #2 Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices during medication pass for two residents (R44 and R46) of four residents observed for infection control during medication administration. Findings include: On 10/25/23 at 11:25 AM, Nurse 'M' was observed exiting R46's room to the medication cart in the 1 [NAME] hallway. At that time, Nurse 'M' was observed to be wearing blue surgical gloves upon exiting the room. Nurse 'M' then opened the medication cart, stored the glucometer in the top drawer then removed and discarded the gloves. Upon removing their gloves, Nurse 'N' was not observed to perform hand hygiene, nor were they observed to sanitize the glucometer prior to storing it back in the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/25/23 at 12:19 PM, Nurse 'M' was observed preparing insulin for administration to R44 at the medication cart on the 1 [NAME] hallway. It was observed Nurse 'M' had on a pair of blue surgical gloves. After preparing the insulin, Nurse 'M' entered R44's room and administered the medication. Nurse 'N' then exited the room with the gloves on. When they got back to the medication cart they discarded the used insulin syringe, removed the gloves, and tossed them in the garbage. On 10/26/23 at 11:44 AM, an interview was conducted with the facility's DON/Infection Control Preventionist. They indicated it was unnecessary to wear gloves when preparing medications, nurses should never wear gloves in the hallway, and after removing gloves hand hygiene should be performed. A review of a facility provided policy titled, Hand Hygiene revised 12/2020 was conducted and read, .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice .5. Additional Considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . 22960 Deficient Practice #3 Based on interview and record review, the facility failed to develop a comprehensive Water Management Plan (WMP) to address the control and spread of Legionella bacteria in the facility water system. The failure to develop and implement a comprehensive Water Management Plan has the potential for the proliferation and transmission of Legionella in the circulating water of the building and the spread of Legionella infections in all 87 residents. Findings include: On 10/24/23 at 10:08 AM, the facility's Water Management Plan (WMP) was requested from the Nursing Home Administrator. The WMP documents provided included a blank CDC template for developing a WMP, and an environmental assessment form for a sister facility located in a different city. On 10/24/23 at 1:45 PM, the Nursing Home Administrator was queried regarding the facility's lack of a WMP, and confirmed that the documents provided were all that they had. On 10/25/23 at 8:46 AM, an undated Legionella Environmental Assessment form completed by the Nursing Home Administrator was provided. No further WMP components were provided. The following components were absent from the facility's WMP: A. Designation of a Water Management Team (WMT) consisting of current employees. B. A diagram of the facility's water system using text and flow diagram. C. Identification of areas in the facility's water system where Legionella could potentially grow. D. Identification of control points where effective mitigation measures can used. E. Ways to intervene when control limits are not met. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. An evaluation process to determine how the WMP is functioning.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 34208 Based on interview and record review, the facility failed to ensure an antibiotic stewardship program that monitored for the appropriateness of antibiotics. This deficient practice had the potential to affect all 87 residents who resided in the facility. Findings include: On 10/26/23 at 12:05 PM, a review of the facility provided infection control program was conducted. At that time, the facility's Director of Nursing (DON)/Infection Control Preventionist said they took over infection control when they started employment at the facility in September 2023. They said they would not be able to provide any infection control data prior to September 2023. The binder provided was reviewed and contained no data such as surveillance, line listings, or any other documentation that indicated the facility was utilizing McGeer's criteria for antibiotic prescription based on infection symptoms, laboratory reports, and pharmacy reports. On 10/26/23 at approximately 2:30 PM, the facility's Administrator was interviewed about the facility's infection control program including antibiotic stewardship, and they readily admitted they did currently have a program. The facility did not provide a policy on antibiotic stewardship, however; a policy provided titled, Infection Surveillance revised 12/2020 was reviewed and read, Policy: A system of infection surveillance serves as a core activity of the facility ' s infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections .

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	10/26/2023

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22960 This citation pertains to intake MI139844. Based on observation, interview, and record review, the facility failed to provide a functional call system that provides direct communication from the residents to the caregivers, in the [NAME] and East hall shower rooms. This deficient practice had the potential to affect all residents that utilize the [NAME] and East hall shower rooms. Findings include: On [DATE] at 10:30 AM, during an environmental tour of the building with the Nursing Home Administrator (NHA), the call lights in the [NAME] hall shower room and the East hall shower room were tested . When both call lights were activated, it was observed that there was no audible sound, the lights outside the shower room did not illuminate, and the call light panel located at the nurse's station did not light up to indicate the call light in the shower room had been activated. NHA confirmed the non-functional call lights and stated they would have maintenance address the issue. Review of the facility's policy Call Lights System revised ,d+[DATE] noted: Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.6. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied .