STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235039	A. Building B. Wing	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Grandville	3400 Wilson Ave Grandville, MI 49418

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00135410 Based on observation, interview, and record review, the facility failed to provide appropriate Activities of Daily Living (ADL) care for 5 residents (Resident #114, #126, #116 , #117, and #107) reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for resident's who are dependent on staff for assistance. Findings: Resident #114 (R114) Review of an Admission Record revealed R114 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes, end stage renal disease, and heart disease. Review of R114's Shower Task revealed R114 was to receive a shower on Monday mornings and Thursday evenings. From 3/18/23-4/17/23 R114 only received a shower on 3/23/23 and 4/3/23. Resident #126 (R126) Review of an Admission Record revealed R126 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes, heart disease, and kidney disease. During an interview on 04/17/2023 at 2:59 PM, Family Member (FM) LL reported that R126 has had to wait for extensive periods of time for assistance after pressing the call light. FM LL reported that on 4/9/23 R126's call light was on for 65 minutes before staff were able to assist. FM LL reported that R126 now has a new pressure injury on her buttocks due to the facility staff leaving R126 in the same position and not following her care plan. FM LL reported that R126 has gone weeks without receiving a shower. FM LL reported that staffing on the weekends is concerning, and residents are not receiving quality care. Review of R126's Shower Task revealed R126 was to receive a shower on Tuesday mornings and Friday mornings. From 3/19/23-4/18/23 R126 only received a shower on 3/29/23 and 3/31/23. There was no documentation that a shower was refused. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #116 (R116) Review of an Admission Record revealed R116 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: muscle weakness, hypertension, and pain. Review of R116's Shower Task revealed R116 was to receive a shower on Monday evenings and Thursday mornings. From 3/18/23-4/17/23 R116 only received a shower on 3/29/23 and 4/5/23. There was no documentation that a shower was refused. Resident #117 (R117) Review of an Admission Record revealed R117 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease and kidney disease. Review of R117's Shower Task revealed R117 did not have a biweekly shower schedule in place. From admission to 4/17/23, R117 did not have a shower documented as completed or refused. Resident #113 (R113) Review of an Admission Record revealed R113 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: Parkinson's Disease. Review of R113's Shower Task revealed R113 was to receive a shower on Monday mornings and Wednesday evenings. From 3/18/23-4/17/23 R113 only received a shower on 3/27/23 and 4/3/23. There was no documentation that a shower was refused. Resident #107 (R107) Review of an Admission Record revealed R107 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dysphagia (difficulty in swallowing food or liquid). Review of R107's nutrition Care Plan revealed, .Pt (patient) to be sitting upright (60-90 degrees) during all intake and to remain upright for 20 minutes. If coughing or throat clearing present, cue patient to do a strong throat clear followed by an additional swallow. Date Initiated: 03/21/2022. Review of the Assignment 1 form (indicates how residents transfer, eat, shower dates, etc) revealed R107 was to be up for all meals, lays down after meals. During an observation on 04/17/2023 from 8:40 AM-8:54 AM, R107 was in bed on his back. His breakfast tray was placed in front of him. The head of R107's bed was at approximately 45 degrees. R107 was left alone, in his bed, and was feeding himself. While feeding himself, R107 was observed continuously coughing for greater than 1 minute until he was able to resume eating (indicating aspiration). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/12/2023 at 6:51 AM, Certified Nursing Assistant (CNA) N reported there were insufficient staff to meet resident needs and facility staff can't reposition, change, shower, and get ADL (Activities of Daily Living) care done for the residents. CNA N stated facility nurses and CNAs have to cut corners and have had to put resident biweekly showers on the backburner in order to ensure residents are supervised and are receiving incontinence care (brief changes) to prevent additional pressure injuries. During an interview on 04/12/2023 at 7:40 PM, Previous CNA S reported that because of the lack of staff and inability to provide care following professional standards of practice (every 2-hour repositioning, incontinence care, out of bed for meals and activities, etc.) there had been a significant increase in falls and pressure injuries, lack of showers and personal hygiene care, and residents left in bed for extended periods of times. CNA S reported that many residents had not received showers in weeks because there were not enough staff to supervise and provide care to all the residents on the unit if they were taken off the floor to provide a shower. During an interview on 04/13/2023 at 11:20 AM, LPN Y reported that there were insufficient staff to meet the residents' basic needs: biweekly showers were not completed for weeks, dressing changes not completed, repositioning and incontinence care not completed timely. During an interview on 04/14/2023 at 10:30 AM, Previous CNA GG reported nurses and CNAs had to cut corners and not do showers in order to prevent falls and pressure ulcers. On 4/18/23 at 10:27 AM, Nursing Home Administrator reported the facility did not have a policy for ADLs.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00135410 Based on interview and record review, the facility failed to ensure staff initiated timely and appropriate Cardiopulmonary Resuscitation (CPR) per standards of care, federal regulation, and their own facility policy and procedures, resulting in an immediate jeopardy when 1 resident (Resident #103), who was a full code (desired full life saving measures), was found unresponsive in respiratory distress and subsequently cardiac arrest. Licensed nursing staff did not know how to appropriately respond causing a delay in rescue attempts and R103's death. This deficient practice placed all residents, who are designated as a Full Code and who suffer cardiac arrest, or are found unresponsive, at risk for serious harm and/or death. Resident #103 (R103) Review of an Admission Record revealed R103 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes and heart disease. Review of R103's Physician Order dated [DATE] revealed R103 code status was CPR-Full Resuscitation. Review of R103's Nursing Progress Note dated [DATE] at 8:40 PM revealed, Entered residents room and observed that she was non-responsive, (blood pressure) ,d+[DATE]-(heartrate) 43-(respirations) 8-(temperature) 96.3 O2 sat (oxygen saturation) 80% on room air. O2 started at 5L/m. Call placed to NP (Nurse Practitioner) (name omitted), order to send to ER (emergency room), called daughter and informed her, and called (ambulance service name omitted). Within a few minutes (ambulance service) and Fire dept. were here. (Respiration range for adults ,d+[DATE], pulse range for adults ,d+[DATE], Oxygen saturation range ,d+[DATE]%). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:53 AM, Licensed Practical Nurse (LPN) Q was asked to describe the events that led to R103's cardiac arrest. LPN Q reported that she was R103's nurse at the time R103 coded (respiratory/cardiac arrest). LPN Q reported R103's blood sugar level was assessed around 4:00 PM which was the last time LPN Q had observed R103. LPN Q reported she returned to R103's room to administer evening medications around ,d+[DATE]:15 PM and found R103 sitting in her chair and unresponsive. LPN Q reported 2 Certified Nursing Assistant (CNAs) assisted with getting R103 back to bed and placed a backboard behind R103 in the event she would require CPR. LPN Q reported vital signs were obtained and R103 was breathing (8 respirations a minute) but did not describe ventilatory depth or rhythm (deep, shallow, normal, labored, regular, irregular). LPN Q reported R103's oxygen level and heart rate were assessed via pulse oximeter and identified R103's pulse in the 40's and oxygen level at 80%. LPN Q was asked if she assessed R103's pulse other than by the pulse oximeter and she reported that she had palpated R103's pulse via radial and carotid. LPN Q was unable to recall the pulse (rate, rhythm, force) or the frequency it was assessed and confirmed that subsequent pulse assessments were not documented. LPN Q reported that she had continued to assess R103's pulse until EMS arrived but did not report that R103 had additional oxygen saturation or respiration assessments. LPN Q reported LPN HH was assisting with R103's care and the crash cart (cart containing medications and equipment used for emergency resuscitation) and the ambu bag (device used for manual ventilation) were brought to R103's room. Although the facility was equipped with an AED (automated external defibrillator portable machine that automatically diagnoses the heart rhythm and determines if a shock or CPR is needed) it was not applied to R103. LPN Q reported that she had not identified asystole and CPR had not been initiated prior to EMS arrival. LPN Q reported that once EMS arrived, EMS identified that R103 was in asystole and directed her to begin CPR. Review of R103's Ambulance Report dated [DATE] revealed the ambulance dispatcher received a call for emergency service at 9:02 PM. At 9:10 PM the paramedics made contact with R103. Narrative History Text: EVENTS LEADING TO ILLNESS/INJURY: staff states Pt (patient) was steadily declining for several hours and complaining of difficulty breathing. POSITION PT FOUND/INITIAL SCENE FINDINGS: pt lying supine on her bed with a backboard under her. Agonal respirations, no pulses, staff was not performing CPR. (Agonal breathing is characterized by slow, very shallow irregular respirations that result from anoxic brain injury. This will often progress to apnea (absence of breath) depending on the underlying cause NIH 2023). PT LAST SEEN AT AND BY: (Staff at the nursing facility throughout the evening) COMPLAINT(S) PRIOR TO ARREST: (Dyspnea) . CHECK THE FOLLOWING CONDITIONS CONSIDERED AS THE CAUSE OF THE CARDIAC ARREST . hypoxia (low oxygen level) (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ADDITIONAL ASSESSMENT NOTES (IF APPLICABLE): Prior to arrival, the call came across as a cardiac arrest. On arrival, Pt (patient) was lying in her bed unresponsive with agonal respirations and secretions coming out of her mouth. Staff were not performing CPR. no pulses were found. CPR was initiated by ALS. ALS directed available staff to assist in chest compressions and ventilations. Staff needed constant coaching on compression rate and depth and were unable to complete two minute cycles of compressions. Average time of compressions was about 30 seconds and then they were too tired and would switch out. Staff also needed constant coaching on mask seal, respiration rate and amount of oxygen per breath. Initial pulse and rhythm check showed asystole with no pulses . Review of R103's Emergency Department Hospital Records dated [DATE] at 10:38 PM revealed This is a [AGE] year-old female with unknown past medical history presenting after cardiac arrest. On arrival, the patient is pulseless. CPR is initiated . After 2 rounds of CPR and 1 dose of epinephrine, the patient regained pulses .Based on the degree of anasarca (fluid accumulation), as well as pulmonary edema, suspect this was likely a respiratory arrest at this time . This is a [AGE] year-old female with unknown past medical history presenting after cardiac arrest. Per EMS, patient was declining at his care facility for 3 hours. When EMS arrived, she was agonal breathing and was pulseless. They started CPR . Review of R103's Emergency Department Hospital Records dated [DATE] at 11:04 PM revealed, This is a 85 y.o. female who presents today as a post arrest. Patient reportedly per EMS had been going downhill for 3 hours before she went down in front of staff. They did not start CPR on the patient. EMS found her to be agonal with PA .She got 5 rounds of epinephrine from EMS and they did get a pulse back. As they were wheeling her into the Trauma Bay, patient lost her pulse and she have CPR started by us. She did get a dose of epinephrine and her pulse came back .Patient was found to be hypoglycemic (low blood sugar) and was given D50 .Patient was admitted to the intensive care unit. The resident did update the family and family wants to pursue all aggressive measures. R103's blood sugar level was 45 (normal range ,d+[DATE]). Review of R103's Inpatient Hospital Records dated [DATE] at 3:34 AM revealed, Pt (patient) is an 85 y/o female with history of DM (diabetes mellitus), PVD (peripheral vascular disease), s/p right BKA (status post right below knee amputation), dementia admitted after cardiac arrest. By report, she was having respiratory distress at her facility and EMS was called. On EMS arrival, she was agonally breathing and found to be in PEA (pulseless electrical activity) arrest. CPR initiated. She received 5 doses of epinephrine prior to ROSC (return of spontaneous circulation). On arrival to the ER, she again was found pulseless and received 2 more rounds of CPR .Her daughter (DPOA) arrived shortly after admission and the patient's grave prognosis was discussed. The patient had escalating presssor (raises blood pressure) requirements and remained unresponsive throughout her stay. Her daughter opted to transition to comfort care after having her pastor come to the bedside. Her high dose pressors were discontinued, a morphine drip started and she was extubated. On ,d+[DATE] at 0330 she was found without spontaneous pulses or respirations. She was unresponsive to any stimuli and her pupils were fixed and dilated. She was pronounced deceased at that time. On [DATE] the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy identified on [DATE] that began on [DATE] due to the facility's failure to immediately perform Cardiopulmonary Resuscitation on a Full Code resident. A written plan for removal for the immediate jeopardy was received on [DATE] and the following was verified on [DATE]: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Identification of Residents Affected or Likely to be Affected: *On [DATE], the facility completed a root cause analysis of the event and determined the licensed nurse did not identify the immediate need to initiate CPR on the resident. The licensed nurse was provided education by the facility Director of Nursing/designee on the BLS guidelines for the initiation of CPR with return demonstration. *The facility determined all other FULL CODE residents are at risk. On [DATE], the facility audited all resident deaths in the last 30 days via review of their electronic health record. The audit results showed that there were no other FULL CODE residents who had a medical emergency who did not receive CPR per current standards of practice. Current residents were assessed for an acute change in condition on [DATE] with no notable deviation from baseline or medical emergency requiring CPR. *Facility Medical Director was notified of the incident on [DATE]. *The DON/designee completed a chart audit on current residents and compared the Medical Treatment Decision Forms to the physician order for accuracy on [DATE]. Identified discrepancies were addressed at the time of the event. *On [DATE], the emergency carts at the facility were audited by the DON/designee to ensure all necessary items are present - no concerns were identified. *On [DATE], all current residents were assessed by a licensed nurse for an acute change in condition. *On [DATE], the Administrator and DON were provided counseling by the Regional Director of Operations on the Mission Point expectations related to investigations and the systemic reporting of adverse events to ensure appropriate personnel are notified of such matters. 2. Actions to Prevent Occurrence/Recurrence: *The Cardiopulmonary Resuscitation Policy was reviewed by the facility Administrator, DON and Medical Director and deemed appropriate. *Beginning on [DATE], the DON/designee educated the licensed nurses on the Cardiopulmonary Resuscitation Policy, including how to assess the need, monitor and perform CPR. *On [DATE], the facility Human Resources Business Partner performed an audit of all licensed nurses CPR certifications - all licensed nurses are up to date with certification. *Beginning on [DATE], DON/designee performed a Code Blue drill and/or return demonstration on all shifts until every nurse had participated at least once. This will continue until all nurses have been educated. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: [DATE] (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although the immediate jeopardy was removed on [DATE], the facility remained out of compliance at a scope of isolated and severity of actual harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency. Review of the facility policy Cardiopulmonary Resuscitation (CPR) - Adult dated ,d+[DATE] revealed, Appropriate cardiac and respiratory function will be maintained until a definitive treatment can be given. CPR will be initiated on all residents with an Advanced Directive stating CPR-Full Resuscitation except in circumstances where you are responding to an emergency (drowning, choking, or electrocution). It is the policy of this facility to respect each resident's individual, informed decision regarding advance directives and code status. Cardiopulmonary Resuscitation (CPR) will be initiated for residents who have requested CPR, for residents who have not formulated an advance directive and for residents who do not have a valid DNR order. To provide Basic Life Support (BLS) to residents with absence of respirations and pulse, as designated by resident or legal guardian except in circumstances listed above. Policy Explanation and Compliance Guidelines: 1. In the event a resident is identified unresponsive and upon a thorough assessment determines that there is no pulse or respiratory activity and the resident has declared a full-code status, a BLS certified staff member will: a. Simultaneously with the initiation of chest compressions direct a staff member to immediately retrieve the emergency cart. b. Continue to administer chest compressions and rescue respirations per the American Heart Association recommendations. c. Direct a staff member to contact the Emergency Response Team (911) immediately to inform them of a full code requiring life support interventions and possible transportation to the emergency department. d. Direct a member of the response team to contact the attending physician and responsible party/DPOA/guardian. This staff member shall also complete a hospital transfer sheet including a copy of advance directives/code status and make these documents available to Emergency Response Personnel. e. Identify a member of the response team to be responsible for documenting the time of each (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	intervention and resulting response. Documentation should include but not limited to: 1) Date and time of arrest and name(s) of person(s) assisting with CPR, including the recorder. 2) Medications given. 3) Treatments performed. 4) Results of resuscitation. 5) Time AED was placed and whether or not shock advised if available. 6) Date and time family and doctor notified. 7) Assessment done. 8) Where resident was transferred to (i.e., EMS Agency or Mortuary). Mission Point Healthcare Systems 9) A debriefing with staff involved in the code response as needed. f. Facility staff shall defer all resuscitation efforts to Emergency Response Personnel once they arrive at the location and declare that they will assume the responsibility of maintaining life support interventions. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, A saturation greater than 93% is acceptable while a saturation of less than 90% is a clinical emergency. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 483). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Hypoxia is inadequate tissue oxygenation at the cellular level. It results from a deficiency in oxygen delivery or oxygen use at the cellular level. It is a life-threatening condition. Untreated, it has the potential to produce fatal cardiac dysrhythmias ([NAME] and [NAME], 2019). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A. ; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 917). Elsevier Health Sciences. Kindle Edition. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Patients with sudden changes in their vital signs, LOC (level of consciousness), or behavior may be experiencing profound hypoxia .If a patient's hypoxia is severe and prolonged, cardiac arrest results. A cardiac arrest is a sudden cessation of cardiac output and circulation. When this occurs, oxygen is not delivered to tissues, carbon dioxide is not transported from tissues, tissue metabolism becomes anaerobic, and metabolic and respiratory acidosis occur. Permanent damage to the heart, brain, and other tissue occurs within 4 to 6 minutes. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. ,d+[DATE]). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Cardiopulmonary Resuscitation During cardiac arrest there is an absence of pulse and respiration. Patients in cardiac arrest require immediate cardiopulmonary resuscitation (CPR), a basic emergency procedure of artificial respiration and manual external cardiac massage. The sequence for CPR is C-A-B: chest compression, early defibrillation, establishing an airway, and rescue breathing (Link et al., 2015). The American Heart Association (AHA, 2015) continues to research cardiac arrest treatment and outcomes. In adults (the majority of cardiac arrests) the critical initial elements found to be essential for survival were adequate chest compressions and early defibrillation. Adequate compressions in adults need to occur at a rate of 100 to 120/ minute with a depth of at least 2 inches and allowance for time for the chest to recoil. Passive ventilation is no longer recommended in patients undergoing conventional CPR in the community setting, although it may be used in emergency medical service settings (Neumar et al., 2015). Defibrillation delivers an electrical current to the myocardium that stops all electrical activity and allows the heart's normal pacemaker to resume its normal activity ([NAME], 2017). It is recommended that defibrillation occur within 5 minutes for an out-of-hospital sudden cardiac arrest and within 3 minutes for a patient in a hospital. An automated external defibrillator (AED) (Box 41.10), available in many public places, such as schools, airports, and workplaces, can be used by health care providers and lay individuals alike to defibrillate people with cardiac arrest (AHA, 2018; Neumar et al., 2015). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 944). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Automated External Defibrillator o The automated external defibrillator (AED) is a device used to administer an electrical shock through the chest wall to the heart to stop the abnormal rhythm and restore a normal heart rhythm. The AED has built-in computers that assess a patient's heart rhythm and determine whether defibrillation is necessary. New technology has made them user friendly, with audio and visual cues telling users what to do when using them. The AED delivers a shock to the patient after announcing, Everyone stand clear of patient. A shock is delivered only if the patient needs it (NHLBI, n.d.b). Lay rescuer AED programs train lay personnel on the use of the AED (AHA, 2018). The AED is used to strengthen the chain of survival. Patients who received a shock from an AED available in the public had a higher survival rate and rate of discharge from the hospital than those who did not (AHA, 2018). For witnessed ventricular fibrillation, early cardiopulmonary resuscitation with defibrillation within the first 3 to 5 minutes results in greater survival rates ([NAME] et al., 2017). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 944). Elsevier Health Sciences. Kindle Edition.

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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 - Immediate jeopardy to resident health or safety 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** 39056 This citation pertains to intake #: MI00135410 Based on observation, interview, and record review the facility failed to 1.) stock or re-stock medication carts with necessary medications for residents and 2.) ensure that all on-duty nurses had access to the pyxis (medication dispensing system) in the event of a medical emergency resulting in an immediate jeopardy when, beginning on [DATE], the facility licensed nurses did not have access to and were unable to administer emergency/life-saving medication to a resident in hypoglycemic crisis (R102) resulting in her death. This deficient practice places all diabetic residents at risk for serious harm, injury and/or death. Findings: Resident #102 (R102) Review of an Admission Record revealed R102 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: Type 2 Diabetes. Review of the Standing Orders revealed that Glucose Gel (Hypoglycemic event-Conscious), Glucose IM (Hypoglycemic event-Unconscious), and Hypoglycemic Crisis-May follow facility policy were available to order as an order set by nursing staff. Review of R102's Order Summary revealed no Standing Orders for hypoglycemic event medications. Review of R102's Blood Sugar Log revealed on [DATE] at 7:23 AM R102's blood sugar was 49 (blood sugar range ,d+[DATE]). Review of R102's Electronic Health Record (EHR) revealed the provider was not notified of the critical low blood sugar result. Review of R102's Nursing Progress Note dated [DATE] at 10:15 AM revealed, Called to residents room- resident with garbled speech and drooling. - Accucheck (blood sugar check) completed- was 37. Pudding , OJ (orange juice), 1 tube glucose, Accucheck 45-provider called- new order for glucagon given. and a repeat glucagon given. Accucheck 123- Resident groggy but beginning to answer questions. 11am blood sugar 210. Provider notified. Will continue to offer fluids and food. Review of R102's EHR revealed the 2 doses of glucagon was not documented as ordered and was not documented as administered. On [DATE] at 7:53 AM, Nursing Home Administrator (NHA) verified R102's glucagon was not ordered in the EMR and was not documented as administered. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R102's Nursing Progress Note dated [DATE] at 6:23 AM revealed, During am (morning) med (medication) pass this nurse entered resident's room to give her am medication and noted resident had small emesis on pillowcase and on shoulder. Resident not arousable. Resident breathing, R18 (respirations 18). Blood sugar checked immediately, 27. Checked unit for Glucagon and/or Glutose gel. None found. Requested assistance from other LPN (Licensed Practical Nurse). Called NP (Nurse Practitioner) on call, ordered to send patient to ER (emergency room). Called 911 at 0503. Glucose tab crushed and administered while waiting for EMS. Daughter notified of situation. Reentered room and found resident was no longer breathing, EMS (Emergency Medical Services) arrived and took over care. Resident DNR (Do Not Resuscitate), no CPR (Cardiopulmonary Resuscitation) provided. EMS called time of death at 0529 (5:29 AM). Notified daughter that resident had passed away. Other LPN notified DON (Director of Nursing). RN (Registered Nurse) arrived at shift changed and notified administrator. Review of R102's Emergency Medical Services Report (company name omitted) dated [DATE] revealed the 911 call was received at 5:05 AM and the paramedics/EMTs made contact with R102 at 5:18 AM. Patient is a nursing home resident was last spoken to at 0300 HRS (3:00 AM). Staff now found unresponsive patient and suspecting a diabetic issue. They called 911. ATF (arrived to find) unresponsive/apneic/pulseless patient in semi-Fowlers (inclined position ,d+[DATE] degrees on back) position in bed. EKG (electrocardiogram) rhythm is asystole (no heartbeat). Pupils dilated/non-reactive .Time of death 0529 HRS (5:29 AM) . During an interview on [DATE] at 9:41 AM, Confidential Informant (CI) A reported that R102 had an incident of hypoglycemic crisis on [DATE] where she required glucagon which resolved her symptoms and raised her blood sugar. On [DATE] in the early morning, R102 was found unresponsive with a blood sugar of 27 and the nursing staff on duty did not have access to glucagon resulting in R102's death. CI A reported R102 was admitted to the facility for short term rehab and was to be discharged home on [DATE]. CI A reported that R102's death was avoidable and felt that facility management did not appropriately handle R102's death, investigate the incident, or put a system in place to ensure this could not happen again. During an interview on [DATE] at 5:35 AM, Licensed Practical Nurse (LPN) E reported that during his shift ([DATE]-[DATE] night shift) R102 had been stable throughout the night. LPN E reported that during morning medication pass around 5:00 AM, R102 would not wake up. LPN E reported he assessed her blood sugar level, and it was incredibly low. LPN E immediately accessed the medication cart to obtain a glucagon IM (intramuscular) injection or gel (emergency medication used to treat severe hypoglycemia) and there was no glucagon available to administer. LPN E reported that he ran to the other units to obtain glucagon and assistance from the only other scheduled nurse in the facility (LPN L). LPN E reported that there was no glucagon available in the medication carts on the other units (4 units in the facility). LPN E and LPN L then attempted to gain access to the facility's pyxis (medication storage unit that requires login and password) but both had not been given access. LPN E reported that because he was unable to obtain the glucagon, he crushed glucose tabs and placed it in R102's mouth in an attempt to raise her blood sugar and save her life. LPN E reported that at that point R102 did have a pulse or respirations and he called 911. LPN E reported that by the time EMS arrived to the facility R102 was without a pulse and/or respirations. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN E reported that glucagon IM, gel, and tabs were to be available in the medication cart on the unit in case of an emergency. LPN E reported that he had not been told in nurse-to-nurse report of R102's low blood sugar levels on [DATE] or [DATE] and was unaware that she had required glucagon x2 on [DATE] as it was not reflected in the EHR. LPN E reported that had he been aware of R102's hypoglycemic emergencies he would have ensure he had glucagon available in the case of an emergency. LPN E reported that had he had access to the emergency medication, glucagon, R102's would likely have had a different outcome (R102 would have survived). LPN E reported R102 was scheduled to discharge home in the next couple days. During an interview on [DATE] at 1:06 PM, LPN J reported that she did not have access to the facility pyxis until after R102 died on [DATE]. LPN J reported that prior to the incident that occurred on [DATE] R102 had had critically low blood sugar and required glucagon. LPN J reported that only an agency nurse had access to the pyxis to pull the glucagon during that incident. LPN J reported that nursing management (Unit Managers and DON) were notified at that time that the facility nurses needed to pull glucagon from the facility pyxis but were unable to because the facility nurses did not have access. LPN J stated, the DON knew we didn't have access to the pyxis prior to the incident. It wasn't a secret. LPN J reported that had the DON ensured all licensed nurses had access to the pyxis when they were made aware, LPN E would have had the ability to obtain the glucagon from the pyxis and administer it to R102. LPN J reported that the facility nurses were upset about R102's death because it was preventable and told the DON that all of the medication carts needed an emergency glucagon IM to ensure this didn't happen again, but the DON reported that glucagon IM expires and therefore it would be kept in the pyxis. LPN J reported R102 was to be discharged home on [DATE] but because the licensed nurses did not have access to emergency medication she died . During an observation and interview on [DATE] at 11:37 AM, the medication carts on the 100 Unit and 200 Unit were reviewed with Registered Nurse (RN) B. The 200 Unit medication cart did not contain glucagon IM or Gel and the 100 Unit medication cart contained 1 glucagon IM injection assigned to 1 resident. The 100 Unit medication cart did not contain glucagon gel. RN B reported concerns that in the case of a hypoglycemic emergency there would be no way to quickly administer glucagon and reported the 100 Unit and 200 Unit had multiple residents on insulin. During an observation and interview on [DATE] at 11:57 AM, the medication cart on the 300 Unit was reviewed with Licensed Practical Nurse (LPN) C. The 300 Unit medication cart contained 1 glucagon IM injection assigned to a resident. LPN C reported that if a resident required glucagon, it would be located in the facility pyxis if there was not one assigned to them in the medication cart. LPN C reported any resident that receives insulin should have an order for glucagon IM and Gel and it should be located on their unit medication cart. During an interview on [DATE] at 11:20 AM, LPN Y reported that at the time the Immediate Jeopardy was served, she had not had access to the facility pyxis. During an interview on [DATE] at 9:38 AM, LPN U reported that at the time the Immediate Jeopardy was served, she had not had access to the facility pyxis. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:00 AM, NHA reported that R102's hypoglycemic crisis/death and was identified and reviewed on [DATE]. NHA reported that the root cause for the incident was lack of access to the pyxis and it was identified as a widespread issue. NHA reported that beginning on [DATE] the Director of Nursing (DON) was completing an audit to ensure all licensed nursing staff, including agency nurses, had access to the pyxis as well as ensuring all diabetic residents had blood sugar parameters and appropriate medications ordered in the Electronic Health Record following the facility hypoglycemia policy and standing orders. On [DATE] the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy identified on [DATE] that began on [DATE] due to the facility's failure to ensure that all on-duty nurses had access to the pyxis in the event of a medical emergency. A written plan for removal for the immediate jeopardy was received on [DATE] and the following was verified on [DATE]: 1. Identification of Residents Affected or Likely to be Affected: *Facility Medical Director was notified of the incident on [DATE]. *All diabetic residents are at risk and are considered like residents. *On [DATE] the DON/designee began an audit of all residents with a diabetes diagnosis for blood sugar parameters, and to ensure orders for glucagon gel/tabs in place. *On [DATE] the DON/designee performed an audit for glucagon gel/tabs available in carts - glucagon available on cart. *On [DATE] current residents were assessed by a licensed nurse for an acute change in condition. Two LOA residents on [DATE] were assessed by a licensed nurse on [DATE]. *On [DATE] the Administrator and DON were provided counseling by the Regional Director of Operations on the Mission Point expectations related to investigations and the systemic reporting of adverse events to ensure appropriate personnel are notified. Actions to Prevent Occurrence/Recurrence: *On [DATE] nursing staff audited for log-in access to backup device of medications. On [DATE] all facility licensed nurses and Agency nurses who did not have access to the backup device were entered and provided access to emergency use medications. The staffing roster is reviewed daily to monitor for Agency nurses who need access. The DON or designee will assign log in and provide training prior to shift start time. *On [DATE] the Diabetes Management policy was reviewed and deemed appropriate by the facility Administrator, DON and Medical Director. *Beginning on [DATE], the DON/designee educated the licensed nurses on the Diabetes Management Policy. Facility licensed nurses and Agency nurses will be educated prior to working their next scheduled shift. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*On [DATE] the facility completed an Ad Hoc QAPI and will continue to review for continued monitoring and compliance during monthly QAPI. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: [DATE] Although the immediate jeopardy was removed on [DATE], the facility remained out of compliance at a scope of isolated and severity of actual harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency. Review of the facility policy Diabetic Management: Hyper/Hypoglycemic Events last revised ,d+[DATE] revealed, .Residents with diabetes mellitus will be monitored and treated for hypoglycemia and/or hyperglycemia according to Clinical Practice Guidelines and per physician orders .1. Hypoglycemic Event: A hypoglycemic event is defined by a blood sugar less than 70 mg/dl or markedly less than usual for a resident who is exhibiting symptoms .2. Hypoglycemic Event Protocol: If blood sugar is less than 70 mg/dl or markedly less than usual for an individual resident who is exhibiting symptoms, suspect a hypoglycemic event and begin treatment as follows .b. PROTOCOL B - for Unconscious Resident: i. Administer one of the following: 1 mg or 1 unit of Glucagon subcutaneous or IM 50 ml of IV 50% Dextrose. ii. Recheck blood sugar in 30 minutes and if blood sugar remains under 100 or if resident is still unconscious or unresponsive phone emergency services .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00135410 Based on observation, interview and record review, the facility failed to 1.) follow physician ordered treatment for pressure injury/wound care 2.) notify the provider of a newly identified pressure injuries, 3.) ensure pressure injury/wound assessments were complete, accurate, and documented in the resident record for 3 residents (Resident #126, #114, and #108) resulting in the development of avoidable pressure ulcers, the delay in wound treatment, and the potential for delayed wound healing, infection, and overall deterioration in health status. Findings: Resident #126 (R126) Review of an Admission Record revealed R126 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes, heart disease, and kidney disease. Review of a Minimum Data Set (MDS) assessment for R126, Functional Status with a reference date of 3/2/23 revealed R126 required extensive 2 person assist with bed mobility and toileting, total dependence of 2 persons for transferring, and extensive 1 person assistance for personal hygiene. During an observation and interview on 04/17/2023 at 2:59 PM, R126 was receiving incontinence care and had been placed in her bed via a hoyer lift. R126's brief was saturated with strong smelling urine and a dressing was observed on her sacrum dated 4/16/23. Family Member (FM) LL reported that R126 was to be put to bed after meals as part of her care plan. FM LL reported that R126 had been up since before lunch and reported frustration that R126's care plan was not being followed especially after R126 developed a pressure injury on her sacrum. FM LL reported that R126 has had to wait for extensive periods of time for assistance after pressing the call light. FM LL reported that on 4/9/23 R126's call light was on for 65 minutes before staff were able to assist. FM LL reported that R126 now has a new pressure injury on her buttocks due to the facility staff leaving R126 in the same position and not following her care plan. FM LL reported that R126 has gone weeks without receiving a shower. FM LL reported that staffing on the weekends is concerning, and residents are not receiving quality care. Review of R126's Nursing Progress Note dated 4/12/23 at 4:59 PM revealed, stage 2 pressure sore observed on sacrum. 0.5cm x 1cm. Physician notified. IDT (Interdisciplinary Team) notified. tx (treatment) in place, wound PA (Physician Assistant) to eval (evaluate) 4/14/23. Review of R126's Weekly Skin Sweeps revealed the assessment was not completed weekly: *3/7/23-skin intact *3/18/23-skin intact (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*3/31/23-skin intact *4/12/23-skin impaired Review of R126's Weekly Skin Sweep dated 4/12/23 revealed documentation that R126 had an open area on her sacrum (no measurements.) Review of R126's Electronic Health Record revealed no documentation that Wound Physician Assistant (WPA) AA completed an evaluation on R126's pressure injury on 4/14/23. On 04/17/2023 at 11:51 AM, WPA AA verified that R126's pressure injury was not evaluated on 4/14/23 and she was not notified R126 required an evaluation. During an interview on 04/18/2023 at 10:05 AM, Infection Control Preventionist (ICP) BB reported that she had not been notified by the Unit Manager of R126's newly identified Stage II sacral pressure injury and verified that WPA AA had not assessed R126 on Friday 4/14/23. Resident #114 (R114) Review of an Admission Record revealed R114 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes, end stage renal disease, and heart disease. Review of a Minimum Data Set (MDS) assessment for R114, Functional Status with a reference date of 2/15/23 revealed R114 required extensive 2 person assist with bed mobility and toileting, total dependence of 2 persons for transferring, and extensive 1 person assistance for personal hygiene. During an interview on 04/17/2023 at 11:51 AM, WPA AA reported that on Friday (4/14/23) she was evaluating R114's right posterior heel and left heel and discovered that R114's dressing had not been changed and were the same dressings she had placed on the resident the week before (4/7/23). WPA AA reported that she had ordered bilateral lower extremity dopplers for R114 back in February for absent pedal pulses and notified Unit Manager (UM) I of the new order at that time. WPA AA reported that she discussed with the facility Nurse Practitioner that the bilateral lower extremity doppler had still not been completed and the facility Nurse Practitioner put in an order for it to be completed ASAP (as soon as possible.) Review of R114's Physician Order dated 2/3/23 revealed, Arterial doppler of bilateral lower extremities one time only for absent pedal pulses for 3 Days. Review of R114's Wound Progress Note dated 2/3/23 revealed, .Resident also noted to have absent pedal pulses, will check bilateral lower extremity arterial dopplers . Review of R114's Wound Progress Note dated 2/10/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse, but it appears they haven't been completed yet . Nurse initials and date, 2/14/23, handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R114's Wound Progress Note dated 2/24/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse, it appears they were done however the results are not available in (Electronic Health Record) for review . Nurse initials and date, 2/27/23, handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 3/5/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse, it appears they were done however the results are not available in (Electronic Health Record) for review . Nurse initials and date, 3/6/23, handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 3/17/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse, it appears they were done however the results are not available in (Electronic Health Record) for review, I did reach out to the CCC (Clinical Care Coordinator/Unit Manager) via email to see if she could check into this but have not heard back . Nurse initials and date, 3/21/23, handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 3/24/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse but I have not seen the results yet, the CCC looked into this and it appears it was not completed, CCC will get it ordered . Nurse initials and date, 3/29/23, handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 3/31/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse but I have not seen the results yet . Nurse initials and date, 4/5/23, handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 4/7/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse but I have not seen the results yet . Nurse initials and date, 4/11/23, handwritten on note ordered 4/11/23. Review of R114's Physician Order dated 4/8/23 revealed, Left heel wound: cleanse with saline and gauze, apply Santyl to the wound base and cover with a silicone super absorbent dressing. every day shift for pressure injury. Review of R114's Physician Order dated 4/11/23 revealed, BLLE arterial dopplers ASAP. one time only for absent pedal pulses for 3 Days. Review of R114's Wound Progress Note dated 4/14/23 revealed, (R114) is seen today to f/u (follow up) on the pressure injuries on her bilateral heels. The wound on the right heel was noted 9 weeks ago and the wound on the left heel was noted last week. At this time (R114) is lying in her bed. She states the wounds can be tender at times .Wound on the right posterior heel measures 1.4 x 1.6 cm, there is a depth of 0.1cm though this is not a true depth due to the presence of slough .Wound on the left heel measures 0.5 x 0.7cm, there is a depth of 0.1cm though this is not a true depth due to the presence of slough .It is noted that the dressings I removed from both wounds were the dressings I put on a week ago . Confirming the presence of a new left heel pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R114's April Treatment Administration Record revealed no entries that the left heel wound treatment on 4/8/23, 4/9/23, or 4/10/23 indicating the treatment was not completed. On 4/11/23, 4/12/23, and 4/13/23 it was documented 9 (other/See Nurse Notes) indicating the treatment was not completed. Review of R114's Physician Order dated 3/25/23 revealed, Right heel wound: cleanse with saline and gauze, apply Santyl to the wound base, cover with a 2x2 gauze lightly moistened with saline then cover with a super absorbent dressing. every day shift for pressure injury. Review of R114's April Treatment Administration Record revealed no entries for the right heel wound treatment on 4/1/23, 4/2/23, 4/5/23, 4/8/23, 4/9/23, or 4/10/23 indicating the treatment was not completed. On 4/11/23, 4/12/23, and 4/13/23 it was documented 9 (other/See Nurse Notes) indicating the treatment was not completed. Review of R114's Electronic Health Record revealed no documentation as to why the treatments had not been completed or that the provider had been notified that the treatment had not been completed. Resident #108 (R108) Review of an Admission Record revealed R108 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of sacral region Stage 4, pressure ulcer of right ankle Stage 4, and Huntington's Disease. Review or R108's Physician Order dated 3/25/23 revealed, Sacral ulcer: cleanse with saline and gauze, apply calcium alginate Ag to the wound base and cover with a 4x4 Comfort foam border dressing every day shift for stage 4 pressure injury. Review of R108's April Treatment Administration Record revealed no entries for the sacral ulcer on 4/14/23 indicating the treatment was not completed. Review or R108's Physician Order dated 4/10/23 revealed, Right Lateral Ankle wound: cleanse with saline and gauze and cover with a bandaid. every day shift every Mon, Wed, Fri for wound. Review of R108's April Treatment Administration Record revealed no entries for the right lateral ankle wound on 4/12/23 and 4/14/23 indicating the treatment was not completed. Due to the treatment schedule, R108's dressing was last changed on 4/10/23. As of 4/17/23 at 9:11 AM the dressing had not been documented as changed. Review of R108's Electronic Health Record revealed no documentation as to why the treatments had not been completed or that the provider had been notified that the treatment had not been completed. Review of R108's Weekly Skin Sweeps revealed the assessment was not completed weekly and was completed on 3/8/23, 3/22/23, and 4/6/23 (as of 4/17/23 at 9:04 AM). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2023 at 9:48 AM, LPN U reported that the facility did not have a dedicated wound care nurse to ensure weekly skin assessments, weekly wound assessments, and treatment orders changes were completed and monitored or a dedicated wound care nurse to follow Wound Physician Assistant (WPA) AA when she made rounds on residents on Fridays. LPN U reported that if there were any new skin concerns, licensed nurses would notify the Unit Managers and they were responsible for notifying WPA AA. LPN U reported that there were 8 Weekly Skin Assessments due for her residents on 4/17/23 but because the facility had only 2 on-duty nurses at that time and she was now responsible for Country Lane Unit residents, she would not be able to complete the Weekly Skin Assessments on her shift. LPN U reported nursing management was aware of her workload/assignment and her inability to complete the tasks accurately and comprehensively. During an interview on 04/17/2023 at 11:51 AM, WPA AA reported that during wound rounds in a facility the expectation is to have a management nurse (Infection Control/Director of Nursing/Unit Manager), assist with pressure injury/wound assessments in order to ensure members of management understand the treatment plan and visualize the progress/decline of the pressure injury/wound. WPA AA reported that she had not had a management nurse round with her in months. At least 4 months. During an interview on 04/18/2023 at 10:05 AM, Infection Control Preventionist (ICP) BB reported that she was not the wound care nurse but did track pressure injuries and wounds as part of the infection control surveillance program. ICP BB reported that the Unit Managers (UM I and UM F) would round with WPA AA weekly for their units, responsible for ensuring Weekly Skin Sweeps and Wound Assessments were completed, responsible for notifying ICP BB of newly identified pressure injuries/wounds, and responsible for notifying WPA AA of wounds that would require WPA AA's consultation. ICP BB reported that WPA AA would round on residents with ongoing pressure injuries/wounds and newly identified pressure injuries at a Stage II and beyond, weekly on Friday's. ICP BB reported that after WPA AA completed wound evaluations/treatments the UM's would provide ICP BB with wound notes and measurements in order for ICP BB to track wound progress and treatment orders/changes on the Wound Log. ICP BB reported that if a CNA identifies a skin integrity concern, they report that to the direct care nurse. The direct care nurse would then complete a Skin Assessment and notify the Unit Manager of the pressure injury/wound. The Unit Manager would follow-up with the pressure injury/wound and, if required, have WPA AA evaluate and treat the resident. ICP BB confirmed that staffing insufficiencies had caused the process to be impeded. (continued on next page)

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	235039	A. Building B. Wing	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Grandville	3400 Wilson Ave Grandville, MI 49418

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/2023 at 6:51 AM, Certified Nursing Assistant (CNA) N and CNA M reported concerns with staffing levels. CNA N stated staffing is unsafe and resident needs are not being met. CNA N reported that there were currently 22 residents on the Garden Unit and the majority are extensive assist and total assist. CNA N reported that falls and pressure injuries had skyrocketed because it was impossible to meet the needs of all of the residents with the number of staff available each shift. CNA N reported that frequently 3rd shift has only one CNA and 1 nurse that covers 2 units which leave the CNA alone to reposition, perform incontinence care, supervise, and toilet residents. CNA N reported that on 1st and 2nd shift there were consistently 2 CNAs scheduled to work the Garden Unit but with only 2 CNAs and a nurse that is required to cover 2 units (Garden and Country Lane), facility staff can't reposition, change, shower, and get ADL (Activities of Daily Living) care done for the residents. CNA N stated facility nurses and CNAs have to cut corners and have had to put resident biweekly showers on the backburner in order to ensure residents are supervised and are receiving incontinence care (brief changes) to prevent additional pressure injuries. CNA N reported they do the best they can to get residents repositioned, up for meals, changed, and fed but how can we do it all with the staff scheduled each shift? During an interview on 04/13/2023 at 9:45 AM, CNA O reported that there were not enough staff to meet residents needs consistently. CNA O reported a significant rise in resident falls and pressure injuries and reported there were multiple residents residing in the facility with behaviors which could not be adequately monitored or supervised because of insufficient staff. During an interview on 04/13/2023 at 8:53 AM, Licensed Practical Nurse (LPN) MM stated staffing is horrible and the facility was to be staffed with 4 nurses on 1st and 2nd shift based on the resident acuity and number of residents, but they rarely schedule 4 and at times only schedule 2 nurses. LPN MM reported that residents do not get checked and changed every 2 hours as required by professional standards which has resulted in an increase in pressure injuries. LPN MM reported that residents with pressure injuries/wounds are not receiving wound care and recently there was a resident that had a dressing in place for an unknown amount of time, without an order, and no documentation. LPN MM reported when the dressing was removed it was stiff from the amount of drainage that was allowed to dry. LPN MM reported that weekly skin assessments were not being completed because of the number of residents nurses are responsible to pass medications to. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/2023 at 4:46 PM, Previous Registered Nurse (RN) T reported that they quit working at the facility due to unsafe staffing ratios and fear of losing their nursing license. RN T reported that they primarily worked the Garden Unit and, on many shifts, they were scheduled with just 1 CNA. RN T reported the Garden Unit housed 24 residents that required extensive and/or total assistance with 2 staff members for transferring, incontinence care, toileting, bed mobility, and personal hygiene. RN T reported that residents would not receive adequate care and supervision and there was a significant rise in resident falls and pressure ulcers. RN T stated there were falls all the time and they had a hard time getting (wound) treatments done or medications passed timely. RN T reported there was an increase in pressure injuries because the staff couldn't turn (reposition) them (residents) when they should and it was frustrating. RN T stated all the little things pile up and reported wound treatments were not completed or completed late, skin assessments were not completed weekly and therefore new pressure injuries were identified late (delay in treatment), showers were not being completed so CNAs were not identifying and reporting skin integrity concerns, ultimately resulting in resident neglect. RN T reported corporate was aware of the staffing concerns but would tell the facility nurses and CNAs that they were meeting the State staffing ratios. RN T reported staffing was based on numbers and not resident acuity or the increase in the residents' negative outcomes. During an interview on 04/12/2023 at 7:40 PM, Previous CNA S reported that they had recently quit working for the facility because of the lack of staff and concerns with resident safety. CNA S reported that the Garden Unit was insufficiently staffed and frequently only had 1 CNA scheduled for the unit with 1 nurse responsible for 2 units (Garden and Country Lane) leaving the CNA alone on the Garden Unit. CNA S reported that 1 CNA was not enough to meet the needs of 24 dementia and high acuity residents, many of whom required extensive and/or total dependence with 2 staff for transferring, repositioning, personal hygiene, and toileting. CNA S reported that because of the lack of staff and inability to provide care following professional standards of practice (every 2-hour repositioning, incontinence care, out of bed for meals and activities, etc.) there had been a significant increase in falls and pressure injuries, lack of showers and personal hygiene care, and residents left in bed for extended periods of time. During an interview on 04/13/2023 at 1:06 PM, LPN G stated the past few months staffing has been so bad and licensed nurses and CNAs can't safely take care of these patients. 35 patients is too many. LPN G reported that on any given shift there would be 1-2 aides per Unit, and it was not possible to ensure all residents were fed, changed, and showered following professional standards of practice. LPN G stated, there have been times people have been sick. I would have noticed if I didn't have 2 units (to cover). How could I catch that. If I'm passing pills on 40 residents. LPN G reported that recently there had been a significant increase in falls, wounds, and deaths and stated, it's been really hard to watch an increase of all of this. On 4/18/23 this surveyor was notified that Unit Manager (UM) I and UM F had ended their employment with the facility. Unable to interview UM I and UM F regarding pressure injury prevention and treatment prior to survey exit on 4/18/23 at 5:30 PM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Skin and Pressure Injury Risk Assessment and Prevention dated 3/23 revealed, It is our policy to perform a skin assessment and pressure injury risk assessment as part of our systematic approach to pressure injury prevention and management. (Facility) utilizes the [NAME] & [NAME] clinical Nursing Skills/Techniques and National Pressure Ulcer Advisory Panel for procedural guidance .1. A skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury . Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Repositioning (turning) patients is a consistent element of evidence-based pressure injury prevention (EPUAP, NPIAP, PPPIA, 2019a). The twofold aim of repositioning should be to reduce or relieve pressure at the interface between bony prominence and support surface (bed or chair) and to limit the amount of time the tissue is exposed to pressure (Maklebust and [NAME], 2016). Elevating the head of the bed to 30 degrees or less decreases the chance of pressure injury development from shearing forces (WOCN, 2016). Change the immobilized patient's position according to tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, skin condition, and comfort (EPUAP, NPIAP, PPPIA, 2019a). A standard turning interval of 1.5 to 2 hours does not always prevent pressure injury development; repositioning intervals are based on patient assessment. Some patients may need more frequent position changes, while other patients can tolerate every-2-hour position changes without tissue injury. When repositioning, use positioning devices to protect bony prominences (WOCN, 2016). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1255). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, The use and documentation of a systematic approach to monitor progress of an actual pressure injury leads to better decision making and optimal outcomes ([NAME], 2016). Several healing and documentation tools are available to document wound assessments over time. Using a tool helps link assessment to outcomes so that an evaluation of the plan of care follows objective criteria ([NAME], 2016). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1256). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, A health care provider's order for wound care indicates the dressing type, the frequency of changing, and any solutions or ointments to be applied to the wound. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1262). Elsevier Health Sciences. Kindle Edition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39056 This citation pertains to intake #: MI00135410 Based on observation, interview, and record review, the facility failed to provide adequate supervision and sufficient staff to prevent falls for 12 residents (Resident #104, #122, #115, #118, #119, #120, #121, #110, #123, #124, #117, and #125) resulting in a total of 14 falls in a 14-day period and R104 sustaining a pelvic fracture after a fall. Findings include: Resident #104 (R104) Review of an Admission Record revealed R104 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: history of falling. Review of a Minimum Data Set (MDS) assessment for R104, with a reference date of 2/16/23 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated R104 was moderately cognitively impaired. Review of the Functional Status revealed that R104 required limited assistance of 1 person for walking in room and personal hygiene and supervision of 1 person for toileting. Review of R104's ADL Care Plan revealed, I have an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Activity Intolerance, Fatigue, Impaired balance with hx (history) of falls .I will attempt to transfer myself. Date Initiated: 05/13/2022 . MOBILITY: I ambulate with walker with one assist 100 feet in hall. Date Initiated: 12/14/2022 . Review of R104's Fall Care Plan revealed, I am at an increased risk for falls r/t Confusion Deconditioning, Gait/balance problems, History of Falls, I have health conditions that increase my risk for falls: cardiovascular, Nutritional, DM (Diabetes Mellitus), Anemia, CVA (stroke). I do not like to call for assistance and have been educated on call light use. Date Initiated: 05/13/2022 . Assist and stay with me while I am in the bathroom Date Initiated: 05/13/2022 . Review of R104's Incident Report dated 4/8/23 at 6:45 AM revealed, As this nurse was counting with relief, this nurse hears Help, help. This nurse opens res' (residents) door, pull back his curtain and observed res lying on his back on the floor feet facing his bed. Res only wearing his brief . Res going back to bed coming from the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R104's Hospital Record dated 4/9/23 revealed, Information provided by patient. (R104) is a 78 y.o. male with a PMHx (past medical history) of failure to thrive, anxiety disorder, Covid 19, depression, HLD (hyperlipidemia), Type 2 Dm (diabetes), and HTN (hypertension), admitted on [DATE] with chief complaint of Fall with right leg pain. The patient is a very poor historian and somewhat confused at the time of my examination. The patient is a resident at (facility) LTC (long term care). The patient tells me that he had a fall yesterday and is now having pain. Per EMS (Emergency Medical Services) and ED (Emergency Department) notes the patient had a unwitnessed fall two days ago at the nursing facility that he resides at . The patient otherwise is not able to tell me much about the fall. He does complain of pain in his right leg and buttock .Hospital Course: The patient was admitted to the hospitalist service for inferior and superior pubic rami fractures as well as right gluteal and obturator intramuscular hematoma with inability to ambulate . Orthopedic surgery recommended non-operative management . During an interview on 04/18/2023 at 6:36 AM, CNA EE reported that there were many residents with behaviors residing in the facility which requires increased monitoring and supervision. CNA EE reported that there were not enough nurses or CNAs to ensure behavioral residents were safe, monitored, and supervised which has resulted in many falls. CNA EE stated we can't manage the number of behaviors with the number of staff scheduled for each shift. CNA EE reported R104 was known to self-transfer and required increased supervision and monitoring. During an interview on 04/18/2023 at 9:38 AM, LPN U reported that R104 fell on [DATE] during nurse-to-nurse report and sustained pelvic fractures. LPN U reported that R104 required increased supervision and monitoring because of his behaviors and unsteadiness and stated, There were not enough staff to watch him, and he fell and broke his pelvis. LPN U reported that he should have been immediately sent to the hospital for evaluation but it took 2 days for them to send him out. Resident #122 (R122) Review of an Admission Record revealed R122 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: history of falling, weakness, unsteadiness on feet, difficulty in walking, dementia, and schizoaffective disorder. During an interview on 04/13/2023 at 9:55 AM, CNA W stated the falls are terrible here. CNA W reported that R122 recently had a fall with an arm fracture because R122 was impulsive and there were not enough staff to supervise her. CNA W reported R122's fall was caused because R122 was supposed to be put to bed after meals, but she was left in her wheelchair because there were not enough staff to assist her to bed. During an observation and interview on 04/13/2023 at 11:35 AM, there were 2 CNAs on the Garden Unit. CNA W reported that R122 had fallen in her bathroom. Upon entering R122's bathroom, she was observed with her head near the door and her feet near the toilet with CNA Z at R122's side ensuring she remained calm. CNA W and CNA Z reported they were unable to locate R122's nurse. A licensed nurse from a different unit was asked to assess R122 and arrived to R122's side at 11:45 AM. Review of the falls documented from 4/3/23-4/17/23 revealed the following: R115 fall on 4/12/23 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R118 fall on 4/3/23 R119 fall on 4/2/23 and 4/10/23 R120 fall on 4/13/23 R121 fall on 4/16/23 R122 fall on 4/13/23 R104 fall on 4/8/23 R110 fall on 4/13/23 and 4/15/23 R123 fall on 4/11/23 R124 fall on 4/8/23 R117 fall on 4/11/23 R125 fall on 4/7/23 12 residents fell with a total of 14 falls. During an interview on 04/12/2023 at 6:51 AM, Certified Nursing Assistant (CNA) N and CNA M reported concerns with staffing levels. CNA N stated staffing is unsafe and resident needs are not being met. CNA N reported that there were currently 22 residents on the Garden Unit and the majority are extensive assist and total assist. CNA N reported it was difficult to manage behaviors with many of the residents experiencing sundowning in the evenings. CNA N reported that there were recent elopements (R106 on 3/30/23 and 3/31/23) because there was insufficient staff to supervise the resident with a known behavior of wandering and stated, it could have ended tragically. CNA N reported that falls and pressure injuries had skyrocketed because it was impossible to meet the needs of all of the residents with the number of staff available each shift. During an interview on 04/13/2023 at 9:45 AM, CNA O reported that there were not enough staff to meet residents needs consistently. CNA O reported a significant rise in resident falls and pressure injuries and reported there were multiple residents residing in the facility with behaviors which could not be adequately monitored or supervised because of insufficient staff. During an interview on 04/13/2023 at 8:53 AM, Licensed Practical Nurse (LPN) MM stated staffing is horrible and the facility was to be staffed with 4 nurses on 1st and 2nd shift based on the resident acuity and number of residents, but they rarely schedule 4 and at times only schedule 2 nurses. LPN MM reported that residents do not get checked and changed every 2 hours as required by professional standards which has resulted in an increase in pressure injuries. LPN MM reported the Garden Unit housed many residents with high behaviors (impulsive, wandering, combative) and with insufficient staff for supervision, there has been a significant increase in falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/12/2023 at 4:46 PM, Previous RN T reported that they quit working at the facility due to unsafe staffing ratios and fear of losing their nursing license. RN T reported that they primarily worked the Garden Unit and, on many shifts, they were scheduled with just 1 CNA. RN T reported the Garden Unit housed 24 residents that required extensive and/or total assistance with 2 staff members for transferring, incontinence care, toileting, bed mobility, and personal hygiene. RN T reported that residents would not receive adequate care and supervision and there was a significant rise in resident falls and pressure ulcers. RN T stated there were falls all the time and they had a hard time getting (wound) treatments done or medications passed timely. During an interview on 04/12/2023 at 7:40 PM, Previous CNA S reported that they had recently quit working for the facility because of the lack of staff and concerns with resident safety. CNA S reported that the Garden Unit was insufficiently staffed and frequently only had 1 CNA scheduled for the unit with 1 nurse responsible for 2 units (Garden and Country Lane) leaving the CNA alone on the Garden Unit. CNA S reported that 1 CNA was not enough to meet the needs of 24 dementia and high acuity residents, many of whom required extensive and/or total dependence with 2 staff for transferring, repositioning, personal hygiene, and toileting. CNA S reported that because of the lack of staff and inability to provide care following professional standards of practice (every 2-hour repositioning, incontinence care, out of bed for meals and activities, etc.) there had been a significant increase in falls and pressure injuries, lack of showers and personal hygiene care, and residents left in bed for extended periods of times. During an interview on 04/14/2023 at 10:30 AM, Previous CNA GG reported that she quit working at the facility because of the poor quality of care she was forced to provide because of insufficient staffing. CNA GG reported that she frequently worked as the only CNA on the Garden Unit even with more than 20 residents that were high acuity extensive assist residents with no nurse on the Garden Unit due to her also working the Country Lane Unit. CNA GG reported prior to her quitting, there had been an increase in the number of falls and pressure injuries. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, When there is poor nurse staffing, resulting in larger numbers of patients assigned to a nurse, there is an increase in the occurrence of medication errors, pressure injury formation, and falls with injuries (Cho et al., 2016). Studies demonstrating the positive impact that increased nurse-to-patient ratios have on outcomes provide nursing administrators with evidence to support the hiring of qualified professional nurses . Patient care units in which there is an increased risk for falls due to the patient population or diseases need increased nurse staffing ([NAME] et al., 2017). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 5). Elsevier Health Sciences. Kindle Edition.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00135410 Based on interview and record review, the facility failed to provide coordinated interdisciplinary care and ensure physician recommended follow-up and diagnostic testing were completed for 4 residents (Resident #101, #109, #114, and #133) resulting in the lack of assessment, monitoring, and delay in treatment and the potential for the worsening of a medical condition. Findings: During an interview on 04/18/2023 at 10:00 AM, Confidential Informant (CI) A reported that R101and R133 had not had follow up appointments completed causing a delay in treatment and R109's procedure had been rescheduled 2 times because nursing staff were not following the presurgical orders and administered medications that caused the procedure to be cancelled. CI A reported missed diagnostic studies and appointments had been an ongoing issue at the facility. Resident #114 (R114) Review of an Admission Record revealed R114 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes, end stage renal disease, and heart disease. Review of a Minimum Data Set (MDS) assessment for R114, Functional Status with a reference date of 2/15/23 revealed R114 required extensive 2 person assist with bed mobility and toileting, total dependence of 2 persons for transferring, and extensive 1 person assistance for personal hygiene. During an interview on 04/17/2023 at 11:51 AM, Wound Physician Assistant (WPA) AA reported that on Friday (4/14/23) she was evaluating R114's right posterior heel and left heel and discovered that R114's dressing had not been changed and were the dressings she had placed on the resident the week before (4/7/23). WPA AA reported that she had ordered bilateral lower extremity dopplers for R114 back in February for absent pedal pulses and notified Unit Manager (UM) I of the new order at that time. WPA AA reported that she discussed with the facility Nurse Practitioner that the bilateral lower extremity doppler had still not been completed and the facility Nurse Practitioner put in an order for it to be completed ASAP (as soon as possible.) Review of R114's Physician Order dated 2/3/23 revealed, Arterial doppler of bilateral lower extremities one time only for absent pedal pulses for 3 Days. Review of R114's Physician Order dated 4/11/23 revealed, BLLE arterial dopplers ASAP. one time only for absent pedal pulses for 3 Days. Review of R114's Wound Progress Note dated 2/3/23 revealed, .Resident also noted to have absent pedal pulses, will check bilateral lower extremity arterial dopplers . (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse initials and dated (2/14/23) handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 2/24/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse, it appears they were done however the results are not available in (Electronic Health Record) for review . Nurse initials and dated (2/27/23) handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 3/5/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse, it appears they were done however the results are not available in (Electronic Health Record) for review . Nurse initials and dated (3/6/23) handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 3/17/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse, it appears they were done however the results are not available in (Electronic Health Record) for review, I did reach out to the CCC (Clinical Care Coordinator/Unit Manager) via email to see if she could check into this but have not heard back . Nurse initials and dated (3/21/23) handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 3/24/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse but I have not seen the results yet, the CCC looked into this and it appears it was not completed, CCC will get it ordered . Nurse initials and dated (3/29/23) handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 3/31/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse but I have not seen the results yet . Nurse initials and dated (4/5/23) handwritten on note indicating it was reviewed and new orders/order changes were confirmed and completed. Review of R114's Wound Progress Note dated 4/7/23 revealed, .Bilateral lower extremity arterial dopplers were ordered due to absent pedal pulse but I have not seen the results yet . Nurse initials and dated (4/11/23) handwritten on note ordered 4/11/23. Resident #101 (R101) Review of an Admission Record revealed R101 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: left femur fracture. Review of R101's Hospital Discharge Planning revealed R101 was to follow up with the orthopedic provider in 2 week(s). If it is difficult to bring the patient to the office, we can do multiple x-rays and evaluate . On 4/12/23 at 6:53 AM, a copy of the 2-week follow-up appointment was requested. During an interview via email on 04/12/2023 at 7:53 AM, Nursing Home Administrator (NHA) verified that R101 had not had the 2 week follow-up appointment following his admission to the facility stating We do not have documentation for this as the appointment was not made. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Grandville	3400 Wilson Ave Grandville, MI 49418

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R101's Physician Order dated 3/20/23 revealed an order for left leg/hip x-rays 2-3 view. NEED DISC for orthopedic office. Review of R101's Electronic Health Record revealed the x-ray had not been completed on this date. Review of R101's Nursing Progress Note dated 3/27/23 at 9:15 AM revealed, (Diagnostic Company) called to order 2-3 view of the left femur and left hip with CD for follow-up appointment .Spoke with (name omitted) and (name omitted) put the order in for ASAP due to res (residents) follow-up appointment is on 3/20 . Confirming the x-ray ordered on 3/20/23 was not completed. R101's date of death was 3/27/23 prior to the orthopedic appointment and xray. During an interview on 04/18/2023 at 2:54 PM, Director of Nursing (DON) reported that the nurse on duty on 3/27/23 identified that the x-ray had not been completed on 3/20/23 and ordered the x-ray on 3/27/23 to ensure it was completed prior to the orthopedic appointment on 3/29/23. DON reported that the way the x-ray was ordered on 3/20/23 resulted in the order appearing as though it was completed and reported nursing staff will be educated on ordering laboratory and diagnostic testing. Resident #109 (R109) Review of an Admission Record revealed R109 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dysphagia (difficulty swallowing). Review of R109's Order Summary revealed R101 had an appointment on 3/3/23 at 12:15 PM for an endoscopy. Review of R109's Electronic Health Record revealed no documentation as to why the endoscopy was not completed. Review of R109's Order Summary revealed R101 had an appointment on 4/12/23 at 12:15 PM for an endoscopy. Review of R109's Nursing Progress Note dated 4/12/23 revealed, Resident's surgery (endoscopy) has to be rescheduled due to resident receiving a dose of Eliquis (blood thinner) this morning. During an interview via email on 4/19/23 at 12:32 PM, NHA stated, The endoscopy was to be cancelled by us - the first time was because the family was unable to join and the second was cancelled because of a medication we provided prior to the endoscopy that should have been held. Review of R109's Order Summary revealed R101 had an appointment on 5/18/23 (waiting for time) for an endoscopy. (Approximately 11 weeks since the first procedure was ordered). Resident #133 (R133) Review of an Admission Record revealed R133 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: dysphagia. Review of R133's Order Summary revealed on 1/12/23 an order for VFSS (Video Fluoroscopic Swallow Study) dx (diagnosis) dysphagia, coughing with liquids. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R133's Order Summary revealed R133 was scheduled for the VFSS on 2/22/23 at 3:30 PM APPT: 2/22/23 (at) 3:30pm Video Swallow Study. Review of R133's Electronic Health Record revealed no documentation for the reason the VFSS was not completed. Review of R133's Order Summary revealed R133 was scheduled for the VFSS on 4/7/23 at 2:00 PM APPT: 4/7 (at) 2:00pm Video Swallow Study. Review of R133's Electronic Health Record revealed no documentation of the results of the VFSS. On 4/18/23 at 3:42 PM, requested the following information on R133 via email to NHA Swallow study was ordered 1/12/23. There were appointments for 1/30/23, 2/22/23, and 4/7/23. I am unable to find the results or documentation as to why it was rescheduled and/or cancelled. During an interview via email on 4/19/23 at 12:32 PM, NHA reported the results from the swallow study had not been obtained. No documentation was provided regarding the VFSS or documentation for the cancellation/missed VFSS's.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00135410 Based on observation, interview, and record review, the facility failed to ensure a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, and plan of care, resulting in the potential for staff burnout, neglect, unmet care needs, and serious adverse physical, mental, and psychosocial harm. This deficient practice has the potential to affect all residents residing in the facility. Findings: During an interview on 04/10/2023 at 9:41 AM, Confidential Informant (CI) A reported that the staffing level is unsafe and resident needs cannot be met. CI A reported that weekend and evening staffing is horrible with multiple call-ins. CI A reported that management continue to admit residents knowing the facility has insufficient number of nursing staff. During an interview on 04/10/2023 at 11:37 AM, Registered Nurse (RN) B reported she concerns with resident safety because of the lack of nursing staff. RN B reported that at that time there were 3 nurses to provide care and administer medications and treatments for more than 90 residents (census 93). RN B was responsible for over 30 residents and was responsible for 3 medication carts for 3 units. RN B reported there were not enough nurses or Certified Nursing Assistants (CNAs) to meet the needs of the residents. During an interview on 04/12/2023 at 6:51 AM, CNA N and CNA M reported concerns with staffing levels. CNA N stated staffing is unsafe and resident needs are not being met. CNA N reported that there were currently 22 residents on the Garden Unit and the majority are extensive assist and total assist. CNA N reported it was difficult to manage behaviors with many of the residents experiencing sundowning in the evenings. CNA N reported that there were recent elopements (R106 on 3/30/23 and 3/31/23) because there was insufficient staff to supervise the resident with a known behavior of wandering and stated, it could have ended tragically. CNA N reported that falls and pressure injuries had skyrocketed because it was impossible to meet the needs of all of the residents with the number of staff available each shift. CNA N reported that frequently 3rd shift has only one CNA and 1 nurse that covers 2 units which leave the CNA alone to reposition, perform incontinence care, supervise, and toilet residents. CNA N reported that on 1st and 2nd shift there were consistently 2 CNAs scheduled to work the Garden Unit but with only 2 CNAs and a nurse that is required to cover 2 units (Garden and Country Lane), facility staff can't reposition, change, shower, and get ADL (Activities of Daily Living) care done for the residents. CNA N stated facility nurses and CNAs have to cut corners and have had to put resident biweekly showers on the backburner in order to ensure residents are supervised and are receiving incontinence care (brief changes) to prevent additional pressure injuries. CNA N reported they do the best they can to get residents repositioned, up for meals, changed, and fed but how can we do it all with the staff scheduled each shift? (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA N and CNA M reported that they had recently had a meeting with Corporate Owner (CO) JJ, Chief Operating Officer (COO) KK, and Regional Director of Operations (RDO) II and multiple staff members had voiced their concerns with the number of staff scheduled to work each shift but they did not listen and no changes were made: stopping admissions, scheduling additional staff, etc. Previous Director of Nursing (PDON) P reported to the facility staff that there were sufficient staff to meet resident needs and scolded the CNAs for not completing showers and other ADLs. During an interview on 04/13/2023 at 9:45 AM, CNA O reported that there were not enough staff to meet residents needs consistently. CNA O reported a significant rise in resident falls and pressure injuries and reported there were multiple residents residing in the facility with behaviors which could not be adequately monitored or supervised because of insufficient staff. During an interview on 04/13/2023 at 8:53 AM, Licensed Practical Nurse (LPN) MM stated staffing is horrible and the facility was to be staffed with 4 nurses on 1st and 2nd shift based on the resident acuity and number of residents, but they rarely schedule 4 and at times only schedule 2 nurses. LPN MM reported that residents do not get checked and changed every 2 hours as required by professional standards which has resulted in an increase in pressure injuries. LPN MM reported the Garden Unit housed many residents with high behaviors (impulsive, wandering, combative) and with insufficient staff for supervision, there has been a significant increase in falls. LPN MM reported it was difficult to assist CNAs with ADL care because of the number of residents the nurses had to administer medications and provide treatments to. LPN MM reported that residents with pressure injuries/wounds are not receiving wound care and recently there was a resident that had a dressing in place for an unknown amount of time, without an order, and no documentation. LPN MM reported when the dressing was removed it was stiff from the amount of drainage that was allowed to dry. LPN MM reported that weekly skin assessments were not being completed because of the number of residents nurses are responsible to pass medications to. LPN MM reported 3 nurses are typically scheduled for 1st and 2nd shift which results in 1 nurse responsible for the Garden Unit and part of the Country Lane Unit, the 2nd nurse responsible for splitting the Country Lane Unit, Brookside Unit, and Lakeshore Unit, and the 3rd nurse covering the rest of the Lakeshore Unit. During an interview on 04/12/2023 at 4:46 PM, Previous RN T reported that they quit working at the facility due to unsafe staffing ratios and fear of losing their nursing license. RN T reported that they primarily worked the Garden Unit and, on many shifts, they were scheduled with just 1 CNA. RN T reported the Garden Unit housed 24 residents that required extensive and/or total assistance with 2 staff members for transferring, incontinence care, toileting, bed mobility, and personal hygiene. RN T reported that residents would not receive adequate care and supervision and there was a significant rise in resident falls and pressure ulcers. RN T stated there were falls all the time and they had a hard time getting (wound) treatments done or medications passed timely. RN T reported there was an increase in pressure injuries because the staff couldn't turn (reposition) them (residents) when they should and it was frustrating. RN T stated all the little things pile up and reported wound treatments were not completed or completed late, skin assessments were not completed weekly and therefore new pressure injuries were identified late (delay in treatment), showers were not being completed so CNAs were not identifying and reporting skin integrity concerns, ultimately resulting in resident neglect. RN T reported corporate was aware of the staffing concerns but would tell the facility nurses and CNAs that they were meeting the State staffing ratios. RN T reported staffing was based on numbers and not resident acuity or the increase in the residents' negative outcomes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/12/2023 at 7:40 PM, Previous CNA S reported that they had recently quit working for the facility because of the lack of staff and concerns with resident safety. CNA S reported that the Garden Unit was insufficiently staffed and frequently only had 1 CNA scheduled for the unit with 1 nurse responsible for 2 units (Garden and Country Lane) leaving the CNA alone on the Garden Unit. CNA S reported that 1 CNA was not enough to meet the needs of 24 dementia and high acuity residents, many of whom required extensive and/or total dependence with 2 staff for transferring, repositioning, personal hygiene, and toileting. CNA S reported that because of the lack of staff and inability to provide care following professional standards of practice (every 2-hour repositioning, incontinence care, out of bed for meals and activities, etc.) there had been a significant increase in falls and pressure injuries, lack of showers and personal hygiene care, and residents left in bed for extended periods of time. CNA S reported that many residents had not received showers in weeks because there were not enough staff to supervise and provide care to all the residents on the unit if they were taken off the floor to provide a shower. CNA S reported that because the nurse on the Garden Unit would have to split their time between the Garden Unit and Country Lane Unit medication were administered late (outside of professional standards) and as needed pain medications were not being administered timely after a resident requested the medication. During an interview on 04/13/2023 at 9:55 AM, CNA W stated the falls are terrible here. CNA W reported that R122 recently had a fall with an arm fracture because R122 is impulsive and there were not enough staff to supervise her. CNA W reported R122's fall was caused because R122 was supposed to be put to bed after meals, but she was left in her wheelchair because there were not enough staff to assist her to bed. During an interview on 04/13/2023 at 11:20 AM, LPN Y reported that there were insufficient staff to meet the residents' basic needs: biweekly showers were not completed for weeks, dressing changes not completed, repositioning and incontinence care not completed timely. LPN Y reported that in one instance the contracted wound provider (Wound Physician Assistant (WPA) AA) was furious because R114's dressing had not been changed since her assessment on her the week prior. LPN Y reported that she and multiple facility staff walked in on a management meeting and reported to COO KK the concerns with insufficient staffing and the negative outcomes residents were experiencing because of the lack of staff. LPN Y reported there were no changes after speaking with COO KK and corporate managers just ignored it all. During an interview on 04/13/2023 at 1:06 PM, LPN G reported that she spoke directly with COO KK and RDO II regarding the seriousness of the insufficient staffing at the facility. LPN G reported that the facility staff were told the facility is compliant with the state numbers for nurse/CNA to resident ratios. LPN G stated, they wont even acknowledge that it's (staffing) a problem and just keep referring to state numbers. LPN G reported that even with the staffing concerns voiced by multiple staff and the increase in negative outcomes for residents, the facility continues to take new admissions. LPN G reported that the facility needed to quit accepting new admissions until the staffing crisis was resolved. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN G stated the past few months staffing has been so bad and licensed nurses and CNAs can't safely take care of these patients. 35 patients is too many. LPN G reported that on any given shift there would be 1-2 aides per Unit, and it was not possible to ensure all residents were fed, changed, and showered following professional standards of practice. LPN G stated, there have been times people have been sick. I would have noticed if I didn't have 2 units (to cover). How could I catch that. If I'm passing pills on 40 residents. LPN G reported that recently there had been a significant increase in falls, wounds, and deaths and stated, it's been really hard to watch an increase of all of this. During an interview on 04/14/2023 at 10:30 AM, Previous CNA GG reported that she quit working at the facility because of the poor quality of care she was forced to provide because of insufficient staffing. CNA GG reported that she frequently worked as the only CNA on the Garden Unit even with more than 20 residents that were high acuity extensive assist residents with no nurse on the Garden Unit due to her also working the Country Lane Unit. CNA GG reported prior to her quitting, there had been an increase in the number of falls and pressure injuries, and she had observed residents pressure injury/wound dressing being left for days and/or saturated with drainage. CNA GG reported nurses would not change dressings when required and felt the residents were being neglected because staff, although tried so hard were unable to meet the standard of care. CNA GG reported nurses and CNAs had to cut corners and not do showers in order to prevent falls and pressure ulcers. CNA GG reported if she was in the shower room with a resident, she would not be able to supervise impulsive/high risk fall residents and ensure all immobile and incontinent residents were repositioned and changed. CNA GG stated, Check and changes were absolutely not done every 2 hours. Couldn't do it. Not with staffing levels. CNA GG reported that CNAs would have to transfer 2 person assist residents and hoyer residents using only 1 person because of the staffing shortage in the facility. CNA GG reported that she notified RDO II and COO KK of the staffing concerns and told him it wasn't acceptable because she was unable to reposition and change residents resulting in pressure injuries, unable to get residents up for meals, and unable to shower residents. CNA GG reported RDO II and COO KK were well aware of the staffing concerns but continued to allow unsafe staffing ratios and ultimately the residents paid physically and mentally for the care they received. During an interview on 04/17/2023 at 2:59 PM, Family Member (FM) LL reported that R126 has had to wait for extensive periods of time for assistance after pressing the call light. FM LL reported that on 4/9/23 R126's call light was on for 65 minutes before staff were able to assist. FM LL reported that R126 now has a new pressure injury on her buttocks due to the facility staff leaving R126 in the same position and not following her care plan. FM LL reported that R126 has gone weeks without receiving a shower. FM LL reported that staffing on the weekends is concerning, and residents are not receiving quality care. During an interview on 04/17/2023 at 3:31 PM, CNA DD there were not enough staff quickly respond to resident call lights or to meet the residents basic needs. During an interview on 04/18/2023 at 6:36 AM, CNA EE reported that there were many residents with behaviors residing in the facility which requires increased monitoring and supervision. CNA EE reported that there were not enough nurses or CNAs to ensure behavioral residents were safe, monitored, and supervised which has resulted in many falls. CNA EE stated we can't manage the number of behaviors with the number of staff scheduled for each shift. Late Medication Administration (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/17/2023 at 9:01 AM, LPN U reported that she and 1 other nurse were the only nurses on duty in the facility at that time. LPN U reported that 4 nurses were scheduled, 1 called off, and the other nurse would not be working until approximately 10:30 AM. LPN U verified that that the Garden Unit had 2 CNAs on the unit at that time but only had 1 until approximately 8:00 AM stating, that's why the residents are still in bed and had not been up for breakfast and/or dressed. During an interview on 04/17/2023 at 9:48 AM, LPN U reported that it had not been communicated to her that she and the only other on-duty nurse were responsible for splitting the other units. LPN U reported that she was notified that she was responsible for passing resident medications and completing treatments on the units that did not have nursing coverage and stated, it's already almost 10:00 AM and noon medications will be due. LPN U reported she would have to review all medications that were late, notify the provider, and obtain orders to either hold or administer late medications. During an interview on 04/18/2023 at 9:38 AM, LPN U reported that on 4/17/23, multiple medications were administered late because there were only 2 licensed nurses on-duty until approximately 10:30 AM. LPN U reported she could not administer the late medications until the late medications were reported to the physician and an order to administer late medications was obtained resulting in residents feeling frustrated that the facility staff could not provide their medications timely and nurses feeling frustrated and overwhelmed that they were not provided the tools (staffing) to complete medication administration timely and meet the residents needs. During an interview on 04/18/2023 at 12:33 PM, Nursing Home Administrator (NHA) verified that there were only 2 licensed nurses on duty for 1st shift (6 AM-2 PM) until approximately 10:30 AM due to a call off and a scheduling miscommunication. Resident #112 (R112) Review of an Admission Record revealed R112 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: chronic pain and hypertension. Review of R112's Physician Orders revealed the following orders: Methadone HCl Oral Tablet 10 MG (Methadone HCl) Give 30 mg by mouth two times a day for chronic pain to be administered at 8:00 AM and 8:00 PM. cloNIDine HCl Oral Tablet 0.3 MG (Clonidine HCl) Give 1 tablet by mouth three times a day for HTN (hypertension) to be administered at 8:00 AM, 1:00 PM, and 8:00 PM. Gabapentin Oral Capsule 100 MG (Gabapentin) Give 1 capsule by mouth three times a day for Neuropathy to be administered at 8:00 AM, 1:00 PM, and 8:00 PM. Review of R112's Medication Administration Record revealed that on 4/17/23 at 10:55 AM R112 had not received the 8:00 AM dose of Methadone, Clonidine, or Gabapentin. Resident #113 (R113) Review of an Admission Record revealed R113 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: Parkinson's Disease. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R113's Physician Orders revealed the following orders: Sinemet Oral Tablet 25-100 MG (Carbidopa-Levodopa) Give 1 tablet by mouth three times a day for Parkinson's disease to be administered at 8:00 AM, 1:00 PM, and 8:00 PM. Tylenol Extra Strength Tablet 500 MG (Acetaminophen) Give 500 mg by mouth three times a day for baseline pain control to be administered at 7:00 AM, 1:00 PM, and 8:00 PM. Review of R113's Medication Administration Record revealed that on 4/17/23 at 10:37 AM R112 had not received the 8:00 AM dose of Sinemet or the 7:00 AM dose of Tylenol. It was identified during the onsite survey that the facility did not ensure there were adequate direct care staff which resulted in the following deficiencies: 1. Failed to 1.) follow physician ordered treatment for pressure injury/wound care 2.) notify the provider of a newly identified pressure injuries, 3.) ensure pressure injury/wound assessments were complete, accurate, and documented in the resident record for 3 residents (Resident #126, #114, and #108). (Refer to noncompliance cited at F686-Treatments and services to prevent and heal pressure ulcers). 2. Failed to provide appropriate Activities of Daily Living (ADL) care for 5 residents (Resident #114, #126, #116, #117, and #107). (Refer to noncompliance cited at F677-ADL care provided to dependent residents.) 3. Failed to provide adequate supervision and sufficient staff to prevent falls for 12 residents: Resident #104, #122, #115, #118, #119, #120, #121, #110, #123, #124, #117, and #125. (Refer to noncompliance cited at F689-Free from accidents hazards/adequate supervision). Review of the Facility assessment dated [DATE], last reviewed with QAPI Committee 7/30/2019 revealed, .3. Facility Resources Needed to Provide Competent Resident Support and Care Daily and During Emergencies .Staffing Pattern: CENA 1st shift 8 (CNAs) 2nd shift 8 (CNAs) 3rd shift 5 (CNAs). The Facility Assessment did not identify the number of licensed nurses required to provide direct care and the Medical Director was not involved in the completion of the assessment.