STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235349	A. Building B. Wing	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Ishpeming	435 Stoneville Rd Ishpeming, MI 49849

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35103 Based on observation, interview, and record review, the facility failed to provide licensed hair cutting/styling services with respect and dignity that promoted resident quality of life and recognized each resident's individuality for four Residents (#3, #4, #5, and #6) of six residents reviewed for dignity. This deficient practice resulted in resident dissatisfaction in haircuts performed by facility staff unlicensed in cosmetology, loss of personal identity, and decreased self-esteem. Findings include: During interviews on 12/8/21 at 8:42 a.m., 11:38 a.m., 4:17 p.m., Certified Nurse Aide (CNA) F, CNA J, and CNAE, respectively, were asked if there were any concerns with staff not treating residents with dignity and respect. CNA F stated, [CNA I is terrible. I have so many residents who are afraid of [CNA I]. CNA F confirmed she was aware of four female residents (#3, #4, #5, and #6) who had their hair cut by CNA I. CNA F said staff have complained to facility administration, and she had personally complained to the Director of Nursing (DON), about CNA I. CNA J stated, My only concern was when we had a staff member (CNA I) that was cutting patients hair, because we are not cosmetologists . especially if they tell you they don't want it cut - it is their right . There are reasons why residents don't want [CNA I] to take care of them. They are afraid of her . CNA E said the night shift CNA (CNA I) cuts the residents hair. She (CNA I) is very intimidating and very bullying . CNA I traumatized Resident #5 over her haircut - she (CNA I) is a mean girl . Review of the facility Resident Response List showed the Brief Interview for Mental Status (BIMS) score for all facility residents, and identified Resident #4 scored 9/15, reflective of moderate cognitive impairment, Resident #3 and Resident #5 scored 15/15, reflective of intact cognition, and Resident #6 had severe cognitive impairment. During an interview on 12/8/21 at 4:55 p.m., when asked how many Residents were identified as having their hair cut by CNA I, Staff B listed four Residents, #3, #4, #5, and #6. Staff B confirmed investigations had been performed. Staff B stated, I talked to [Nursing Home Administrator (NHA)] right away, before I even write up the grievances, as soon as I am told anything. When asked if Staff B had made a face when she first observed Resident #5's hair cut performed by CNA I, Staff B agreed Resident #5's haircut looked like the effects of chemotherapy and stated, It is the loss of dignity and respect. The NHA, also present for this interview, said he had talked to CNA I about Resident #3's haircut, but no disciplinary action was documented. Both agreed the identified haircuts were not done professionally and were performed by a CNA untrained in cosmetology. (continued on next page)

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Ishpeming	435 Stoneville Rd Ishpeming, MI 49849

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/8/21 at 1:10 p.m., Resident #4 confirmed her hair was cut without her permission, while she was in the shower. She said she did not want to have it cut, and she was not happy. Resident #4 said her hair had been down her back, and she didn't know why it was cut. During an interview on 12/8/21 at 1:15 p.m., Resident #6 said she was given a shower approximately 2-3 weeks ago, and her hair was in knots in the back. Resident #6 stated, [CNA I] said she was going to cut out the knots, but then continued to cut the hair to even it up. Resident #6 expressed dissatisfaction with her hair and stated, Look at this hair, as she held up ragged wisps of hair approximately 1-2 inches in length. Resident #6 stated, There is nothing that can be done now, because it is cut. Resident #6 was observed with very short red hair, with wisps of hair that appeared to be shorter and longer, like the hair loss pattern of some chemotherapy patients. Resident #4, present in the same room, stated, If she [CNA I] had cut my hair like that (Resident #6's hair), I would have clocked (hit) her. Resident #4 said Resident #6's hair was much shorter than previous, and she could understand why Resident #6 was upset. Both Resident #4 and Resident #6 said staff immediately were able to tell their hair was cut and commented to them on it being cut. During an interview on 12/8/21 at 1:20 p.m., Resident #3 was asked if her hair had been cut by facility staff. Resident #3's eyes filled with tears, and she stated, Yes, it was . It was my second night in the facility. I was sleeping, and the lights were off. She (CNA I) came into the room, and I had my hair in a bun. She said, 'Let's get rid of this (bun)'. I told her (CNA I) that I was sleeping, and I did not want to cut my hair. The lights were off, and she used what I think was a nurse's scissor to cut the bun off the top of my head. Resident #3 said she had always had long hair because of her cultural beliefs, and it was deeply disturbing to have her hair cut. Resident #3 said having her hair cut had changed how she feels about herself, because her cultural heritage is who she was, and when she looked in the mirror, she looked so ugly now. Review of Grievance and Satisfaction Form(s) received from Staff B on 12/9/21 at 8:41 a.m., revealed the following, in part: 1. Resident #3, Date of Report: 12/3/21, Staff stated that [Resident #3] feels CNA I is not safe. [CNA I] cut her hair when she was on a heavy dose of medication, and she was vulnerable at the time and had no way to escape from getting a haircut or to make a choice of saying no to haircut. 2. Resident #5, Date of Report: 11/22/21, On several occasions, [CNA I] will take residents to shower on her midnight shift and cut all their hair or rather to cut/shave the residents where their dignity is at jeopardy. [Resident #5] was in shower, [CNA I] stated, You have a knot in your hair I cannot get out and proceeded to cut her hair. [Resident #5] is very upset. Also, [CNA I] did this to her roommate [Resident #4], who remembered it happened the same way and was upset that this continues to happen with [CNA I]. See attached . Form attached revealed the following, Names of Resident of whom lost their dignity from [CNA I] cutting hair; [Resident #6, Resident #5, Resident #4]. Staff B was unable to find Grievance and Satisfaction Forms(s) for Resident #4 or Resident #6. Staff B was confident the forms had been completed and the information provided to the Nursing Home Administrator (NHA), but Staff B could not locate the forms. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 12/9/2021 at 12:58 p.m., CNA I returned this Surveyor's call, and confirmed she had cut many residents' hair, including Residents #3, #4, #5, and #6. When asked if she had contacted Resident #6's responsible party for authorization prior to cutting of Resident #6's hair, CNA I stated, No, I did not do that. CNA I confirmed: 1. CNA I had cut Resident #3's hair on the second day Resident #3 was in the facility. 2. CNA I had cut Resident #3's, #4's, and #5's hair because there were knots in their hair that she could not get out. 3. CNA I did not document the cutting of Resident #3, #4, #5, or #6's hair, with the expectation nursing staff would document that it had been performed. 4. Exact dates for the cutting of Resident #4, #5, and #6's hair were not identifiable. CNA I said she was asked by facility staff to cut resident hair, and it was the facility practice to allow her to cut the hair. When asked if she had ever been spoken to, or received disciplinary action for cutting resident hair, CNA I stated, No one ever spoke to me about cutting resident hair. CNA I acknowledged worrying about the lack of documentation, but because it was a facility practice she did not ever receive disciplinary action of any kind for cutting of resident hair in the facility. CNA I was unaware of any resident grievances related to cutting of their hair. Review of CNA I's personnel file with the NHA found no disciplinary action related to the cutting of residents' hair. Review of the Resident Rights policy, revised 8/21, revealed the following, in part: The resident has a right to be treated with respect and dignity, including: .c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences .5. Self-determination . b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident . During an interview on 12/8/21 at approximately 9:00 a.m., the NHA confirmed staff had previously complained about CNA I, but no disciplinary action had been documented.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to provide adequate supervision and assistive devices to prevent a fall, and failed to perform a complete physical assessment following a fall with major injury to one Resident (#1) of three residents reviewed for falls. This deficient practice resulted in harm to Resident #1 with bilateral (right and left) medial malleolus (interior ankle bone) fractures, increased pain, and decreased mobility. Findings include: Review of a Fall Incident Report, for Resident #1's 11/15/21 fall at 17:01 (5:01 p.m.), revealed the following, in part: .Resident slow to respond verbally, resident has hx (history) of TIA (transient ischemic attack) type episodes and is being followed by neurology. Resident very weak and unable to help roll, sit up, or stand. Resident noted to be in a kneeling position with feet under her and was unable to independently get legs out from underneath her. Immediate Action Taken: Resident's bed moved, and resident was rolled to her left side on to her back. Resident Hoyer (mechanically) lifted back to bed via 2 CNA (Certified Nurse Aide) staff, floor nurse, and wound care nurse. Resident noted still to be weak and slow to respond. Resident unable to perform ROM (range of motion) independently .Resident noted with increased lethargy. No date/time of creation of this document was present on the document. Review of Resident #1's Minimum Data Set (MDS) assessment, dated 10/23/21, revealed Resident #1 was readmitted to the facility on [DATE] with active diagnoses that included: other neurological conditions, osteoporosis, seizure disorder, history of TIA, chronic fatigue, muscle weakness, and repeated falls. Resident #1 scored 9 of 15 on the Brief Interview for Mental Status (BIMS) reflective of moderately impaired cognition and required extensive two-person assistance for bed mobility, transfer, and toilet use. Resident #1 used a wheelchair and walker for mobility, and had two or more falls with no injury, and two or more falls with injury documented on the MDS assessment. Resident #1 was 67 inches tall and weighed 210 pounds. Review of the Post-fall/Fall Risk Assessment, signed as completed on 11/22/21, with an effective date of 11/15/21 at 7:01 (5:01 p.m.), revealed the following information: Resident #1's wheelchair was locked, a gait belt was in use, a mobility device (walker) was not in use at the time of the fall, and Resident #1 was lethargic and weak at the time of the fall. Review of a Late Entry progress note, created by the Director of Nursing (DON) on 11/22/21, revealed the following related to Resident #1's fall with injury on 11/15/21: Event occurred on 11/15/2021 5:01 PM. [CNA A] came down the hall stating that [Resident #1] had to be lowered to the floor with [co-CNA E] due to resident legs giving out completely from under her. Resident lowered but in a kneeling position sitting on top of both feet, with torso leaning backwards. CNA sitting behind to support torso . During an interview on 12/7/21 at 1:30 p.m., Resident #1 was asked about any falls. Resident #1 said she was returning from the bathroom in her wheelchair and was trying to get into bed. Resident #1 reported her left leg felt like it had no support, like she didn't have any bones in her legs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's progress notes 11/1/21 - through 12/7/21 found no timely documentation of Resident #1's fall with injury on 11/15/21. The medical record showed all fall documentation was completed following Resident #1's return from the Emergency Department with diagnoses of bilateral ankle fractures. Review of Resident #1's Electronic Medical Record (EMR) found no complete physical assessment that documented post-fall physical assessment findings related to Resident #1's skin, legs and ankles. Review of the Fall Reduction Policy, date revised 8/21, revealed the following, in part: Policy: Our residents have the right to be free from falls, or to sustain no or minimal injury from falls .5. When any resident experiences a fall, the facility will: a. Assess the resident .f. Document assessments and actions . Review of an SBAR (Situation-Background-Assessment-Recommendation) Communication Form, dated 11/17/21 at 8:00 a.m., completed by Licensed Practical Nurse (LPN) N, revealed the following information, in part: Pain in left hip. Foot is internally rotated/Left Trochanter (hip) . Intensity of Pain (rate on scale of 1-10, with 10 being the worst): '10' . Review of the SNF (Skilled Nursing Facility)/NF (Nursing Facility) to Hospital Transfer Form, dated 11/17/21, time of transfer 8:19 a.m., revealed the Reason for Transfer was altered mental status, with left trochanter (hip) pain, rated as a 10 on the pain scale at time of transfer. Review of the emergency room X-ray reports, dated and transcribed on 11/17/21 at 11:30 a.m. and 11:38 a.m., respectively, revealed the following in part: Three-View Right Ankle, Indication: .right ankle trauma, pain, and swelling . Findings: There is a minimally displaced avulsion fracture through the base of the medial malleolus (inside ankle bone) . Three-View Left Ankle, Indication: .Fall and left ankle trauma and pain . Findings, There is an avulsion fracture through the base of the medial malleolus . Review of an orthopedic Physician/Clinic Consult Form, dated 11/29/21, revealed Resident #1 had bilateral ankle fractures and was ordered to be non-weight bearing for 4 weeks, with a return visit in 4 wks (weeks) . Review of a typed document entitled, Staff Statements on Pain and Incident, related to Resident #1's Fall 11/15/21 resulting in FX (fracture), signed as completed on 11/16/21 by the DON, revealed the following witness statement information, in part: 1. DON: 11/15/21, .Resident was placed in bed and continued to be lethargic VS WNL (Vital Signs within normal limits). Resident with complaints of pain directly after fall resident unable to assist with ROM (Range of Motion) . 2. CNA E: On 11/16/21 Resident (#1) complained of pain to her legs and wanted some [Acetaminophen] and to get back in bed . 3. Licensed Practical Nurse (LPN) C: [Resident #1] (on 11/16/21) . was complaining of pain to her legs to [CNA I], [Resident #1] was given [Acetaminophen] . by the other wing nurse . I would never have imagined her ankles were broken (broken ankles not identified until the next day (11/17/21) following completion of this report on 11/16/21, when x-rays were completed at the emergency department). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4. CNA I: On 11/16/21 in the early morning I gave Resident (#1) a shower . she was complaining of pain in both of her legs . She then had an appointment and at the appointment and upon her return she was complaining of pain to both legs and requested some [Acetaminophen] but was having a hard time with her right and left legs, but did say she had pain in feet, ankles, and legs. During an interview on 12/7/21 at 4:40 p.m., the DON, Nursing Home Administrator (NHA), and LPN D were asked about Resident #1's 11/15/21 fall with injury. The DON said Resident #1 had been having syncope (fainting/weak) spells, and that is what they (facility administrative staff) think happened, even though two staff were assisting her with a gait belt on. All present acknowledged the staff who attempted to transfer Resident #1 from the wheelchair to the bed were responsible for providing adequate supervision and safety during the transfer. The DON and LPN D confirmed no ADL (Activities of Daily Living) change related to the level of safe transfer was completed for Resident #1, even when there was knowledge of Resident #1's syncope episodes. When asked about reference to Resident #1's broken ankles in the signed Witness Statement Summary, signed on 11/16/21 by the DON, when the broken ankles were not identified until 11/17/21, the DON said she did not think there was any reference to broken ankles in the Witness Statement documentation. Review of Resident #1's Pain Level Summary revealed the following pain reports between 1-10 on 11/13/21 through 11/17/21: 11/13/21: 8:23 a.m. and 8:04 p.m., 2, and 2 respectively. 11/14/21: 7:51 a.m., and 7:08 p.m., 0, and 0 respectively. 11/15/21: 2:15 p.m., and 7:57 p.m., 1 and 0 respectively. 11/16/21 (one day post fall): 12:18 a.m., 1:52 a.m., 8:50 a.m., 2:22 p.m., 4:48 p.m., 7:30 p.m., pain scores of 4, 2, 4, 5, 2, 6 and 0 respectively. 11/17/21: 7:40 a.m., 8:17 a.m., 7:40 p.m., 8, 10, and 8 respectively. During an interview on 12/8/21 at 4:17 p.m., CNA E confirmed she had assisted Resident #1 on 11/15/21 at the time of the fall and said Resident #1 was care planned for extensive assist of one staff member with transfers but noted that day she required two staff members for assistance. The gait belt was placed on Resident #1 and It (fall) happened so fast . we were transferring her from the wheelchair to the bed . [Resident #1] got so weak or something . we have to push the wheelchair (out of the way) so [Resident #1] can turn (to get into bed). When we moved it (wheelchair moved backward away from standing resident) we may have unlocked it so that it is out of the way. I always unlock them (wheelchair) once I get them up (standing). CNA E said she observed Resident #1's right leg the following day (11/16/21) and stated, I didn't notice something wasn't right until the next day. [Resident #1] was sitting in her wheelchair - it was making her right leg hurt - it was almost like it (her right leg) was going the other direction. I said something about it when I saw the leg wasn't right - on November 16th to my wing nurse. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 12/8/21 at 12:43 p.m., CNA A confirmed she was assisting Resident #1 at the time of the fall on 11/15/21. CNA A stated, The wheelchair was locked when we went to stand [Resident #1]. When we got her (Resident #1) up (standing), we unlocked the wheelchair, and moved it back . She (Resident #1) went down so fast . I worried that she may have hurt her ankles because they were in such a weird position .the inside of her ankle bone was down on the floor, and they were spread outward . To try to keep her up, you would not have been able to do that . she fell with enough force that she could have injured herself. I am pretty sure she hurt herself. There is no way she would not have. We tried to stop it, but it was so fast we could not have stopped it . I would say she (Resident #1) fell to the floor. I don't think that we could have lowered her to the floor . We just started to push the chair (wheelchair backwards) and she went down . During an interview on 12/9/21 at 11:29 a.m., Certified Occupational Therapist Assistant (COTA) G, and Physical Therapy Assistant (PTA) H were asked about Resident #1's transfer status. Both therapy staff said Resident #1 was a 1-2 person assist with transfers but said facility staff should have used a mechanical lift if they felt they could not keep her upright with a gait belt. COTA G said they were keeping a mechanical lift pad underneath Resident #1 (for use when needed) since a previous fall with injury on 10/15/21. COTA G stated, They (CNAs A and E) should have used a walker for stability (with the transfer). When asked about the wheelchair being unlocked and moved during the transfer, both COTA G and PTA H confirmed the wheelchair should not have been unlocked and moved away from the Resident while in the process of transfer. COTA G stated, I didn't know how she could break both ankles if she was lowered (assisted) to the floor.