STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. Building B. Wing	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 This deficient practice pertains to the following Intakes: #MI00130890, #MI00130578, #MI00130567, #MI00130451, #MI00130427, #MI00130213, #MI00129738, #MI00129110, AND #MI00131016. This citation has two deficient practice statements (DPS's): DPS A and DPS B. Deficient Practice Statement A: Based on observation, interview, and record review the facility failed to provide necessary structures to provide goods and services to meet the needs of all residents as evidenced by: 1. Insufficient nursing staff to meet resident needs. 2. Failure to follow protocols related to turning and repositioning, checking and changing of briefs, showers, and basic supervision and care needs. 3. Failure to timely pay facility vendors to ensure supply chain fluidity. 4. Failure to maintain facility environmental safety, function, and order for all facility residents. This deficient practice resulted in wide-spread neglect of all 42 facility residents at a level of immediate jeopardy. Findings include: Due to the critical content of the interviews and evidence provided during this survey with repeated verbalization of resident and staff concerns related to potential retaliation by the facility, all staff will be identified as Staff unless the position title is critical to deficiency understanding. Insufficient Staff for Resident Needs (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on [DATE] at 5:22 p.m., Complainant FF, a former resident of the facility who resided in the building for approximately five months said in June and July of 2022 the facility was very short of nursing staff, especially on the night shift. Complainant FF stated, Once in a while there was only one nurse and one aide (all night). Complainant FF said the concern was voiced to facility administration who said they were doing the best they could. Complainant FF said the Director of Nursing (DON) position was not filled promptly and stated, Apparently nobody was in charge of the nursing things. I often had to wait for a respiratory treatment, and that made me short of breath and more anxious. I am incontinent and with one aide you may get changed once a night, and on afternoons you (I) had to wait over a half hour for a brief change with stool in it . They had a couple of weeks where they had to cancel my appointment because the bus didn't work . They were forever running out of washcloths and face towels. With the showers, you never got the showers you were scheduled. I probably got a shower a month . Complainant FF reported to staff wanting showers, but staff said they did not have time, and one of the resident shower rooms had been closed for repairs. As far as I know the other bathroom (shower room) was still torn apart . With the food . I was supposed to be on a diabetic diet, and I would get half a plate of corn. They way over serve the starches and the mashed potatoes. They don't very often get fresh fruit and vegetables . During a telephone interview on [DATE] at 8:06 a.m., anonymous Complainant EE, an advocacy organization employee, reported having been in the building approximately three to four weeks previous. Anonymous Complainant EE stated, The day I was there many of the residents were fearful of the staffing situation (low staffing levels). One of the huge complaints I got was the (lack of) showering. Resident #59 Review of Resident #59's Minimum Data Set (MDS) assessment, dated [DATE], revealed the Resident required extensive two-person assistance with bed mobility, dressing, toilet use, personal hygiene, and was totally dependent upon staff for bathing. Resident #59 scored 13 of 15 on the Bried Interview for Mental Status (BIMS) reflective of intact cognition. Review of Resident #59's Shower Task documentation in the Electronic Medical Record (EMR) for the last 30 days as of [DATE], revealed Shower/Bathing/Bed Bath as Scheduled Monday & Thursday AM shift - use Ketoconazole 2% shampoo on Thursdays. Leave shampoo on for ,d+[DATE] minutes before rinsing. A shower was documented on [DATE] and [DATE], a bed bath on [DATE], with one Resident Not Available documented on [DATE]. During an interview on [DATE] at 10:00 a.m., Emergency Staff F said she was working due to an emergency staffing crisis in the facility. Staff F said she felt emergency staff now working in the facility were like the last resort for a facility that is in a staffing crisis. Staff F said a Resident (Resident #59) died very recently while the emergency staffing aides were working in the building and noted Resident #59 had a pressure injury on her coccyx. Staff F said the emergency staffing aides would make sure to turn and reposition her when they were working, and when they left each day they would put a piece of paper underneath her, that would show if Resident #59 had been repositioned. Staff F said she did not believe Resident #59 was repositioned appropriately because they (emergency staffing aides) would come in and find the paper in the exact same place as they had placed it. Staff F said it was incredibly sad. Staff N stated in an interview on [DATE] at 3:20 p.m., I was concerned Resident #59 was not getting the care she needed, and now she passed away. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on [DATE] at 2:00 p.m., Staff N confirmed the following concerns related to Resident #59, who was transferred out to the acute care hospital with emergency care needs: 1. Prior to discharge to the hospital Resident #59 was observed to be dehydrated, with extremely dry oral mucosa, and was not observed to be offered sufficient oral hydration. 2. Resident #59 was not being timely changed and repositioned at nights, which was observed, reported, and education provided to the involved CNA's (Certified Nurse Aides) related to checking and changing briefs and repositioning of the resident. 3. Resident #59 was found wet, when she should have been checked and changed by inexperienced CNA staff. Resident #62 Review of Resident #62's EMR revealed she scored 15 of 15 on the BIMS reflective of intact cognition. Resident #62 required extensive two-person assistance with bed mobility, dressing, toilet use, personal hygiene, and was totally dependent upon staff for bathing. Resident #62 was always incontinent of urine, and frequently incontinent of stool. Active diagnoses included chronic kidney disease (Stage 4), and personal history of urinary (tract) infections. During an observation/interview on [DATE] at 2:58 p.m., when asked about care received in the facility, Resident #62 said she was not routinely receiving showers from the facility and had been left in a cold, wet brief for two and a half hours one night. Resident #62 said she has a problem with recurrent urinary tract infections, so sitting in a wet brief was a concern to her. Resident #62 was observed in bed wearing a hospital gown. Resident #62 said she had to be relocated from a different room because the previous room roof was leaking directly onto her bed. The Resident reported half of her personal belongs were still back in the other room, and she had not been moved back to that room (room [ROOM NUMBER]). She was unsure if the roof had been repaired. Review of Resident #62's care plans revealed, in part: BRIEF USE: I use disposable incontinence products. Change daily, when soiled and PRN (as needed) . Revision on [DATE]. INCONTINENT: Check me every 2 hours and as needed for episodes of incontinence . Revision on: [DATE]. No shower interventions were documented in Resident #62's care plan. Review of the Master Bath List provided by the NHA of Record/Regional Director of Operations revealed Resident #62 was scheduled for twice-weekly showers on Tuesday PM and Saturday AM. Review of Resident #62's Shower Task documentation in the EMR revealed showers were performed three times in the last 30 days as of [DATE], on: ,d+[DATE] (Tuesday), ,d+[DATE] (Friday), and ,d+[DATE] (Monday). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #62's Turning and Reposition Task Documentation in the EMR revealed not all shifts were documenting repositioning of this Resident, and on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and , d+[DATE] documentation checked revealed Resident #62 was turned and repositioned two times during the shifts documented. Checks for not applicable were noted on ,d+[DATE], ,d+[DATE], and ,d+[DATE]. Resident #51 Review of Resident #51's Shower/Bathing/Bed Bath Schedule revealed the following: I prefer to let staff know when I would like to shower. No alcohol gel for hand washing. Use only Dove/Ivory soap. POC Response History (staff documentation software) revealed Resident #51 only had one shower on [DATE]. The form was absent any other staff documentation. Resident #52 Review of Resident #52's complete EMR revealed a BIMS score of 15, reflective of intact cognition. Resident #52 MDS assessment documented extensive two-person assistance with bed mobility, transfers, dressing, toilet use, personal hygiene and Bathing was documented as Physical help in part of bathing activity with one-person assistance. Resident #52 had active diagnoses that included urinary tract infections in the last 30 days. During an observation and interview on [DATE] at 3:48 p.m., Resident #52 self-propelled up to this Surveyor in his wheelchair and stated, loudly, I really, really need a shower. I have been sick and had diarrhea, and I need to get cleaned up, but even the new aides say they don't have time to give me a shower. I get really mad when I have to ask and ask, and I need a shower and I don't get one. Resident #52 said several aides who had recently quit would get his showers done. Resident #52 stated, Now, they don't get done. Review of Resident #52's Shower Task documentation in the EMR revealed a Shower/Bathing Scheduled Wednesday & Saturday shift. During the previous 30 days, as of [DATE], Resident #52 received one shower on [DATE], one bed bath on ,d+[DATE], and was documented with three not applicable dates checked on , d+[DATE], ,d+[DATE], and [DATE]. Resident #53 Review of Resident #53's complete EMR revealed a BIMS score of 15, reflective of intact cognition. Resident #53 MDS assessment documented extensive, two-person assistance with bed mobility, transfers, dressing, toilet use, and Bathing was documented as Activity itself did not occur. Resident #53 had active diagnoses that included: end stage renal disease and urinary tract infections in the last 30 days. Review of Resident #53's Shower Task documentation in the EMR revealed a Shower/Bathing Scheduled Monday & Friday AM shift. During the previous 30 days reviewed, Resident #53 received no showers, one bed bath on ,d+[DATE], and was documented as refusing on ,d+[DATE] and ,d+[DATE], with two not applicable dates checked on ,d+[DATE] and [DATE]. Resident #54 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #54's complete EMR revealed a BIMS score of zero, indicative of severe cognitive impairment. Resident #54's MDS assessment, dated [DATE], revealed Resident #54 required extensive, two-person assistance with bed mobility, transfers, and toilet use. Bathing was documented as Activity itself did not occur. Active diagnoses included Alzheimer's disease and non-Alzheimer's dementia. On [DATE] at 8:44 a.m., Resident #54 was in bed yelling out, Help, help, help repeatedly. No facility staff came and after 20 minutes the Resident gave up. The Resident was unable to/did not use her call light. There was an office just down from the room with management staff who did not come out of the office. Review of Resident #54's Shower Task documentation in the EMR for the last 30 days revealed one shower was given on ,d+[DATE], three bed baths, on ,d+[DATE], ,d+[DATE], and ,d+[DATE]. Resident Refused was documented on ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE]. The Task was identified as Shower/Bathing/Bed Bath as scheduled Sunday & Thursday AM Shift - I require physical help with part of bathing and sometimes total assistance. Resident #55 Review of Resident #55's MDS assessment, dated [DATE], revealed the Resident required extensive two-person assistance with bed mobility, transfers, toilet use, and one-person physical help in part of bathing. Resident #55 scored 15 of 15 on the BIMS assessment reflective of intact cognition. During an interview on [DATE] at 3:01 p.m., when asked about showers in the facility, Resident #55 stated, Sometimes I go two weeks without a shower. I (had) a shower day on Monday, and that was the first shower I had in 21 days. Resident #55 denied ever refusing a shower and said staff would tell him they did not have time to give him a shower. When asked about call light response times, Resident #55 said he would be on the toilet and press the call light for assistance. Someone would came and said they would find someone to help him right away. Nobody came, and he had to use the call light again. Resident #55 stated, It is sometimes horrible at night here. Sometimes it is just the nurse here, and there is no aide. When asked about food, Resident #55 said the facility ran out of eggs, both fresh and hard boiled, they hardly ever had cottage cheese, and they ran out of brown sugar packets and oatmeal. Resident #55 stated, The good aides quit now. They were getting sick of being mandated. They quit and went somewhere else. Resident #55 said the facility was still short staffed, and no one come for months to [NAME] the lawn. Resident #55 stated, The lawn was almost three feet long. It looked horrible. Review of Resident #55's Shower Task documentation in the EMR for the last 30 days as of [DATE], revealed a shower was provided on ,d+[DATE], ,d+[DATE], and [DATE], with Shower/Bathing/Bed Bath as Scheduled Monday & Thursday AM Shift noted on the POC Response History. Resident #56 Review of Resident #56's MDS assessment, dated [DATE], revealed the Resident required one person assistance with physical help in part of bathing activity, and scored 15 of 15 on the BIMS assessment reflective of intact cognition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #56's Shower Task documentation in the EMR for the last 30 days as of [DATE], revealed no showers or bed baths were provided by facility staff with the Task of Shower/Bathing/Bed Bath as Scheduled Monday AM & Thursday PM Shift noted on the POC Response History. Resident #57 Review of Resident #57's MDS assessment, dated [DATE], revealed the Resident required extensive two-person assistance with bed mobility, dressing, toilet use, personal hygiene. Bathing was documented as Activity itself did not occur. Resident #57 scored 11 of 15 on the BIMS assessment reflective of moderate cognitive impairment. During an observation and interview on [DATE] at 3:45 p.m., Resident #57 was observed sitting in her wheelchair in the hallway with long (approximately 1 inch in length) facial hairs on her chin. When asked how she felt about grooming in the facility, especially the long chin hairs, Resident #57 stated, I want them to shave that, but they only do that when I get a shower, and I am not getting showers like I am supposed to. Resident #57 said the nurse aides were not nice and said the nurse aides did not have time to give her a shower. When asked about bed repositioning, Resident #57 said she could do that independently, but stated, There are not enough staff, and you have to wait a long time for them to respond if you need them . I want to get my hair cut . but said there had not been a hairdresser in the building for a long time. Resident #57's hair was long and unkempt. Review of Resident #57's Shower Task documentation in the EMR for the last 30 days as of [DATE], revealed Shower/Bathing/Bed Bath as Scheduled Tuesday & Friday PM shift. A shower was documented on [DATE], and a bed bath on [DATE]. Refusals were noted on ,d+[DATE] and [DATE]. Resident #58 Review of Resident #58's MDS assessment, dated [DATE], revealed the Resident required extensive one-person assistance with bed mobility, dressing, toilet use, personal hygiene, and bathing. Resident #58 scored 14 of 15 on the BIMS reflective of intact cognition. During an interview on [DATE] at 12:30 p.m., when asked about facility staffing, Resident #58 stated, They do not have enough staff, and noted staffing was less at night. Resident #58 stated, On night shift I have to wait a long time for call light assistance and have had to wait wet and in BM (bowel movement/stool) for a long time. Resident #58 said showers were not received twice a week, as they were supposed to be given. Resident #58 stated, The main thing is they are short of help . Review of Resident #58's Shower Task documentation in the EMR for the last 30 days as of [DATE], revealed Shower/Bathing/Bed Bath as Scheduled Monday & Wednesday AM shift. A shower was documented on [DATE], and bed baths on [DATE] and [DATE], with one Refusal documented on [DATE]. Resident #60 Review of Resident #60's MDS assessment, dated [DATE], revealed the Resident required extensive two-person assistance with bed mobility, toilet use, and personal hygiene. Bathing was documented as Activity itself did not occur. Resident #60 scored 15 of 15 on the BIMS reflective of intact cognition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #60's Shower Task documentation in the EMR for the last 30 days as of [DATE], revealed Shower/Bathing/Bed Bath as Scheduled Tuesday & Friday PM shift. A shower was documented on [DATE] and [DATE], with Not Applicable documented on [DATE] and [DATE]. Resident #61 Review of Resident #61's MDS assessment, dated [DATE], revealed the Resident required extensive two-person assistance with bed mobility, transfers, dressing, toilet use, and was totally dependent upon staff for Bathing. Resident #61 scored zero on the BIMS reflective of severely impaired cognition. Review of Resident #61's Shower Task documentation in the EMR for the last 30 days as of [DATE], revealed Shower/Bathing/Bed Bath as Scheduled Sunday & Wednesday PM shift. A shower was documented on [DATE], bed baths on [DATE] and [DATE], with Not Applicable documented on [DATE]. Resident #63 Review of Resident #63's MDS assessment, dated [DATE], revealed the Resident required extensive two-person assistance with bed mobility, and dressing. Bathing was documented as Activity itself did not occur. Resident #63 scored zero (0) on the BIMS reflective of severely impaired cognition. During an observation and interview on [DATE] at 5:00 p.m., Resident #63 was observed crying out for help while lying in her bed, flat on her back. Resident #63 was dressed only in a hospital gown and incontinence brief. Resident #63 had tears in her eyes as she cried, I hardly have any help anymore. I am not able to get the help I need. I don't want to be here anymore, I want to go somewhere else. They don't hardly come and see me (staff). I am so lonely, with nobody to talk to. Resident #63 confirmed she had not been getting her showers/bathing consistently as scheduled, and that she was not repositioned every two hours like she should be. Observation of Resident #63's positioning, with Staff V, at this same time, found Resident #63's left heel positioned directly on the bed, with a pillow under her right knee only, to keep the right heel floating in bed. Review of Resident #63's care plan revealed the following, in part: Assist me to turn &/or reposition routinely during CNA rounds while in bed and frequently redistribute my weight . Date Initiated: [DATE] and Assist/encourage me to elevate my heels off the bed. Date Initiated: [DATE]. Review of Resident #63's Shower Task documentation in the EMR for the last 30 days as of [DATE], revealed Shower/Bathing/Bed Bath as Scheduled Sunday PM Shift & Tuesday AM shift. No showers were provided to this Resident, bed baths were given on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE]. Not Applicable was documented on [DATE]. Resident #64 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #64's MDS assessment, dated [DATE], revealed the Resident required extensive two-person assistance with transfers and bathing, and extensive one-person assistance with bed mobility, locomotion, dressing, toilet use, and personal hygiene. Resident #64 was always incontinent of urine, and frequently incontinent of bowel. Resident #64 was documented as Severely Impaired on the Cognitive Skills for Daily Decision Making Review of Resident #64's Shower Task documentation in the EMR for the last 30 days as of [DATE], revealed Shower/Bathing/Bed Bath as Scheduled Wednesday & Saturday PM shift. No showers were provided, one bed bath on [DATE], with Not Applicable documented on [DATE], [DATE], and [DATE]. Staff documentation on the Turning and Repositioning and Bed Mobility POC Response Histories in the previous 30 days were inconsistently completed by staff on various shifts, with not all shifts recording task completion on the above residents. Review of Resident Council Meeting Minute concerns, March through [DATE], revealed the following, in part: New Business: [DATE] 1. Too many residents yelling in hallway. 2. CNA's getting mouthy with residents . 3. Getting left on toilet because EZ stand dies . 4. Want haircuts . [DATE] 1. Nurses don't always know how to answer [NAME] (call lights) . 2. Someone to keep an eye on people by the nurses' station (staff education/behavior intervention) . [DATE] 1. CNA's ignoring people . 2. Changing shower assignments . [DATE] 1. Showers still not being offered . New Business 1. CNA's being mean . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 3:25 p.m., Staff H confirmed the facility was very short of staff, particularly CNA's. Staff H stated, Staffing has been terrible. There are some days I leave here (at approximately 10:00 p. m.) and there is nobody to work for nights . There are always two nurses if there are no aides, but there may be no aides. I am sure they (residents) don't get changed as often as they should be on night shift. The nurse can't pass pills and do all the medical things, and make sure everyone is checked and changed. Showers do not get done often, unless we have a shower aide . It is hard enough to take care of 16 people and make sure they are clean, dry, and safe. The with-it (cognitively intact) residents say, 'I haven't had a shower in weeks', and you feel sorry for them (residents), but you just don't have the time. Half the time I get the BM's and food charted, but to get the rest, I don't have time. Staff H said there was only one shower room for resident use. Staff were told it was being renovated, but Staff H said she had not seen anyone working on it. When asked about residents being left for extended periods of time in wet and/or soiled briefs, Staff H said that was a possibility because staff were so short. During an interview on [DATE] at 3:35 p.m., when asked about staffing levels, Staff I stated, It has been terrible. Everyone is getting mandated (required overtime) over and over and over. Everyone is exhausted . Showers do not get done . I get mandated into nights, and one night it was one nurse and me . The residents are complaining about care not being provided . During an interview on [DATE] at 9:30 a.m., when asked about staffing, Staff J stated It is horrible. I think we only have five people that are full-time. We had two of our best employees quit because they were getting nailed for four 16-hour shifts when mandated. It is insane here - because we don't have enough staff. It is insane because we don't have the right management here. What does corporate do for you? Nothing. We tell them and tell them, and they don't do nothing . Showers are not getting done. There is no staff time to do them. They got used to saying, 'I don't have time to do it'. They got into that rut, and we were really short, and we didn't have time. They are not getting done. I think there are pressure ulcers because people are not getting turned. They are not getting out of bed, because there is no time to get them out of bed. Elders (residents) will be left in their bed because it is easier. They are not getting checked and changed as frequently as they should During an interview on [DATE] at 10:50 a.m., when asked about facility functioning, including staffing, Staff D stated, Staffing is terrible, they have been begging for help forever. Last time we had this meeting with corporate, (it was) all about how to build a tree from its roots. Staff D said it had nothing to do with the living conditions in the facility and the lack of staff for resident care needs. Staff D said two CNA's recently quit because they worked four 16 hour shifts in a row. The wound care nurse quit too, because she worried she was going to have to go (work) on the floor. We had several people quit. They were good workers too. They didn't want to do all those shifts. During an interview on [DATE] at 9:55 a.m., the new NHA confirmed Social Service Designee C resigned on Monday ([DATE]) morning via email, with no notice provided. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 10:24 a.m., Administrative Staff (Staff) A and Administrative Staff (Staff) B confirmed new admissions were being planned; one for that day, and one on [DATE]. When asked if the facility had adequate staff to provide for current resident care needs, Staff A stated, Absolutely not, I do not have enough staff to provide care for the residents we have without the emergency staff that we currently have. Staff B stated, Corporate is pushing for us to take admissions. Staff A agreed and stated, Personally my thoughts, and I have had communication with [the NHA of Record] regarding my concerns - I personally don't feel we should be admitting right now . Corporate has asked us and told us to take admissions . It is crazy here. I didn't know that coming in. During an interview on [DATE] at 12:09 p.m., Administrative Staff B requested to speak with this Surveyor because Corporate instructs us on what to say about admissions and I didn't want to say anything in front of [Administrative Staff A] . I agree that our residents are not being taken care of with the staff that we have, and it is irresponsible for us to take more new admissions. That is not in the best interest of the residents or our staff. During an interview on [DATE] at 10:39 a.m., Staff T was asked for Nursing Competency Evaluations for five CNA's and three nurses. Staff T stated, I don't have any competencies for any of the CNA's or the nurses. I presented the list of all the nurses and CNA's that needed to be done. They could be in the DON's office, but I know that she would have them, and she would have given them to me. During an interview on [DATE] at 8:30 a.m., CNA and Nursing Competency Evaluations were requested from the new NHA for five CNA's and three facility nurses. The new NHA said that Staff T would have copies of those competencies, which Staff T had previously said the competencies were not found. During an interview on [DATE] at 11:52 a.m., the new NHA, regarding nurse competency evaluations, stated, I do not have any nurse aide, or nursing competencies to provide to you. No policy, or job descriptions detailed the requirement for annual competencies, but blank competency checklist forms were provided by the facility to show what information should have been completed. During an interview on [DATE] at 3:20 p.m., Staff N said right before the Emergency CNA's started, a night shift was staffed with two nurses. Staff N stated, We also had a weekend and a few other night shifts where it was one nurse and one CNA. The CNA had just graduated high school. [A Resident] said 'Nobody came in and offered to change and turn me.' It happened a second time, and it was each time it was just the one CNA working at night. I don't think we can provide the care that the residents need. [Resident #59] was also a bed bound resident who was not turned and repositioned and her bottom developed a coccyx wound which was previously healed and then she wasn't turned, and she developed a Stage III pressure injury to her coccyx. Staff N said Resident #59's urine was thick. We had been leaving one nurse (LPN) who had just graduated from LPN school a month ago, and the one CNA in the building at night . I have lost all hope and heart in this place. Staff N said management would rarely show up on Fridays and that is when she would get all the collection calls: [Paint Store], [hospitals], [internet provider], Medical Director sent faxes that we had outstanding bills. They were hand-written faxes, and I saw them saying she had not been paid . The wheelchair van bill had not been paid so they would not transport. [The Hospital] paid the wheelchair van so we could get our Resident (#53) back. Staff N was present when bill collectors dropped of envelopes for collection at the facility door. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Staff N said permission had been given to not have a manager on weekends. Staff N stated, We have had just an LPN and a CNA. Staff V became the interim DON two days ago. Two days ago, she was told she was that role. We did not even have Staff V's telephone number. Staff N said Staff V was not reachable over the weekends and was not reachable when she was not here. We had no group communication - some things got taped to the desk. Staff N said there was no Director of Nursing (DON) between the last DON and yesterday when the new DON started. We were never able to communicate with Staff V as the DON. If there was an incident - I called the Administrator . No residents can get their Resident Trust Fund money - it is incredibly difficult. It is embarrassing . Review of emails provided between facility staff and corporate officers revealed the following, in part: [DATE] 9:46 a.m. - FROM: NHA of Record/Regional Director of Operations: .With the annual survey cleared and behind us, it is time to get the word out to the hospitals and actively engage in new admissions. Thank you all for your efforts with the survey process so that we can now 'get back to normal' . [DATE] 10:28 a.m. - FROM: Facility Staff V to NHA of Record/Regional Director of Operations: I was not under the impression that we cleared our annual survey. During exit the surveyor stated that she cannot clear us in regard to the incident due to unvaccinated staff not following the policy/guidelines during the revisit . She did say our timeline will continue and we will still be in denial of payment. Along with our current critical CNA staffing shortage I do not believe it is ethical to begin taking admissions as our current residents are not receiving[TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35730 This citation pertain to intake MI00131019 Based on interview and record review, the facility failed to report an allegation of physical abuse for one Resident (#57) from 16 reviewed for abuse. This deficient practice resulted in the potential for continued abuse. Findings include: On 9/6/22 at 11:40 a.m., Resident #57 told this Surveyor a Certified Nurse Aide (CNA) hurt her the day prior, by pulling and jerking her arms during care. Resident #57 said the CNA yelled at her to stop yelling. The Resident said she told the other CNA working but couldn't remember who it was. On 9/6/22 at 11:45 a.m., the agency administrator worker, Staff A confirmed she was the working administrator in the building. This Surveyor reported the allegation and Staff A said it was the first she heard about it. During an interview on 9/6/22 at 12:30 p.m., CNA F confirmed Resident #57 told her of the allegation that morning just after 6:00 a.m. when she arrived to work. CNA F confirmed she did not tell anyone about the allegation because she thought the Resident was Just talking. During an interview on 9/6/22 at 12:36 p.m., Interim Director of Nursing (Staff) V, confirmed CNA F was aware of the allegation at 6:00 a.m., but did not report it to anyone. When explained the concern regarding timely reporting, Staff V stated, I know. I know. The policy, Abuse, Neglect and Exploitation, dated 6/2022, revealed, .The facility will .Report .all alleged violations to the Administrator, state agency .immediately, but not later than 2 hours after the allegation is made .

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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 - 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** 35103 This deficient practice pertains to Intake #MI00131016 and MI00130451. Based on interview and record review, the facility failed to provide appropriate activities of daily living (ADLs) that included, turning and repositioning, checking and changing of incontinence briefs, hydration, and wound care management to prevent the development and worsening of a facility-acquired Stage 3 pressure injury resulting in harm to one Resident (#59) of two residents reviewed for pressure injuries. This deficient practice resulted in worsening of condition, an increased in size of the Stage 3 pressure injury, and potential coccyx wound infection that required emergent medical care. Findings include: A Facility Reported Incident of potential neglect was identified and reported to the State Agency on [DATE]. The investigation summary, completed by the Nursing Home Administrator as of that date ([DATE]) revealed Certified Nurse Aide (CNA) TTT was 'neglecting' the residents on [DATE] when incontinence checks were not done on the night shift. Five residents including Residents #57, #59, #63, #64, and #65 were incontinent (wet) when staff came on at 2:00 a.m. on [DATE]. The night nurse informed CNA TTT it was an expectation to perform incontinence checks. When CNA TTT was interviewed by the NHA, regarding this allegation, the Investigation Summary documented [CNA TTT] stated the staff on duty had told her not to worry about the incontinence checks, and the investigation concluded [CNA TTT] did not perform midnight incontinence checks on [NAME] 14, 2022 . Review of Resident #59's MDS assessment, dated [DATE], revealed the Resident required extensive two-person assistance with bed mobility, dressing, toilet use, personal hygiene, and was dependent upon staff for bathing. Resident #59 had functional limitations in range of motion (ROM) of bilateral upper extremities (arms) and used a wheelchair for mobility. Resident #59 did not ambulate and was documented as Activity occurred only once or twice for transfers, and (wheelchair) locomotion on or off the unit. Resident #59 was always incontinent of urine and bowel, and had active diagnoses that included: anxiety, depression, heart failure, need for assistance with personal care, and history of urinary (tract) infections (UTIs). Resident #59 was documented as at risk for development of pressure ulcers, with no unhealed pressure injuries as of the [DATE] MDS assessment. Resident #59 scored 13 of 15 on the BIMS reflective of intact cognition. Review of Resident #59's Admission Record, printed [DATE], found no diagnoses related to pressure ulcers as of that date. Review of Resident #59's functional bowel and bladder incontinence care plan revealed the following intervention, in part: INCONTINENT Check me every 2 hours and as needed for incontinence. Wash, rinse, and dry perineum. Apply barrier cream after each incontinent episode and PRN (as needed) . Date Initiated: [DATE]. Review of the Positioning and Transfer policy, revised ,d+[DATE], revealed the following, in part: .Any resident confined to bed should be repositioned at least every two (2) hours unless contraindicated . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #59's Turned and Repositioned every 2 hours POC (point of care) Response History, revealed Certified Nurse Aide (CNA) staff documentation of turning and repositioning of Resident #59 during the past 30 days (from [DATE]) included the following, in part: 1. Eight days were documented for one shift only. 2. Ten days were documented on two shifts only. 3. No documentation of task completion was noted on [DATE] and [DATE]. During an interview on [DATE] at 3:20 p.m., Staff N said right before the Emergency CNAs started a night shift was staffed with two nurses. Staff N stated, We also had a weekend and a few other night shifts where it was one nurse and one CNA. The CNA had just graduated high school. [A Resident] said 'Nobody came in and offered to change and turn me.' It happened a second time, and it was each time it was just the one CNA working at night. I don't think we can provide the care that the residents need . During an interview on [DATE] at 3:20 p.m., Staff N stated, We had a weekend and a few other night shifts where it was one nurse and one CNA (working). The CNA had just graduated high school. [A Resident] said 'Nobody came in and offered to change and turn me.' It happened a second time, and it was each time it was just the one CNA working at night. I don't think we can provide the care that the residents need. [Resident #59] was also a bed bound resident who was not turned and repositioned and her bottom developed a coccyx wound which was previously healed and then she wasn't turned, and she developed a Stage III pressure injury to her coccyx. Staff N said Resident #59's urine had a strong odor and was a thick consistency. I was concerned Resident #59 was not getting the care she needed . I have lost all hope and heart in this place. During a telephone interview on [DATE] at 2:00 p.m., Staff N confirmed the following concerns related to Resident #59, who was transferred out to the acute care hospital with emergency care needs: 1. Prior to discharge to the hospital Resident #59 was observed to be dehydrated, with extremely dry oral mucosa, and was not observed offered sufficient oral hydration. 2. Resident #59 was not being timely changed and repositioned at nights, which was observed, reported, and education provided to the involved CNAs related to checking and changing briefs and repositioning of the resident. 3. Resident #59 was found wet, when she should have been checked and changed by inexperienced CNA staff. Resident interviews conducted on [DATE] at 12:30 p.m. and 3:01 p.m., [DATE] at 2:58 p.m., 3:45 p.m. and 3:48 p.m., and [DATE] at 9:00 a.m., with Residents #58, #55, #57, #62, #63, and Resident #55 respectively, all said the facility did not have adequate staff to meet their needs, showers were not being performed as scheduled, and call light response times were very slow, especially at night. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Staff interviews conducted on [DATE] at 12:02 p.m., 1:17 p.m., 2:17 p.m., 3:25 p.m., and 3:35 p.m., [DATE] at 9:30 a.m., 10:24 a.m., 10:50 a.m., 12:09 p.m. and 3:20 p.m., [DATE] at 10:08 a.m., Staff L, Staff E, Staff T, Staff H, Staff I, Staff J, Administrative Staff A, Staff D, Administrative Staff B, Staff N, and Medical Provider NN, acknowledge a serious staffing shortage. Direct care staff, of the above identified Staff, confirmed showers were not being done as scheduled, call lights were not being timely addressed, and dependent residents were not being repositioned every two hours. Review of Resident #59's Progress Notes revealed the following, in part: [DATE] 12:04 p.m., Resident obtained stage 3 pressure injury to coccyx . Educated CNA staff on freq (frequent) repositioning and brief changing . [DATE] 11:46 a.m., Weekly wound assessment to stage 3 coccyx wound show (sic) area larger . Reminded staff to do more freq brief checks with peri cares and repositioning at least q (every) 2 hours . [DATE] 12:59 p.m., Weekly wound assessment to stage 3 show little improvement . [DATE] 11:58 a.m., Weekly Wound Note . unstageable pressure injury to coccyx. Wound Measurements: Length x Width x Depth: 2.5 x 2 x 0.2 cm (centimeters) . [DATE] 10:47 a.m., .Resident calling for nurse; this nurse found resident to be on a deflated mattress. Upon investigation, the CPR cord had been detached, therefore, not retaining air/allowing air to escape . [DATE] 11:05 a.m., New pressure injury right coccyx unstageable pressure injury r/t slough. Wound Measurements: Length x Width x Depth: 1.5 x 1 cm . New Wound . [DATE] 12:04 p.m., IDT team wound and weight; Resident continues with pressure injuries to coccyx, right buttock and left buttock areas noted to be open with slough to the wound beds. New open area right of previous coccyx wound measuring 1.5 x 1 cm with slough in the wound bed .Orders placed for weekly weights r/t pressure injuries . [DATE] 2:32 a.m., Coccyx pressure injury .Unable to get into treatment cart for supplies . [DATE] 11:15 a.m., Late Entry: Coccyx III (Stage 3 Pressure Injury) . Wound Measurements: Length x Width x Depth: 4 x 2.5 . [DATE] 8:44 a.m., Weekly weights on Mondays r/t pressure injuries .We are extremely short staffed and have not gotten a weight yet . [DATE] 12:27 p.m., Note sent to MD regarding deteriorating wound and request foley to aid in wound healing . [DATE] 23:20 (11:20 p.m.) and [DATE] 23:14 (11:14 p.m.) Weekly weights on Mondays r/t pressure injuries . Weight not obtained . [DATE] 13:48 (1:48 p.m.), Coccyx stage III pressure injury . 3.4 x 2 x 0.2 . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	[DATE] 17:15 (5:15 p.m.), Resident's catheter was leaking all night and this morning . not able to be flushed . catheter removed and replaced . Urine is amber. Frequent thick white matter noted in the catheter tubing. MD notified via fax. [DATE] 14:40 (2:40 p.m.), Coccyx pressure injury's (sic): Change 3 times a week and PRN if soiled or lifting every day shift every Mon, Wed, Sat for wound care. Pressure ulcer dressing not changed sleeping x 2 when I went in . [DATE] 14:54 (2:54 p.m.), Approximately at 1330 (1:30 p.m.) sent resident to the ER (emergency room) . for changes in condition . she had low urine output and it did have blood in it. [DATE] 17:39 (5:39 p.m.), [ER] called report on Resident (#59), stated she has pneumonia, UTI, Septic . Nurse stated they cannot keep her blood pressure up despite all their interventions . [DATE] 11:23 a.m., Nurse received phone call from [acute care hospital], Resident (#59) passed away. Review of Resident #59's Wound Assessment forms included the following information, in part: [DATE] New skin condition, acquired in-house, coccyx, pressure, Stage III (3), 1 x .4 x .2 cm. [DATE], coccyx, Stage III pressure, 2 x 1 x .2 (increased in size). [DATE], coccyx, Stage III pressure, 2 x 1 x .2 cm. [DATE], coccyx, Stage III pressure 2 x 1 x .2 cm. [DATE], coccyx, Stage III pressure 1.8 x 1.0 x .2 cm. [DATE], coccyx, Unstageable, pressure 2.5 x 2 x 0.2 cm (increased in size). [DATE], coccyx, Unstageable, pressure 2.5 x 1.7 x 0.1cm. (This wound assessment signed on [DATE] by a sister facility Director of Nursing (DON).) [DATE], coccyx, Stage II Pressure, 3.5 x 3 x 0.1 cm. [DATE], coccyx, Unstageable pressure, 4.2 x 8 x 0.2 cm, Additional Information: Deteriorating: wounds (left and right coccyx pressure injuries combined to 1). Pain was associated with wound. Education provided related to frequent repositioning and the air mattress. [DATE], Stage III pressure, originally unstageable wound, 4 x 2 x 0.2 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the [Physician Group] Wound Care Clinic documentation signed [DATE] at 12:34 p.m., The #7 Stage III (3) Coccyx pressure injury was not healed and measured 2.2 x 1.3 x 0.2. and the new #8 Stage 2 coccyx pressure injury which was not healed and measured 0.7 x 0.5 x 0.1. These wounds were both documented as the Initial wound encounter, and the Initial exam. The Multi Wound Chart Details, dated [DATE], included additional facility acquired pressure injuries that included: #4, Left, proximal, lateral sacral Stage III pressure injury that measured 0.6 x 1.5 x 0.1, #5, Left, proximal sacral Stage II pressure ulcer that measured 0.5 x 0.5 x 0, and a right, proximal sacral Stage III pressure ulcer that measured 1.5 x 1.7 x 0.2. Review of the acute care hospital Emergency Department Physician Documentation: History of Present Illness, dated [DATE], revealed the following, in part: .Patient (Resident #59) has known sacral (coccyx) ulcer. She had an indwelling Foley catheter as she is incontinent of urine, and this was to protect the sacral ulcer . Foley in place with urine that is thick, purulent, and discolored. Breathing is shallow . B/P (blood pressure) was ,d+[DATE], and pulse oximetry (percentage of oxygen in the blood) was 95% on room air . ED Summary: Initial evaluation patient appears septic . Review of the [Acute Care Hospital] Assessment/Plan, signed [DATE], and [DATE], revealed the following, in part: 1. Septic Shock: Patient with chronic indwelling Foley catheter and stage III (Stage 3) sacral ulcer. Both could be related to septic shock. Pressure improved with fluid resuscitation . patient is not making enough urine. Will wait for urine output with fluid resuscitation . ([DATE]) . Blood culture positive for enterobacteria family and Proteus . 8. Dehydration: Continue IV hydration . Review of the facility Skin and Pressure Injury Risk Assessment and Prevention, revised ,d+[DATE], revealed the following, in part: .Interventions for Prevention and to Promote Healing: a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions . b. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care intervention could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting, and/or offloading heels, etc.); ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing, support surfaces; iv. Maintain or improve nutrition and hydration status . 11. Modifications of Interventions: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include: i. Changes in resident's degree of risk for developing a pressure injury. ii. New onset or recurrent pressure ulcer development. iii. Lack of progression towards healing .

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Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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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 - 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. 35730 Based on observation, interview and record review, the facility failed to appropriately supervise and monitor residents and the environment, for hazards and prevention of accidents, affecting potentially any facility resident able to mobilize throughout the facility. This deficient practice resulted in the potential for injuries and illness. Findings include: On 9/7/22 at 10:15 a.m., this Surveyor walked down the hallway along the laundry room to find water flooding the carpeted hallway, from under the laundry room doors. It was not known if the water was contaminated, electrified or otherwise unsafe. This Surveyor was aware of a 220 volt electrical cord from the residential dryer in use, lying on the floor inside the laundry room, and was immediately alarmed for the safety of the flooding water. An unidentified resident was wheeling toward the water with only socks on the feet and a urinary drainage bag hanging no more than one half inch above the floor from the underside of the wheel chair. No staff were in the vicinity. This Surveyor loudly called out for help three times before any staff arrived. The unidentified resident wheeled within inches of the rising water before staff arrived without urgency. This Surveyor then had to assume command of the situation and instruct arriving staff to keep residents away from the area, as several more residents arrived from the smoking area. This Surveyor then entered the laundry room to find hot water spraying from a fixture on the opposite wall. There was approximately two inches of hot water covering 90% of the laundry room floor and spilling out into the hall. At that time the water was within three feet of the 220 volt electric line on the floor behind residential dryers. There was an overhead page for a staff person to come to the laundry room. No staff reported the emergency to the Administrator (NHA). This Surveyor, when all residents in the vicinity were safely monitored and with staff, reported the emergency to the NHA. The NHA and several corporate staff from the office proceeded down the hall. As of the survey exit on 9/14/22 at 2:30 p.m., no qualified professional performed a water system analysis to determine safety of the system, or root cause analysis of the ruptured line. During an interview on 9/7/22 at 11:00 a.m., agency administrator as listed worker on the staff list, Staff A was asked her expectation of staff in response to any perceived emergency. Staff A said her expectation was that #1 residents are kept safe and secondly that staff would report the emergency to her immediately. The policy Environmental Services Safety Procedures, dated, 1/11/21, revealed, It is the policy of this facility to ensure general safety procedures are followed in the course of performing housekeeping and/or laundry duties . The Emergency Operations Program and Plan Manual, not dated, on pages 66-68, revealed, .It is the policy of this facility to protect our residents, staff and others who may be in our facility from harm during emergency events Monitor emergency progress, structural integrity of the facility and infrastructure systems . continue care and monitoring of residents .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35103 This deficient practice pertains to the following Intakes: #MI00130451, #MI00130427, #MI00130213, #MI00129738, #MI00129110, and #MI00131016. Based on observation, interview, and record review, the facility failed to provide adequate and competent staff to provide for resident care and safety needs, to ensure the highest practicable physical, mental, and psychosocial well-being of all facility residents. This deficient practice resulted in lack of scheduled showers, delayed or unmet incontinence care, slow call light responses, failure to reposition dependent residents, and the potential for resident-to-resident altercations and injuries with insufficient staff available for adequate supervision. Findings include: Due to the critical content of the interviews and evidence provided during this survey with repeated verbalization of resident and staff concerns related to potential retaliation by the facility, all staff will be identified as Staff unless the position title is critical to deficiency understanding. During a telephone interview on 9/6/22 at 5:22 p.m., Complainant FF, said in June and July of 2022 the facility was noticeably short of nursing staff, especially on the night shift. Complainant FF stated, Once in a while there was only one nurse and one aide (all night). Complainant FF said the concern was voiced to facility administration who said they were doing the best they could, I often had to wait for a respiratory treatment, and that made me short of breath and more anxious. I am incontinent and with one aide you may get changed once a night, and on afternoons you (I) had to wait over a half hour for a brief change with stool in it . With the showers, you never got the showers you were scheduled. I probably got a shower a month . Complainant FF reported wanting showers, but staff said they did not have time . During a telephone interview on 9/7/22 at 8:06 a.m., anonymous Complainant EE, an advocacy organization employee, reported having been in the building approximately three to four weeks previous. Anonymous Complainant EE stated, The day I was there many of the residents were fearful of the staffing situation (low staffing levels). One of the huge complaints I got was the (lack of) showering. During an interview on 9/7/22 at 12:02 p.m., Staff L stated, Staffing has been absolutely horrible. Staff L said they were terribly short on Certified Nurse Aides (CNAs), with three CNAs working day shift that day. Staff L said normally there would be five, and stated, .but we are short today. During an interview on 9/7/22 at 12:30 p.m., when asked about facility staffing, Resident #58 stated, They do not have enough staff, and noted staffing was less at night, call light response times were slow, with an extended time left wet and in BM (bowel movement), and showers were not received twice as week as scheduled. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/7/22 at 1:17 p.m., when asked about staffing, Staff E stated, They (Corporate Management) say we have adequate staff, but we don't . We have been begging and pleading with corporate. Out of a five-day week, staff are working four 16 hours shifts (because of mandated overtime) . They (residents) are not getting the care they need .We are in a crisis for staffing. I am scared (about) staffing . During an interview on 9/7/22 at 2:17 p.m., Staff T stated that staffing had been horrible before the State Emergency Staff arrived the previous week. Staff T stated, Regional (Corporate) kept saying it was fine and there was not an issue. We see them (CNAs) working 16-hour shifts - you cannot do that (to staff) . It is day to day right now on staffing . During an interview on 9/7/22 at 3:01 p.m., when asked about showers in the facility, Resident #55 stated, Sometimes I go two weeks without a shower. I (had) a shower day on Monday, and that was the first shower I had in 21 days. Resident #55 said staff would say they did not have time to give him a shower. When asked about call light response times, Resident #55 stated, It is sometimes horrible at night here. Sometimes it is just the nurse here, and there is no aide. Resident #55 stated, The good aides quit now. They were getting sick of being mandated. They quit and went somewhere else. During an interview on 9/7/22 at 3:25 p.m., Staff H confirmed the facility was noticeably short of staff, particularly CNAs. Staff H stated, Staffing has been terrible. There are some days I leave here (at approximately 10:00 p.m.) and there is nobody to work for nights . There are always two nurses (at night) if there are no aides, but there may be no aides. I am sure they (residents) don't get changed as often as they should be on night shift. The nurse can't pass pills and do all the medical things, and make sure everyone is checked and changed. Showers do not get done often, unless we have a shower aide . The 'with-it' (cognitively intact) residents say, 'I haven't had a shower in weeks', and you feel sorry for them (residents), but you just don't have the time. When asked about residents being left for extended periods of time in wet and/or soiled briefs, Staff H said that was a possibility because there wasn't enough staff. During an interview on 9/7/22 at 3:35 p.m., when asked about staffing levels, Staff I stated, It has been terrible. Everyone is getting mandated (required overtime) over and over and over. Everyone is exhausted . Showers do not get done . I get mandated into nights, and one night it was one nurse and me . The residents are complaining about care not being provided . Review of the Facility Assessment, updated July 1, 2022, revealed the following, in part: Staffing is maintained at a level to meet the needs of the resident population. Mandatory overtime is utilized to maintain levels and increased efforts have been made to recruit and retain staffing . The facility assesses the resident population through review of documentation from referral source (i.e., hospital, family, physician, homecare agency) prior to admission, assessments conducted upon admission into facility by IDT (Interdisciplinary Team), initial care planning meeting held with resident and/or their family or responsible party, and ongoing assessments completed per policy. The facility determines the acuity of residents following review of above documentation and assessments. The facility determines staffing levels upon review of acuity and availability and will adjust staff as needed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Activities of Daily Living documentation in the Facility Assessment included the following numbers for Assist of 1 or 2 which included 30-55 residents for transfers, dressing, and toileting, and Dependent which included 5-10 for transfers, and 0-10 for Mobility. No data was present showing the level of staffing that would be provided based on the resident acuity level for the facility. Review of the Updated Facility Assessment Staffing Appendix - 9/13/22 revealed the following additional information: Staffing is maintained at a level to meet the needs of the resident population. Mandatory overtime is utilized to maintain levels and increased efforts have been made to recruit and retain staffing . Base on the average acuity of [Facility Name], direct care staffing to meet the needs of the facility has been determined to be 2.9 PPD as of 9/13/22, but this PPD (patient pay day) is subject to change based on acuity and needs of the facility . [Facility Name] uses 2 licensed nurses per 12 hour shift, however, this may vary based on acuity changes. Based on the average acuity in the facility, the facility has determined an adequate staffing pattern. This pattern is subject to change based on acuity and is to be reviewed by the QA (Quality Assurance) committee during routine meetings. The example staffing pattern (subject to change) is shown below: Census Licensed Nurse Hours per Day [CNA hours per day] 30 48 39 35 48 54 40 48 68 45 48 83 50 48 97 55 48 112 Review of the Nursing Department Daily Staffing sheets from 8/22/22 through 9/13/22 revealed the following days with inadequate CNA hours based upon the updated facility assessment, which previous did not identify how staffing was determined: (Note: The Nursing Department Daily Staffing sheets do not identify the facility Census, so the actual number of residents is not able to be determined. A Resident Census of 42, as present on 9/6/22 will be presumed). 8/22/22, 50 CNA hours on Nursing Department Daily Staffing sheet, 68 required for Census of 40 as noted above. 8/23/22, 48 CNA hours, 68 required for Census of 40 as noted above. 8/24/22, 40 CNA hours, 68 required . 8/25/22, 56 CNA hours, 68 required . 8/26/22, 48 CNA hours, 68 required . 8/27/22, 32 RN hours, 48 required, 64 CNA hours, 68 required . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8/28/22, 60 CNA hours, 68 required . 8/29/22, 56 CNA hours, 68 required . 8/30/22, 40 RN hours, 48 required, 48 CNA hours, 68 required . 9/4/22, 36 RN hours, 48 required . 9/6/22, 56 CNA hours, 68 required . 9/7/22, 36 RN hours, 48 required, 64 CNA hours, 68 required . 9/8/22, 36 RN hours, 48 required . 9/9/22, 36 RN hours, 48 required . 9/11/22, 36 RN hours, 48 required, 48 CNA hours, 68 required . 9/12/22, 56 CNA hours, 68 required . 9/13/22, 64 CNA hours 68 required . 9/14/22, 32 RN hours, 48 required, 56 CNA hours, 56 required. Review of Payroll documentation for facility staff between 8/17/22 and 9/14/22, revealed Emergency CNA staff provided through the [State Name] began on 8/30/22 with the addition of five additional CNA agency staff members. The staffing shortage continued during this time, as the facility continued to operate with an insufficient amount of nurse and CNA hours to meet resident needs, although notification of an Immediate Jeopardy (IJ) at F600 for Neglect was served on 9/13/22. During an interview on 9/8/22 at 9:30 a.m., when asked about staffing, Staff J stated It is horrible. I think we only have five people that are full-time. We had two of our best employees quit because they were getting nailed for four 16-hour shifts when mandated. It is insane here - because we don't have enough staff . Showers are not getting done. There is no staff time to do them. They got used to saying, 'I don't have time to do it'. They got into that rut, and we were really short, and we didn't have time. They are not getting done. I think there are pressure ulcers because people are not getting turned. They (Residents) are not getting out of bed, because there is no time to get them out of bed. [Residents] will be left in their bed because it is easier. They are not getting checked and changed as frequently as they should During an interview on 9/8/22 at 10:00 a.m., Emergency Staff F said she did not believe residents were being repositioned timely, because they (emergency staffing aides, including Staff F) placed a piece of paper under [Resident #59] and when they would come in next, they would find the paper in the exact same place as they had placed it. Staff F said it was incredibly sad. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/8/22 at 10:24 a.m., when asked if the facility had adequate staff to provide for current resident care needs, Staff A stated, Absolutely not, I do not have enough staff to provide care for the residents we have without the emergency staff that we currently have . It is crazy here . Review of emails provided between facility staff and corporate officers revealed the following, in part: 8/26/22 10:28 a.m. - FROM: Facility Staff to NHA of Record/Regional Director of Operations: . Along with our current critical CNA staffing shortage I do not believe it is ethical to begin taking admissions as our current residents are not receiving the care that they deserve at this time. We do have 5 CNAs coming from emergency staffing on Monday but, this is not a solution to the crisis we are in. Plus, they will only be giving us 250 hours over 2 weeks which is only 25 hours over 2 weeks per CNA . We currently have 2 CNA's today for day shift and both will be mandated to work 16 hours. This message is not meant to be negative but . I need to advocate for all the staff and the residents. 9/3/22 10:51 a.m. - FROM Facility Administrative Staff to NHA of Record/Regional Director of Operations: . One of the day shift nurses called in for today due to a family emergency out of state and there is no one who is willing to pick it up at this point . Also, they should have two licensed nurses on nights, and they are running with one. Unfortunately, I was led to believe by both Administrative Staff Y and Staff E that the nurse(s) are pretty well covered. This is absolutely not the case. The RN staff are burnt, and many have left . 9/5/22 2:53 p.m. - FROM Administrative Staff to NHA of Record/Regional Director of Operations: .If we cannot secure adequate staffing, in all honesty, the corporation should be considering all options. To ensure the safety of the residents and whether it would not be in their best interest to close this facility During an interview on 9/8/22 at 10:50 a.m., when asked about facility functioning, including staffing, Staff D stated, Staffing is terrible, they (facility administration and staff) have been begging for help forever Review of an email dated 8/18/22 at 3:55 p.m., from Staff E to facility Owner Z, Chief Operating Officer AA, Nursing Home Administrator (NHA) of Record/Regional Director of Operations, NHA of another [Corporate Name] facility Y, Regional HR (human resources) Director BB and VP (Vice President), Clinical Operations CC, revealed the following: Emergent need of help. [Corporate Owner], I am still awaiting your assistance requested on Monday in which you replied: 'I'll take care of this today'. We are still waiting on a reply from a travel CNA agency. Our staffing is at a critical level as of Tuesday, August 22, 2022. We have been begging for help for months now. We have been mandating staff for 16 hrs. (hours) a day 4 days a week and have lost many good CNA's due to the excessive workload. They are feeling hopeless because corporate promises of help have not been met. PLEASE give us some help or direction as this building is at a critical level right now. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/8/22 at 12:09 p.m., Administrative Staff B requested to speak with this Surveyor and stated, . I agree that our residents are not being taken care of with the staff that we have, and it is irresponsible for us to take more new admissions. That is not in the best interest of the residents or our staff. Review of Resident Council Meeting Minute concerns, 3/2022 through 7/2022, revealed the following concerns identified, in part: unsupervised residents, CNAs ignoring people (lack of response to care needs), and multiple complaints related to lack of showers. During an observation and interview on 9/8/22 at 2:58 p.m., when asked about care received in the facility, Resident #62 said she was not routinely receiving showers from the facility and had been left in a cold, wet brief for two and a half hours one night. Resident #62 said she has a problem with recurrent urinary tract infections, so sitting in a wet brief was a concern to her. Resident #62 was observed in bed wearing a hospital gown. Resident #62 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Review of 14 Shower POC (point of care) Response Histories for Residents (#51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, and #64), revealed showers were not provided per the shower schedule for any of the 14 Residents reviewed. Sample Resident #50 and #65 were not reviewed for receipt of scheduled showers. Staff documentation on the Turning and Repositioning and Bed Mobility POC Response Histories were inconsistently completed by staff on various shifts, with not all shifts recording task completion on the above 14 residents. During an interview on 9/8/22 at 3:20 p.m., Staff N said right before the Emergency CNAs started a night shift was staffed with two nurses. Staff N stated, We also had a weekend and a few other night shifts where it was one nurse and one CNA. The CNA had just graduated high school. [A Resident] said 'Nobody came in and offered to change and turn me.' It happened a second time, and it was each time it was just the one CNA working at night. I don't think we can provide the care that the residents need . During an observation/interview on 9/9/22 at 3:45 p.m., Resident #57 was observed sitting in her wheelchair in the hallway with long (approximately 1 inch in length) facial hairs on her chin. Resident #57 stated, I want them to shave that, but they only do that when I get a shower, and I am not getting showers like I am supposed to. Resident #57 said the nurse aides were not nice and said the nurse aides did not have time to give her a shower. When asked about bed repositioning, Resident #57 said she could do that independently, but stated, There are not enough staff, and you have to wait a long time for them to respond if you need them . Resident #57's hair was long and unkempt. During an observation and interview on 9/9/22 at 5:00 p.m., Resident #63 was observed crying out for help while lying in her bed, flat on her back. Resident #63 was dressed only in a hospital gown and incontinence brief. Resident #63 had tears in her eyes as she cried, I hardly have any help anymore. I am not able to get the help I need. I don't want to be here anymore . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation/interview on 9/9/22 at 3:48 p.m., Resident #52 self-propelled up to this Surveyor in his wheelchair and stated, loudly, I really, really need a shower. I have been sick and had diarrhea, and I need to get cleaned up, but even the new aides say they don't have time to give me a shower. I get really mad when I have to ask and ask, and I need a shower and I don't get one. Resident #52 said several aides who had recently quit would get his showers done. Resident #52 stated, Now they don't get done. Review of Resident #52's Progress Notes revealed the following, in part: 9/8/22 01:37 (1:37 a.m.), Note Text: The resident was found to have dried BM in his groin creases during cares this night . Review of facility policies, including: Routine Resident Checks, dated July 2013, Incontinence, revised 12/20, Bathing, Revised 4/22, and Positioning and Transfer, dated 12/2018, revealed the following, in part: 1. Incontinence policy: .Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services . No reference to standard of practice time requirements for checking and changing of incontinent residents was identified in this policy. 2. Routine Resident Checks policy: To ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each unit at least once per each 8-hour shift. During interview with Staff P and the new NHA, on 9/14/22 at 10:35 a.m., regarding this policy, Staff P stated, Standard of Practice would be checking and changing as necessary every 2 hours. The new NHA stated, That is not a good policy. 3. Bathing policy: .4. A complete tub or shower bath shall be taken, under staff supervision, by (or administered to) an ambulatory resident at least once a week .5. A bedfast resident shall be assisted with bathing or bathed completely at least twice a week and shall be partially bathed daily and as required due to secretions, excretions, or odors. 4. Positioning and Transfer policy: Policy: The patient with limited mobility will be positioned and transferred in a safe manner . 1. Any resident confined to bed should be repositioned at least every two (2) hours unless contraindicated .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 35103 This citation pertains to intake MI00129110 and MI00130451. Based on interview and record review, the facility failed to ensure that licensed nurses had the specific competencies and skill set, and nurse aides demonstrated competency in skills and techniques necessary to care for residents needs in accordance with the facility assessment for three licensed nurses and five certified nurse aides (CNAs) out of eight staff reviewed for completion of annual competency checklists. This deficient practice resulted in the potential for lack of knowledge, competency, and skill in the provision of resident care needs, unmet care needs, and resident anxiety, depression, and feelings of hopelessness and helplessness when their needs were not addressed. Findings include: Due to the critical content of the interviews and evidence provided during this survey with repeated verbalization of Resident and Staff concerns related to potential retaliation by the facility, all staff will be identified as Staff unless the position identification of the position title is necessary. During an interview on 9/13/22 at 10:39 a.m., Staff T was asked for licensed nurse and CNA competency checklists for five CNAs and three licensed nurses. Staff T stated, I don't have any competencies for any of the CNAs or the nurses. I presented the list of all the nurses and the CNAs that need(ed) to be done (completed). They could be in the Director of Nurses (DONs) office, but I know . she would have given them to me (if she had them) . During an interview on 9/14/22 at 8:30 a.m., CNA and Nursing Competency Evaluations were requested from the new NHA for five CNAs and three facility nurses. The new NHA said that Staff T would have copies of those competencies, which Staff T had previously said the competencies were not found. During an interview on 9/14/22 at 8:30 a.m., nursing competency evaluations were requested for the following staff members from the new NHA and Staff V: 1. Staff H 2. Staff I 3. Staff VVV 4. Staff HH 5. Staff CCC 6. Staff O 7. Staff N and (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. Staff UUU During an interview on 9/14/22 at 1:00 p.m., the new Nursing Home Administrator (NHA) confirmed the only documentation to show what information would have been reviewed on licensed nurse and Certified Nurse Aide (CNA) annual competencies, were not job descriptions or a policy (as there was none found), but the blank Certified Nurse Aide Annual Competency Checklists. The new NHA said no completed Registered Nurse (RN)/Licensed Practical Nurse (LPN), /or CNA competencies were found/available for any of the eight staff requested. Review of the facility provided blank Certified Nurse Aide Annual Competency Checklist, and the Licensed Nurse Annual Competency Checklist, contained no documentation, but provided space for the CNA checklist for: Date Passed Verbally, Dated Passed by Demonstration, and Observer Signature, and for the Licensed Nurses: Instructor's Initials, Employee's Initials, Date, and Return Demonstration Date. No policy was ever provided by the facility before the end of the survey.

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	235552	A. Building B. Wing	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Deficiency Text Not Available

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 35730 Based on observation, interview and record review the facility failed to monitor resident behaviors to ensure safety and minimize adverse outcomes, for all residents in the facility. This deficient practice resulted in continued resident to resident altercations, wandering and the potential for injuries and disease transmission. Findings include: Throughout the following time frames several residents were observed to be congregated at the nursing station in chairs and wheel chairs, while staff were at times present and at times not present. Residents had no busying activities and several times were observed with near miss falls from chairs, unkind remarks to each other and others, yelling out, wandering and sleeping: On 9/6/22 from 11:15 a.m. till 12:45 p.m. and 1:30 p.m. till 4:30 p.m. On 9/7/22 from 9:30 a.m. till 10:00 a.m. and 11:00 a.m. till 2:00 p.m. On 9/13/22 from 10:00 a.m. till 11:00 a.m. and 1:00 p.m. till 3:00 p.m. Resident Council Minutes from 4/13/22, revealed the following concerns: Someone to keep an eye on people by the nurses' station (staff education/behavior intervention) On 9/13/22 at 11:06 a.m., Resident #50 was observed wandering into the room just off the nursing station with contact precautions in place. Registered Nurse, (RN) M was directly in view, standing at the medication cart, but did not pay attention. A few moments later, RN M called to the Resident, who was severely cognitively impaired, and said repeatedly, Come out of there, come on come on, come on, come out of there. RN M noticed this Surveyor observing and walked over to the room, donned a gown and gloves and entered the room to retrieve the Resident, pulling her backwards in the wheel chair from the bathroom, repeating 'no, no, no'. Resident #50 wore no mask, gown or gloves. RN M confirmed the resident living in the room was in precautions for C-difficile. During an interview on 9/7/22 at 8:40 a.m., the social service designee (Staff) C confirmed she was the facility behavior monitor, and a member of the interdisciplinary team (IDT). When asked how she monitored behaviors, Staff C said she did not regularly monitor behaviors and the only way she knew of any resident behaviors was if the nurse told her of them or if she heard someone yelling in the hall. When asked how Certified Nurse Aides (CNAs) documented behaviors, Staff C stated, I do not know. Staff C confirmed the facility had many residents with psychological diagnoses including psychoses, PTSD (Post Traumatic Stress Disorder) and other mental illnesses. Staff C said she knew how to interact with these kinds of residents but most staff did not. When asked if she provided education to staff about residents with behaviors, Staff C said did not because she didn't have a college degree and did not know the resources to tap. Staff C said the squeaky wheel gets greased and she was made aware of a behavior if she heard yelling episodes; otherwise she was unaware of any behaviors. Staff C confirmed she did not go to the floor to monitor behaviors during cares, meals, activities or resident to resident interactions. Staff C said she never received any trauma informed training and was unaware of three of the four resident to resident altercations being investigated. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The survey included four reported incidents of resident to resident altercations, including Resident #51 hitting and swearing at Resident #50, Resident #52 hitting Resident #50, Resident #54 throwing coffee on Resident #53, and Resident #55 swearing at Resident #56. According to the electronic medical records (EMRs), Resident #50 was severely cognitively impaired and wandered aimlessly, Resident #51 was cognitively intact with diagnoses including schizophrenia and anxiety, Resident #52 suffered from a traumatic brain injury, Resident #53 had PTSD. The policy Behavior Management Program, dated 12/2020, revealed, .Residents who display mental disorder, substance abuse, psychosocial adjustment difficulty, trauma, post-traumatic stress disorders, and dementia should receive appropriate services as indicated to optimize the resident's overall wellbeing . Residents will receive culturally competent, trauma informed care in accordance with professional standards of practice accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause retraumatization .Behaviors shall be identified through .staff interaction .further assessments to identify and manage behaviors may be conducted .Identified behaviors should be evaluated for frequency, duration, intensity and pattern .decide which residents need a behavior management program by evaluating the documented behaviors .Assess the behavior to discern why the resident is engaging in the behavior . Describe in detail the behavior .Examine the extent to which the behavior is a problem .:

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 This deficient pertains to Intake #MI00129738 & #MI00130451. Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety, by failure to dispose of outdated, visibly deteriorated salad and prepared cottage cheese, and prevent contamination of food when two boxes of tater tots (one open box, and one unopened) were stored on the floor in the walk-in cooler. This deficient practice resulted in the potential for foodborne illness with the use of expired and degraded food, and the risk of food contamination when being stored on the walk-in freezer floor. Findings include: During kitchen observation and interview on [DATE] at 1:10 p.m., in the presence of Staff R, the following items were found: 1. Two, 5 pound bags of shredded lettuce with a manufacturer's use by date of [DATE] were found in the walk-in refrigerator. The lettuce was browning and liquid was forming in the packages: one bag was opened and appeared to have been used, the other bag was unopened. 2. Two ,d+[DATE] cup servings of cottage cheese were found uncovered, on a tray with a use by date written on the tray of [DATE]. 3. Two boxes of tater tots: one open box, one sealed were placed directly on the walk-in freezer floor. Staff R observed the food items identified above and stated, Oh yeah, they (expired food items) are not to be used. When shown the boxes of tater tots on the walk-in freezer floor, Staff R said they were not to be stored on the freezer room floor, but should be stored on the shelves in the walk-in freezer. No cottage cheese was found in the cooler, and the amount of eggs was not sufficient for a facility meal (breakfast) per Staff R. 2013 FDA Food Code reference: ,d+[DATE].11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE] (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility Food Storage policy, revised ,d+[DATE], revealed the following, in part: .2. Food stored in walk-in refrigerators and freezers will be sorted on shelves, racks or other surfaces that facilitate thorough cleaning and air flow . 3.a. Fresh produce will have a receive date and be monitored for quality, discarding bruised or spoiled product . 5. Ready to eat food can be stored by expiration date, until opened, then labeled with open and use-by date if not discarded. 6. Use-by-dates are different for different food products, but do not exceed the product expiration date. 7. Food items that are opened shall be put into sealable container of bag, labeled and dated with open and use-by-date . During an interview on [DATE] at 3:01 p.m., Resident #55 said the facility had run out of eggs, both fresh and hard-boiled, brown sugar, and they hardly ever had cottage cheese (which Resident #55 enjoyed eating). During an interview on [DATE] at 3;:41 p.m., Staff Q confirmed they had received the wrong eggs; regular instead of pasteurized, cottage cheese had run out occasionally, on [DATE] the facility ran out of oatmeal, and on Saturday ([DATE]) [Dietitian S] had to go and buy five or six gallons of milk with her (personal) funds. When asked how the facility had run out of milk, Staff Q was unsure, and said the facility did not have petty cash, the corporation didn't pay for anything, and if Staff Q needed to buy something at the store it was with personal funds. Staff Q stated, I try my best to not run out of things. I am working so much in the kitchen (as a cook or dietary aide) I am not spending as much time doing my own job as I should. During an interview on [DATE] at 4:14 p.m., Consultant Dietitian S confirmed she purchased milk for the facility with personal funds. Dietitian S stated, I was here Saturday and I had to buy milk out of my own pocket. I know we have had some supply chain issues. Dietitian S confirmed they had run out of eggs, cottage cheese, and oatmeal.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 This deficient practice pertains to Intake #MI00130451 Based on observation, interview and record review, the facility administration failed to effectively and efficiently maintain sufficient resident care services and facility environment resources and supply chains to ensure: 1. Resident care needs were met. 2. Adequate staffing was available to provide resident care. 3. Timely payment of outstanding balances for: pharmaceutical supplies, transportation, facility repairs, lawn maintenance, mechanical vendors, flooring vendors, and medical supply vendors. 4. Facility management was in place to assess and manage critical facility concerns identified and expressed to corporate management. This deficient practice resulted in the potential for compromised resident physical, mental, and psychosocial well-being and had the potential to affect all 42 facility residents. Findings include: Due to the critical content of the interviews and evidence provided during this survey with repeated verbalization of resident and staff concerns related to potential retaliation by the facility, all staff will be identified as Staff unless the position title is critical to deficiency understanding. An abbreviated survey was completed on 9/14/22 that investigated multiple confidential and anonymous complaints with multiple allegations related to environmental and physical care of facility residents, and insufficient staffing levels. Residents interviews conducted on 9/7/22 at 12:30 p.m. and 3:01 p.m., 9/9/22 at 2:58 p.m., 3:45 p.m. and 3:48 p.m., and 9/14/22 at 9:00 a.m., with Residents #58, #55, #57, #62, #63, and Resident #55 respectively, all said the facility did not have adequate staff to meet their needs, showers were not being performed as scheduled, and call light response times were very slow, especially at night. Staff interviews conducted on 9/7/22 at 12:02 p.m., 1:17 p.m., 2:17 p.m., 3:25 p.m., and 3:35 p.m., 9/8/22 at 9:30 a.m., 10:24 a.m., 10:50 a.m., 12:09 p.m. and 3:20 p.m., 9/9/22 at 10:08 a.m., Staff L, Staff E, Staff T, Staff H, Staff I, Staff J, Administrative Staff A, Staff D, Administrative Staff B, Staff N, and Medical Provider NN, acknowledge a serious staffing shortage. Director care staff, of the above identified Staff confirmed showers were not being done as scheduled, call lights were not being timely addressed, dependent residents were not being repositioned every two hours, and all said that the Corporate Officers had been informed of the critical concerns for the facility. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/7/22 at 3:41 p.m., Staff Q confirmed she had worked at the facility from March 2021 and had not started her training for becoming a Certified Dietary Manager (CDM) until June of 2022. When asked why there was such a long delay in beginning the CDM training, Staff Q said the Facility Corporation had agreed to pay for the CDM training when she was hired in March of 2021. Staff Q stated, I had been submitting the expense reports for it to be paid for months and months . Eventually we tried to charge the credit card (for the training) and that (was) declined for several months . During an interview on 9/8/22 at 9:30 a.m., Staff J confirmed the facility bus had been repaired at a local facility, and the bill was paid with the personal credit card of Administrative Staff Y, who also used the personal credit card to pay for gasoline for the facility bus. Staff J identified multiple safety concerns with the facility bus that had gone unrepaired although the repairs had been reported to facility administration. Review of voluntarily provided emails from facility Staff, revealed the following, in part: Review of an email dated 8/15/22 at 7:41 a.m., sent by Staff E to facility Owner Z, Chief Operating Officer AA, Nursing Home Administrator (NHA) of Record/Regional Director of Operations, NHA of another [Corporate Name] facility Y, and W. Regional Director of Operations DD revealed the following: Non-payment: I am not sure whom to go to anymore, our facility is failing. We had calls over the weekend from [Internet Provider], our computer/internet, non-payment, they are going to turn us off. The hospital did not want to transport a resident back as we owe them money. We cannot rent from [Medical Supply Vendor] anymore, Non-payment. We cannot rent from [Medical Supply Vendor], wander guard monitors, non-payment. After August 24th we have 4 full-time CNA's (sic) left in this facility. Our lawn looks like a jungle. We have a handful of [NAME] employees sticking it out, what is happening with [Corporation Name]. We have been begging for help. Review of an email dated 8/18/22 at 3:55 p.m., from Staff E to facility Owner Z, Chief Operating Officer AA, Nursing Home Administrator (NHA) of Record/Regional Director of Operations, NHA of another [Corporate Name] facility Y, Regional HR (human resources) Director BB and VP (Vice President), Clinical Operations CC, revealed the following: Emergent need of help. [Corporate Owner], (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	I am still awaiting your assistance requested on Monday in which you replied: 'I'll take care of this today'. We are still waiting on a reply from a travel CNA agency. Our staffing is at a critical level as of Tuesday, August 22, 2022. We have been begging for help for months now. We have been mandating staff for 16 hrs. (hours) a day 4 days a week and have lost many good CNA's due to the excessive workload. They are feeling hopeless because corporate promises of help have not been met. We have numerous vendors complaining of non-payment. Most supply companies are on a credit hold. Transportation is an issue because of non-payment. We are unable to transport residents to their specialized MD (doctor) appts. (appointments) and procedures that are scheduled. This is putting them at risk. We never had petty cash available for emergency use. Our fax machine is not faxing out making outside communication difficult. All our management staff are working in all departments. The first appearance of our building is appalling. Our lawn hasn't been mowed. Weeds are overgrown. Dead trees are still standing. We are unable to get lawn service due to non-payment. Shut off notices are coming in the mail. The staff are concerned that we are going to have to close. This is a small community, and everyone talks. We have little to no suppliers that will deal with us due to our reputation. Our medical director was not paid since February (2022). Our kitchen, housekeeping, and several manger positions are open. We are at our wits end up here. PLEASE give us some help or direction as this building is at a critical level right now. 8/26/22 10:28 a.m. - FROM: Facility Staff to NHA of Record/Regional Director of Operations: . Along with our current critical CNA staffing shortage I do not believe it is ethical to begin taking admissions as our current residents are not receiving the care that they deserve at this time . 8/31/22 9:07 a.m., - FROM Facility Staff: We have 3 rooms closed due to leaking windows and have 2 rooms closed for carpeting issues. A total of 8 beds down. During a telephone interview on 9/13/22 at 3:10 p.m., when asked if an email had been received in August regarding the staff's request for help from the corporate office, Corporate Owner Z stated, I have not. Chief Operating Officer AA confirmed he had received an email from facility staff, but could not recall what assistance the facility requested. During telephone interviews on the following dates, revealed the following service and supply chain concerns: 9/8/22 12:48: [Pharmacy Vendor] reported charge account frozen. $611.61 owed and sent to collection. They do have a corporate account with us, and they are delinquent. 9/8/22 12:58 p.m.: [Medical Supply Vendor], Invoices that were paid in August (2022), included invoices from 3/24/22 and 3/25/22, being paid greater than four months past due. 9/8/22 1:05 p.m.: [Grocery Vendor] .Ownership changed for the facility and (we) were left with a $2,000 balance that never got paid . They (facility) reopened the account in February 2022. The last time they charged was in April (2022) . They (facility) still haven't paid anything and there is a $400 dollar balance that was owed . 9/8/22 1:16 p.m., [Transportation Vendor] The wheelchair van is not available from [Ambulance Service] . Because they have not paid any of the invoices since we started providing services (in) May of 2021. It is right around $1400.00 (we are owed) . We were not paid for a year and a half. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/6/22 at 11:45 a.m., the agency administrator, listed as worker on the facility staff list (Staff) A confirmed she was a traveling Nursing Home Administrator and was working temporarily as the administrator in the building. Staff A confirmed her first day of employment was Friday, 9/2/22. Staff A was not the Administrator of record with the State Agency (SA). During an interview on 9/6/22 at 12:36 p.m., Interim Director of Nursing (IDON) Minimum Data Set (MDS) coordinator and Infection Preventionist (IP), (Staff) V confirmed she was the IDON. Staff V said there was a new DON starting the next day (9/7/22). Staff V confirmed she was also the IP and MDS coordinator in the building and was working some floor shifts. During an interview on 9/7/22 at 11:05 a.m., Staff GG confirmed the Maintenance Director was usually the supervisor for laundry and housekeeping as well as maintenance, but there was no Maintenance Director employed at that time. Staff GG said the staff just work there normal shifts and figure it out. During an interview on 9/7/22 at 1:45 p.m., the Administrator (NHA) said he was in the building since about 9:00 a.m. that day. The NHA said he was employed with the corporation since 6/20/22 and the NHA of record for the building since 6/21/22. The NHA said his title was Director of Operations for the corporation. When asked how often he was in the building, the NHA said most Mondays since 6/21/22. When asked to provide the exact dates of his presence in the building, the NHA said he would have to get that information. During an interview on 9/13/22 at 10:00 a.m., Staff V confirmed she was the interim DON until the previous week on 9/7/22, when a new permanent DON started. Staff V said her responsibilities as the interim DON included clinical monitoring, oncall 24/7, staffing audits, risk management, 24-hour reports from staff, and meetings. Staff V confirmed these were in addition to her IP and MDS coordinator responsibilities. Staff V also confirmed she worked the floor for several shifts during August 2022. Staff V said her phone number was in the staffing book and all staff had access to her twenty four hours per day. Staff V said she did not think the general staff were informed of her interim DON status and some staff may not have known who to call for various issues or concerns. Staff V confirmed she never signed anything formally recognizing her or accepting an interim DON position and never received a position description for the DON position. When asked if she was able to fulfill all of the responsibilities of the DON, IP, MDS coordinator, especially while simultaneously working the floor, Staff V said she was not able to fulfill her duties. During an inteview on 9/13/22 at 4:02 p.m., Staff V reviewed the staffing book at the nursing station with this Surveyor and confirmed her phone number was not in the book nor posted anywhere for staff to contact her in the event of a need.

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Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 35730 Based on interview and record review, the facility failed to engage an active governing body that appropriately developed and implemented policies to manage the operation of the facility, for all 42 vulnerable residents. This deficient practice resulted in the mis-management of the facility, lacking consistent leadership and adequate staffing to meet resident needs. Findings include: During an interview on 9/13/22 at 11:26 a.m., the incoming Administrator (Staff) PP confirmed the previous day (9/12) was his first day of employment at the facility as Administrator. Staff PP said the governing body was the corporation, and the president was the outgoing Administrator of record and Director of Operations for the corporation (NHA). Staff PP said he was not yet informed of any regular accountabilities or communications or meetings with the governing body. During a phone interview on 9/13/22 at 11:41 a.m., the NHA (Regional Director of Operations) patched in the Regional Clinical Director (Staff) X. The NHA was asked who the governing body was for the facility and responded with the corporation's name. When asked who the members specifically were, the NHA said the owner and (Chief Executive Officer) CEO Z and the (Chief Operating Officer) COO AA. When asked if there were any other members, the NHA asked for the definition of governing body. When asked who the members of the governing body as described/defined in CMS (Center for Medicare and Medicaid Services) regulations, were, the NHA stated, We can get you that information. When asked if he or Staff X were members of the governing body, the NHA said he would have to see who was on the governing body. During a phone interview on 9/13/22 at 3:10 p.m., the CEO Z and COO AA were conferenced in. CEO Z was asked who the governing body for the facility was and responded, the corporation name. CEO Z went on to say the NHA was legally responsible for the facility operations. CEO Z then said he, COO AA, the NHA, Staff GGG and Staff CC, two other corporate individuals, were the governing body. When asked if he could recall what QAPI (Quality Assurance and Performance Improvement) projects were going on in the facility, CEO Z stated, No, I couldn't. During an interview on 9/14/22 at 11:53 a.m., incoming Administrator (Staff) PP reviewed QAPI meeting agendas and sign in sheets for August 2022. Staff PP stated, This doesn't look like very good QAPI notes. When asked if one could decipher what performance improvement projects (PIP) were in place and how the projects progressed, based on data, Staff PP confirmed one could not tell what was happening in QAPI. Staff PP said no direct care staff were involved with QAPI, but should be. Staff PP said generally standard QAPI agenda items and PIPs should include the last standard survey deficiencies, with updates regarding the progress of the PIPs and the data associated with them. When asked if the agenda and notes demonstrated a good faith attempt at correcting identified deficiencies, Staff PP stated, I would have to agree. When asked for clarification, Staff PP confirmed there was no evidence in the agenda or notes that good faith attempts were made to improve systems or processes. Staff PP also confirmed there was no evidence the Governing Body was involved with the QAPI program or its projects. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The policy Quality Assurance and Performance Improvement, dated 4/2019, revealed, .The governing body . is responsible and accountable for the QAPI program .oversight responsibilities include .Ensuring the program is ongoing, defined, implemented, maintained, and addresses identified priorities .Ensuring the program is sustained during transitions in leadership and staffing .Ensuring the program is adequately resourced .Ensuring the program identifies and prioritizes problems .with a formal meeting no less than annually . The policy Governing Body, dated 1/2021, revealed, .[Corporation name] governing body is legally responsible for management and operations .Establishes a designated body responsible for implementing and managing the operations of facilities according to federal, state and local laws .Ensure expectations of the organization are set around safety, quality, rights, choice and respect .Administrator .Reports to and is accountable to the governing body .Responsible for the facility practice of hiring .nurse aides .Responsible and accountable for QAPI program in accordance with RoP (requirements of participation) .Sustained during transition of leadership and staffing Adequately resourced .Corrective actions address gaps in systems .

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 35103 This deficient practice pertains to the following Intakes: #MI00130451, #MI00130427, #MI00129738, and #MI00131016. Based on interview and record review, the facility failed to fully complete a facility-wide assessment that documented how facility staffing levels were determined and utilized based on the facility census and acuity of the resident population to ensure necessary staffing and resources to meet the care needs for facility residents. This deficient practice resulted in insufficient staffing and resources to provide for resident care needs and had the potential to affect all 42 vulnerable residents. Findings include: Due to the critical content of the interviews and evidence provided during this survey with repeated verbalization of resident and staff concerns related to potential retaliation by the facility, all staff will be identified as Staff unless the position title is critical to deficiency understanding. During a telephone interview on 9/6/22 at 5:22 p.m., Complainant FF, said in June and July of 2022 the facility was noticeably short of nursing staff, especially on the night shift. Complainant FF stated, Once in a while there was only one nurse and one aide (all night). Complainant FF said the concern was voiced to facility administration who said they were doing the best they could. Complainant FF reported, I often had to wait for a respiratory treatment, and that made me short of breath and more anxious. I am incontinent and with one aide you may get changed once a night, and on afternoons you (I) had to wait over a half hour for a brief change with stool in it . With the showers, you never got the showers you were scheduled. I probably got a shower a month . Complainant FF reported wanting showers, but staff told him they did not have time . During a telephone interview on 9/7/22 at 8:06 a.m., anonymous Complainant EE, an advocacy organization employee, reported having been in the building approximately three to four weeks previous. Anonymous Complainant EE stated, The day I was there many of the residents were fearful of the staffing situation (low staffing levels). One of the huge complaints I got was the (lack of) showering. Review of the Facility Assessment, updated July 1, 2022, revealed the following, in part: Staffing is maintained at a level to meet the needs of the resident population. Mandatory overtime is utilized to maintain levels and increased efforts have been made to recruit and retain staffing . The facility assesses the resident population through review of documentation from referral source (i.e., hospital, family, physician, homecare agency) prior to admission, assessments conducted upon admission into facility by IDT, initial care planning meeting held with resident and/or their family or responsible party, and ongoing assessments completed per policy. The facility determines the acuity of residents following review of above documentation and assessments. The facility determines staffing levels upon review of acuity and availability and will adjust staff as needed. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Activities of Daily Living documentation in the Facility Assessment included the following numbers for Assist of 1 or 2 which included 30-55 residents for transfers, dressing, and toileting, and Dependent which included 5-10 for transfers, and 0-10 for Mobility. No data was present showing the level of staffing that would be provided based on the resident acuity level, which was not documented in the Facility Assessment for the facility. Review of the Updated Facility Assessment Staffing Appendix - 9/13/22 (updated seven days following start of the abbreviated survey) revealed the following additional information: Staffing is maintained at a level to meet the needs of the resident population. Mandatory overtime is utilized to maintain levels and increased efforts have been made to recruit and retain staffing . Base on the average acuity of [Facility Name], direct care staffing to meet the needs of the facility has been determined to be 2.9 PPD as of 9/13/22, but this PPD is subject to change based on acuity and needs of the facility . [Facility Name] uses 2 licensed nurses per 12 hour shift, however, this may vary based on acuity changes. Based on the average acuity in the facility, the facility has determined an adequate staffing pattern. This pattern is subject to change based on acuity and is to be reviewed by the QA committee during routine meetings. The example staffing pattern (subject to change) is shown below: Census Licensed Nurse Hours per Day [CNA hours per day] 30 48 39 35 48 54 40 48 68 45 48 83 50 48 97 55 48 112 This Appendix was not included on the Facility Assessment received 9/7/22, when originally requested from the facility Review of the Nursing Department Daily Staffing sheets from 8/22/22 through 9/13/22 revealed multiple days with inadequate staffing hours based upon the updated facility assessment Staffing Appendix for both nurses and CNAs. The Facility Assessment did not previously identify how staffing was determined. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Facility Assessment policy, dated 12/20, revealed the following, in part: Policy: The facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its resident competently during both day-to-day operation and emergencies . The facility assessment will include but not limited to (sic) the following . 1. The care required by the resident population considering the types of diseases, condition, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population . The staff competencies that are necessary to provide the level and types of care needed for the resident population . 2. The facilities resources, including but not limited to; . All personnel, including manager, staff (both employees and those who provide services under contract, and volunteers, as well as their education and/or training and any competencies related to resident care .3. A facility-based and community-based risk assessment, utilizing an all-hazards approach. 4. The facility assessment will be reviewed and updated whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment .

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 35730 Based on interview and record review, the facility failed to utilize outside resources to maintain the physical building when identified concerns could not be met with existing staff affecting all 42 vulnerable residents. This deficient practice resulted in the potential for worsening dilapidation, unsafe living conditions, and embarrassment for residents. Findings include: During an entrance conference on 9/6/22 at 11:45 a.m. the agency administrator (Staff) A confirmed the facility had no maintenance personnel employed including no maintenance director. During an interview on 9/6/22 at 1:35 p.m., Staff II confirmed there was no supervisor overseeing facility maintenance, housekeeping or laundry. During an interview on 9/13/22 at 2:37 p.m., the incoming Administrator, Staff PP and Staff III both confirmed no outside vendors/companies were contacted to fill the building maintainance needs. Two sister facilities in the area had maintenance staff but were not contributing to the facility. Both Staff PP and Staff III confirmed knowledge of a laundry flood with no follow up, a leaking roof and windows, out of order commercial dryers, an out of order shower room, wall damage, and other maintenance issues. Both confirmed at that time repairs were on hold awaiting hire of a new maintenance person. At time of survey there were no likely candidates for this position.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 35730 Based on interview and record review, the facility failed to employee a social service worker to provide medical social services to all 42 vulnerable Residents. This deficient practice resulted in the potential for injury and depression. Findings include: During an interview on 9/14/22 at 9:00 a.m., Resident #55 stated, Now they don't even have a Social Worker . Social Workers keep coming and going .The Social Workers start planning a discharge, working on how I can go home, and then everyone quits. At this rate, I am never going to get home. Resident #55 said it was extremely discouraging, because all he wanted to do was go home. Resident Council Minutes from 4/13/22, revealed the following concerns: Someone to keep an eye on people by the nurses' station (staff education/behavior intervention) On 9/13/22 at 11:06 a.m., Resident #50 was observed wandering into the room just off the nursing station with contact precautions in place. Registered Nurse, (RN) M was directly in view, standing at the medication cart, but did not pay attention. A few moments later, RN M called to the Resident, who was severely cognitively impaired, and said repeatedly, Come out of there, come on come on, come on, come out of there. RN M noticed this Surveyor observing and walked over to the room, donned a gown and gloves and entered the room to retrieve the Resident, pulling her backwards in the wheel chair from the bathroom, repeating 'no, no, no'. RN M confirmed the resident living in the room was in precautions for C-difficile. During an interview on 9/7/22 at 8:40 a.m., the social service designee (Staff) C confirmed she was the facility behavior monitor, and a member of the interdisciplinary team (IDT). When asked how she monitored behaviors, Staff C said she did not regularly monitor behaviors and the only way she knew of any resident behaviors was if the nurse told her of them or if she heard someone yelling in the hall. When asked how Certified Nurse Aides (CNAs) documented behaviors, Staff C stated, I do not know. Staff C confirmed the facility had many residents with psychological diagnoses including psychoses, PTSD (Post Traumatic Stress Disorder) and other mental illnesses. Staff C said she knew how to interact with these kinds of residents but most staff did not. When asked if she provided education to staff about residents with behaviors, Staff C said did not because she didn't have a college degree and did not know the resources to tap. Staff C said the squeaky wheel gets greased and she is made aware of a behavior if she hears yelling episodes; otherwise she was unaware of any behaviors. Staff C confirmed she did not go to the floor to monitor behaviors during cares, meals, activities or resident to resident interactions. Staff C said she never received any trauma informed training and was unaware of three of the four resident to resident altercations being investigated. The survey included four reported incidents of resident to resident altercations, including Resident #51 hitting and swearing at Resident #50, Resident #52 hitting Resident #50, Resident #54 throwing coffee on Resident #53, and Resident #55 swearing at Resident #56. According to the electronic medical records (EMRs), Resident #50 was severely cognitively impaired and wandered aimlessly, Resident #51 was cognitively intact with diagnoses including schizophrenia and anxiety, Resident #52 suffered from a traumatic brain injury, Resident #53 had PTSD. (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/14/22 at 9:55 a.m., the new NHA confirmed Social Service Designee C resigned on Monday (9/12/22) morning via email, with no notice provided.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 35730 Based on interview and record review, the facility failed to implement and maintain an effective Quality Assurance Performance Improvement (QAPI) program to ensure continuously improved quality of care and quality of life for all 42 vulnerable Residents. This deficient practice resulted in the potential for Resident functional debility, depression and withdrawal. Findings include: During an interview on 9/14/22 at 11:53 a.m., Incoming Administrator (Staff) PP reviewed QAPI meeting agendas and sign in sheets for August 2022. Staff PP stated, This doesn't look like very good QAPI notes. When asked if one could decipher what performance improvement projects (PIP) were in place and how the projects progressed, based on data, Staff PP confirmed one could not tell what was happening in QAPI. Staff PP said it looked like there was supposed to be a PIP for pressure wounds, but couldn't tell what was happening with it. Staff PP said no direct care staff were involved with QAPI, but should be. Staff PP said generally standard QAPI agenda items and PIPs should include the last standard survey deficiencies, with updates regarding the progress of the PIPs and the data associated with them. When asked if the agenda and notes demonstrated a good faith attempt at correcting identified deficiencies, Staff PP stated, I would have to agree. When asked for clarification, Staff PP confirmed there was no evidence in the agenda or notes that good faith attempts were made to improve systems or processes. Staff PP also confirmed there was no evidence the Governing Body was involved with the QAPI program or its projects. The policy Quality Assurance and Performance Improvement, dated 4/2019, revealed, .It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life .Develop and implement appropriate plans of action to correct identified quality deficiencies .Regularly review and analyze data .and act on available data to make improvements .The QAPI program will address .activities necessary to identify and correct quality deficiencies .Tracking and measuring performance .Establishing goals and thresholds .identifying and prioritizing quality deficiencies .Systematically analyzing underlying causes of systemic quality deficiencies . Monitoring and evaluating the effectiveness of corrective action .draw data from multiple sources .The facility assessment .Clinical logs such as for .pressure injuries .Staffing trends .Survey outcomes .