STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235664	A. Building B. Wing	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to treat residents in a dignified manner affecting four (R62, R316, R61 and R24) of seven residents reviewed for dignity. Findings include: R62: On 8/28/22 at 1:30 PM, R62 was observed lying in bed with a hospital gown loosely tied and hung down to their waist. R62 was holding their feeding tube and stated, Hi repeatedly. On 8/29/22 at 9:15 AM, R62 remained in bed with a hospital gown loosely secured around their neck. On 8/30/22 02:40 PM an interview was conducted with the two Certified Nursing Assistants (CNA 'G' and CNA 'O') that were assigned to R62 over the past couple of days. When asked if the resident has clothes to wear, they reported R62 did have clothes but were unable to explain why they did not get the resident up and dressed until today. CNA 'G' reported R63 zooms all over once they're in the wheelchair. Review of the clinical record revealed R62 was admitted into the facility on [DATE] and was readmitted on [DATE] with diagnoses that included: epilepsy, pervasive developmental disorder, and severe intellectual disabilities. According to the Minimum Data Set (MDS) assessment dated [DATE], R62 had significant communication limitations, had short and long term memory impairment and severely impaired cognitive skills for daily decision making, had no mood or behavior concerns, and was totally dependent upon one person for dressing. 34208 R316 (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/22 at 12:17 PM CNA 'F' was observed from the hallway in R316's room performing peri-care for R316. R316 was fully nude from the waist down and their genitals could be observed from the hallway. R316 was overheard to ask CNA 'F' who was out in the hallway. CNA 'F' told R316 they should have closed their privacy curtain before providing care. When CNA 'F' finished the care and exited the room, they said they should have closed the door. On 8/28/22 at approximately 5:12 PM, R316 was observed lying in bed. A dinner tray was on top of the bedside table that was not within reach of the resident. Certified Nursing Assistant (CNA)TT entered into the room and asked R316, Ain't you going to eat that food? The resident responded by asking how long has the food been there. CNA TT told the resident maybe like 10 minutes and stated, Don't you wanna get it? The resident reported that he was not able to get it on his own. CNA TT tried to pull the resident up by herself, but was not able to do it on her own. CNA TT then stepped out of the resident's room. When interviewed, CNA TT reported this was her second time working at the facility. When asked if she knew the resident could not ambulate on his own to obtain his meal, CNA TT reported that she wasn't even sure if the resident was on her assignment, and was also not aware of his transfer status. R61 On 8/30/22 at 4:20 PM, R61 was observed in their bed. When asked how they were doing, R61 said they were hungry. On 8/30/22 at 4:21 PM, Registered Nurse (RN) 'N' was asked if they were R61's assigned nurse, and said they were. RN 'N' was made aware R61 was hungry, but responded with, Dinner will be here soon. They were then asked if R61 could have a snack and said they would have to find someone to help R61 with a snack because they were, a feeder. On 8/30/22 at 4:27 PM, an interview was conducted with the Director of Nursing (DON) and they were asked if snacks were available, and said they were. They were made aware of a hospice resident's request for a snack and RN 'N's response of dinner being served soon and referring to a resident as, a feeder. The DON said it was not appropriate to refer to a resident as a feeder, and said residents on Hospice can, have whatever they want. The DON asked who the resident was and was informed it was R61. The DON said R61, always says he's hungry. They were asked if R61 was care planned for always being hungry and provided no response. R24 On 8/31/22 at 2:00 PM the dining room was observed with approximately nine residents preparing to play Bingo. At that time, R24 was observed in their wheelchair and CNA 'I' was observed trimming their fingernails at a table in the dining room. 34275 R317 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/31/22 at approximately 12:33 PM, R317 was observed laying on their back on the floor mat next to their bed. The resident was not wearing any cloths and appeared to have only a wet diaper on. About three inches away from the resident was a full lunch tray. The resident was not eating or attempting to eat anything on the lunch tray. The resident was alert, but not able to answer questions asked. The DON was asked to observe the resident. When asked why the resident was on the floor with their food tray, the DON and was not able to provide. The DON further indicated that it was inappropriate that he was lying flat on the floor mat without clothes.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 34275 Based on observation, interview, and record review, the facility failed to ensure call lights and water were accessible to five residents (R10, R11, R30, R316, R317) out of 26 resident reviewed for accommodation of needs. Findings include: On 8/28/22 at approximately 1:10 PM the observations were made: The call lights for R10 and R30, who reside in the same room, were observed on the floor and out of reach of the residents. There was no water within reach of either of the residents. R30 reported that it would not even matter if they could press the call-light as staff is not helpful. R30 noted that she had not received a shower or had their room cleaned in a long time. The call light for R11 was observed on the floor. The resident reported that he was not able to get out of bed on his own and stated that he feels stuck in bed all the time. The resident started to cry and reported that he needed therapy for their hand. The call lights for R316 and R317, who reside in the same room were observed on the floor and out of reach of the resident. There was no fresh water in reach for either resident. R316 appeared confused and was lying sideways on the bed as if he was trying to get up. On 8/28/22 at approximately 2:28 PM, Certified Nursing Assistant (CNA) EEE was interviewed. When asked about the facility protocol for call lights and water, CNA EEE stated that they should be in reach of the residents, but noted she was the only CNA working the hall at the moment. On 8/28/22 at approximately 3:48 PM, the call lights still remained on the floor for R10, R30, R11, R316 and R317. On 8/9/22 at approximately 11:23 AM, the Director of Nursing (DON) was interviewed. When queried about resident call light, the DON reported they should always be accessible to the resident.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 34208 Based on observation, interview, and record review the facility failed to protect the confidentiality of medical records for eight residents (R#'s 3, 48, 270, 25, 17, 59, 216 and 267), resulting in the potential for unsecured health information to be accessed by unauthorized persons. Findings include: A review of a facility provided policy titled, The Health Record for Legal and Business Purposes with a revision date of 12/2020 was conducted and read, .The HIPAA (Heath Insurance Portability Accountability Act) Privacy Rule requires establishing and implementing measures to ensure the confidentiality, integrity, and availability of all electronic Protected Health Information .2. Definition of Terms: .Hybrid record: The state of the medical record during transition of the EHR (electronic heath record) that causes part of the record to be on paper and part of the record to be in electronic form On 8/28/22 at 12:05 PM, an observation of the medication cart on the gold hallway was conducted. No staff were present at the cart, the nursing station, or down the hallway. It was observed the cart contained empty medication packaging and pharmacy labels with private health information and specific resident medications for R#s: 59, 216 and 267. On 8/28/22 at 12:15 PM an observation of the medication cart on the 1 East unit was conducted. No staff were present at the cart, the nursing station, or down the hallway. It was observed the cart contained empty medication packaging and pharmacy labels with private health information and specific resident medications including medications for mental health conditions for R#'s 3, 48, 270, 25, and 17. On 8/30/22 at 2:50 PM, an interview was conducted with Unit Manager 'A' and they acknowledged the concern and said the personal information should not have been left on the top of the medication cart. 30675

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00130095. Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, homelike environment, as evidenced by soiled floors and privacy curtains, broken furniture and fixtures, missing tiles, heavy buildup of mold in shower rooms, large gaps under doors, dusty fans, and broken windowpane. These deficient practices had the potential to affect all 62 residents in the facility. Findings include: On 8/28/22 at 1:00 PM, the floor drain cover on the 1 [NAME] hallway was missing. On 8/28/22 at 1:12 PM, room [ROOM NUMBER]-B (occupied by R45) was observed to have exposed wiring along the wall near the end of the bed. There was a broken metal piece from the bed resting on the floor. On 8/28/22 at 1:15 PM, room [ROOM NUMBER]-B (occupied by R18) was observed to have many large black flies throughout the room. On 8/28/22 at 1:24 PM, room [ROOM NUMBER]-B (occupied by R3) was observed to have a large black fly on their bed linen near their head. R3 did not respond to questions asked. On 8/28/22 at 1:30 PM, room [ROOM NUMBER]-A (occupied by R14) was observed to have many large black flies throughout the room. On 8/28/22 at 1:59 PM, room [ROOM NUMBER]-B (occupied by R54) was observed to have a tube feeding pump on a pole next to the bed. The surface area of the tube feeding pump was observed to have a heavy build-up of a brownish colored debris. There was garbage under the bed (wrappers, mouth swab), the flooring was heavily soiled, the blinds were bent and broken, and the light covering directly above the resident's head of the bed was observed to be cracked in half. The same was observed on 8/31/22 at 9:43 AM. On 8/28/22 at 2:02 PM, room [ROOM NUMBER]-A (occupied by R26) was observed to have heavily soiled privacy curtains, the bedside dresser was worn, with broken (missing) top part of the dresser and a broken handle that hung down. On 8/28/22 at 2:07 PM, room [ROOM NUMBER]-A (occupied by R50) was observed to have large black flies throughout the room. The wall in the hallway just outside of this room was observed to have a dark gray/brownish colored substance covering the wall. On 8/28/22 at 2:08 PM, room [ROOM NUMBER]-A (occupied by R46) was observed to have food debris and garbage on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/28/22 at 2:13 PM, room [ROOM NUMBER]-A (occupied by R15) was observed to having exposed wiring along the wall near the end of the bed. There was a broken metal piece from the bed resting on the floor. On 8/28/22 at 2:18 PM, the residents in room [ROOM NUMBER] (occupied by R55 and R20) reported a concern that the wax ring for the toilet might be broken as the toilet had been leaking for a while. They reported the facility was aware, but nothing had been done yet. Resident Council: On 8/29/22 at 11:00 AM, residents in attendance of the confidential resident council interview were asked about whether they were satisfied with their environment, or if there were any concerns. Six of the six residents in attendance reported concerns with the frequency of room cleaning and pests. Responses included: My room needs more cleaning. The corners need to be cleaned, there are spider webs. There's lots of flies and spiders. On 9/6/22 at 9:50 AM, an observation and interview was conducted with the Maintenance Director (Staff 'JJ'). They reported their department consisted of two staff, themselves, and Assistant (Staff 'KK') who started about a week ago. Staff 'JJ' was asked to observe several of the rooms identified with environmental concerns and reported they were not aware of most of them and did not recall seeing any of those reported in the facility's electronic reporting system. Staff 'JJ' further reported that these environmental concerns Must've just happened. Staff 'JJ' reported they were observed initially on 8/28/22 and remained a concern on 9/6/22. When asked about the missing floor drain cover, Staff 'JJ' reported they would get a cover now. When asked about why no one had identified this earlier as this was a concern with leaving an open hole of approximately 2 inches in a heavily traveled part of the hallway, they offered no further response. When asked about the exposed wiring in R15's room, Staff 'JJ' reported they were aware of that last week when they rounded with Life Safety staff. When asked why it still wasn't addressed, they offered no further response. 22960 On 8/29/22 between 9:00 AM-10:00 AM, during a tour of the facility with Maintenance Supervisor JJ, the following items were observed: In the Basement boiler room, there was a large area of standing water on the floor, and a slow drip observed from the kitchen water tank piping. Maintenance Supervisor JJ confirmed he was aware of the standing water, but provided no further explanation. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The exit door in the basement located next to the boiler room, and leading up into the courtyard, was observed with a large gap along the bottom edge of the door. In addition, the exit door near the 1st floor dining room was observed with a large gap at the bottom of the door. Maintenance Supervisor JJ confirmed the gaps at the exit doors, but provided no further explanation. room [ROOM NUMBER]- There were missing floor tiles near the toilet in the bathroom. The 1 East shower room was observed with heavy buildup of mildew in the grout on the walls and the shower floor. Maintenance Supervisor JJ confirmed the mildew and stated he would have housekeeping clean it. In the 1 [NAME] shower room, the grout in the shower was heavily soiled with a black substance. The wall mounted fan located in the beauty shop was observed with dust on the blades and outer caging. room [ROOM NUMBER]- The window blinds were observed with missing, broken panes, leaving a large (approximately 9X9) open area exposed to the outside. In addition, the night stand was observed with broken handles, which were loose and hanging down. The bathroom floor was observed to be dull with black stains on the floor tiles. Maintenance Supervisor stated they strip and wax the floors on a monthly basis. There was a heavy infestation of large, black flies in the 1 [NAME] Hallway. Maintenance Supervisor confirmed the presence of the flies, but provided no explanation. 34208 On 8/28/22 at 12:43 PM, a review of resident occupied room [ROOM NUMBER] was conducted and revealed a garbage can with no liner and trash inside the can and dirty gloves and a syringe wrapper littered on the floor near the garbage can. 8/28/22 at 1:02 PM, an untouched breakfast tray was on the bedside table of room [ROOM NUMBER] bed C. A record review conducted on 8/28/22 at 8:50 PM revealed the resident in 121 bed C discharged on [DATE]. On 8/28/22 at 1:08 PM, an observation was made of room [ROOM NUMBER]. The floor area near 119 bed A was sticky with stains and had food and paper debris littering floor. The trash can near the bathroom was full, with no can liner containing the trash. An observation of the area of 119 bed C was observed to have soiled linens and two unfolded adult incontinence briefs on the floor at the foot of the bed. It was also noted the area of the bed had a strong urine odor. On 8/29/22 at 9:28 AM, an untouched dinner tray from 8/28/22 was observed on the bedside table of room [ROOM NUMBER]. On 8/29/22 at 11:25 AM, room [ROOM NUMBER]'s floor remained sticky, stained, and with food and paper debris littering the floor. A resident in the hallway was overheard complaining about the conditions of room [ROOM NUMBER] saying they were afraid the condition of room was going to bring in lice, rats, and mice. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	32568 On 8/28/22 at 12:54 PM, R217 was observed lying in bed. A trash can filled with dirty briefs was observed next to R217's bed. On 8/28/22 at 1:19 PM, R56's room was observed. The floor was soiled with dried tube feeding formula, trash, large crumbs, and spilled food. There was a strong urine odor in the room and the floor was sticky and appeared to not be mopped. On 8/28/22 at 2:06 PM, R56's room remained in the same condition. On 8/28/22 at 4:10 PM, R56's room was observed. The crumps of food and trash were removed from the floor, but the dried tube feeding formula remained.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 32568 Based on observation, interview, and record review, the facility failed to ensure an environment free from neglect for nine (R29, R35, R36, R58, R59, R61, R64, R266, and R268) of nine residents reviewed for neglect. This resulted in an Immediate Jeopardy (IJ) to the health and safety of the residents when these residents were not assigned a licensed or registered nurse for eight and a half hours (7:42 AM until 4:15 PM) and did not receive multiple physician ordered medications needed to treat medical conditions, such as, seizures, diabetes, blood clots, edema, neurological and psychiatric disorders, and pain; did not provide treatments including tracheostomy care, wound care, and PEG tube care; complete nursing assessments for pain and blood sugar monitoring; provide supervision; and respond to potential crisis/medical complications. This increased likelihood of serious injury, serious harm, and/or death to these nine residents. Findings include: On 8/29/22 at 9:40 AM, an interview was conducted with Nurse 'K' regarding their assignment. Nurse 'K' said their assignment was the entire [NAME] Wing and they believed they were splitting the center Gold Hall with Nurse 'M' until another nurse arrived to take the Gold Hall assignment. On 8/29/22 at approximately 9:45 AM, the Director of Nursing (DON) was observed counting controlled medications with the oncoming nurse (Nurse 'K') at the [NAME] Wing medication cart. At that time, the DON was observed informing Nurse 'K' they would have [NAME] Wing and a portion of the Gold Hall. On 8/29/22 at 10:25 AM, an interview was conducted with Nurse 'M' and they reported their assignment was the East Wing and half of the Gold Hall. On 8/29/22 at 10:35 AM, an interview was conducted with Unit Manager, Nurse 'A' regarding the staff assignments. They reported Nurse 'K' had the [NAME] Wing, and half of the Gold Hall, and Nurse 'M' had the East Wing and the other half of the Gold Hall until 11:00 AM when a third nurse was scheduled to arrive. Nurse 'A' explained when the third nurse arrived, their assignment would be the entire Gold hallway. On 8/29/22 at approximately 11:47 AM, R268 was heard yelling for help. When interviewed as to why she was yelling, R268 reported that she was still waiting for her medication that was not provided earlier. R268 stated that she has been asking for a Nurse all morning, had pain in her back and was not feeling well. The resident pointed to a list of medications that was taped on the wall of her room and stated those are all the medications I did not receive. The resident pressed her call light and CNA QQ entered the room. CNA QQ told R268 that she was looking for a nurse but was not able to locate anyone working on the floor. At approximately 12:47 PM, Nurse M was asked about who was responsible for providing R268's medication and they reported they believed Nurse J was assigned to the resident but had never met the Nurse and was not sure where they were. On 8/29/22 at 2:45 PM, R61 was observed and did not respond when asked if they received their morning medications. On 8/29/22 at approximately 2:58 PM, R268 reported that they still had not received their morning medications and the dressings to their legs had not been changed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/29/22 at 3:15 PM, R59 was observed entering her room in a wheelchair. R59 asked, Can I please have my medications? When asked if she received medication that day, R59 reported she did not. R59 explained they took a medication that helped them to not urinate as frequently and reported she was uncomfortable because I have been going (urinating) so much all day today! On 8/29/22 at 3:16 PM, R266 was observed slouched in a chair in her room, shaking and crying. When addressed R266 was difficult to understand and spoke about aliens and needing help, but was unable to articulate what she needed. On 8/29/22 at approximately 3:17 PM, R64 reported she did not receive medications that day. On 8/29/22 at approximately 3:18 PM, R36 was lying in bed. R36's mother was in the room and noted that they had been with the resident since 11:00 AM and reported that no medication had been given to the resident and she was concerned that R36 did not receive his necessary seizure medication. On 8/29/22 at 3:20 PM, a follow-up interview was conducted with Nurse 'K'. Nurse 'K' said they were informed a nurse arrived from the staffing agency at 11:00 AM and now their current assignment was limited to the [NAME] Hall minus R29, R35, and R58. Nurse 'K' reported they arrived for their shift at approximately 8:30 AM or 9:00 AM. R35 Review of R35's physician orders and Medication and Treatment Administration Records (MAR/TAR) was conducted on 8/29/22 at 3:30 PM. Review of the Physician's orders revealed R35 was scheduled to receive the following medications, treatments, and assessments: Bumetanide Tablet (a diuretic used to prevent fluid overload in patients with congestive heart failure - CHF) 1 MG Give 1 mg by mouth in the morning for Bumex Take 1 tab daily, scheduled at 9:00 AM and was not administered (no nurse's signature was documented on the MAR and no progress note was written to indicate this medication was given or the provider was notified of the missed medication). Insulin Glargine Solution 100 UNIT/ML Inject 10 unit subcutaneously one time a day for diabetes, scheduled at 8:00 AM and was not administered. Novolog Solution (insulin) 100 UNIT/ML Inject as per sliding scale .two times a day for DM, scheduled at 9:00 AM and 9:00 PM. The 9:00 AM dose was not administered and R35's blood sugar was not monitored. Eliquis Tablet (a medication used to prevent blood clots) 2.5 MG Give 2.5 mg by mouth every 12 hours for Eliquis Take 2.5 mg every 12 hours, scheduled at 9:00 and 9:00 PM. The 9:00 AM dose was not administered on 8/29/22. Entresto Tablet (a medication used to treat high blood pressure) 24-26 MG Give 1 tablet by mouth every 12 hours, scheduled at 9:00 AM and 9:00 PM. The 9:00 AM dose was not administered on 8/29/22. Prandin Tablet (a medication used to treat diabetes) Give 0.5 mg by mouth with meals, scheduled at 8:00 AM, 12:00 PM and 6:00 PM. The 8:00 AM and 12:00 PM doses were not administered. Further review of R35's MAR on 8/30/22 revealed the 6:00 PM dose was not administered. (continued on next page)

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	235664	A. Building B. Wing	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the clinical record revealed R35 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: acute on chronic systolic heart failure, peripheral vascular disease (PVD), inflammatory liver disease, ascites, chronic kidney disease stage 3, chronic atrial fibrillation, essential hypertension, and type 2 diabetes mellitus (DM). The MDS assessment dated [DATE] noted R35 had intact cognition. Review of R35's progress notes revealed the following documentation regarding the missed medication on 8/29/22: An entry on 8/29/22 at 11:55 PM from Physician 'BB read, .Pt (patient) seen for increasing swelling in his legs and scrotum. States the am nurse did not give him his meds. Has hx (history) of ischemic CMP (Cardiomyopathies) EF (Ejection Fraction - heart failure measurement) 20-25%. Pt was asking to go to the hospital .+ Scrotal edema mild, no drainage, no erythema or warmth .Assessment and Plan: 1. Legs edema/scrotal edema/volume overload 2/2 (secondary to) acute decompensated CHF likely 2/2 meds and diet noncompliance. -Pt states he did not receive meds this an<sic> including Bumex (bumetanide)-d/w (discussed with) RN (Registered Nurse) to give bumex dose now (around 4:30 PM) and to inc (increase) bumex to 1 mg BID (twice a day) and give 2nd dose tonight around 9 PM. -if no improvement in the next couple days or worsening in symptoms, will send pt to the ER/Hosp (emergency room /Hospital) for IV (intravenous) diuretics . On 8/31/22 at 9:08 AM, Physician 'BB' was attempted to be reached by phone. There was no return call prior to the end of the survey. R29 Review of R29's physician orders and MAR/TAR was conducted on 8/29/22 at 3:30 PM. Review of the Physician's orders revealed R29 was scheduled to receive the following medications, treatments, and assessments: Provide tracheostomy care and replace inner cannular each morning every day. Further review of R29's MAR revealed this was not completed on 8/29/22 between the hours of 7:00 AM and 7:00 PM. Levothyroxine Sodium (a medication used to treat underactive thyroid) Tablet 137 MCG (micrograms) - Give 137 mcg by mouth one time a day for low thyroid hormone, scheduled at 9:00 AM and was not administered. Enteral Feed Order two times a day for NPO (nothing by mouth) Glucerna 1.5 1200ml (milliliters) @ 75ml/hr (milliliters per hour) x 16 hrs (run from 6PM-10AM.) Bolus flush 150ml ac/pc (before and after) feeding administration, with auto flush of 50ml/hr x 16 hrs for duration of infusion. 1200ml formula, 1800kcals (kilocalories), 2000ml free H2O (water). This was not administered on 8/28/22 at 6:00 PM and 8/29/22 at 9:00 AM. Further review of R29's MAR on 8/30/22 revealed he did not receive tube feeding on 8/29/22 at 6:00 PM. Levetiracetam (a medication used to treat seizures) Solution 100 MG/ML (milligram per milliliters) Give 15 ml via G-Tube two times a day, scheduled at 9:00 AM and was not administered. Heparin Sodium (a medication used to prevent blood clots) PF Solution 5000 Unit/ml Inject 1 ml subcutaneously every 8 hours, scheduled at 2:00 PM and was not administered. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Insulin Lispro Solution 100 Unit/ml Inject as per sliding scale .subcutaneously every 8 hours, scheduled at 6:00 AM, 2:00 PM and 10:00 PM and was not administered on 8/29/22 at 2:00 PM. Phenytoin Suspension (a medication used to prevent seizures) 125 MG/5ML Give 7.5 ml via G-Tube three times a day, scheduled at 8:00 AM, 1:00 PM and 9:00 PM and was not administered on 8/29/22 at 8:00 AM and 1:00 PM. Enteral Feed Order every 4 hours for NPO Flush 10 ml H2O ac/pc each medication administration and 5ml between each medication, scheduled at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. This was not administered on 8/29/22 at 8:00 AM and 4:00 PM. Oxygen at 5L/min (liters per minute) via trach continuously every shift related to tracheostomy status, scheduled to be done on the 7A-7P shift. Further review of R29's MAR revealed this was not completed on 8/29/22 between the hours of 7:00 AM and 7:00 PM. Further review of the clinical record revealed R29 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: malignant neoplasm of larynx, tracheostomy status, type 1 diabetes mellitus, unspecified diastolic heart failure, hypothyroidism, other seizures, hemiplegia, and hemiparesis following cerebral infarction affecting left dominant side, and essential hypertension. According to the MDS assessment dated [DATE], R29 had severe cognitive impairment. Review of the progress notes since 8/29/22 revealed documentation that the practitioner was not notified of the delayed/missed medications until 8/30/22 at 9:49 AM by Nurse Manager 'A'. R58 Review of R58's physician orders and Medication and Treatment Administration Records (MAR/TAR) was conducted on 8/29/22 at 3:30 PM. Review of the Physician's orders revealed R58 was scheduled to receive the following medications, treatments, and assessments: Allopurinol (a medication used to treat gout) Tablet 100 MG Give 1 tablet by mouth one time a day, scheduled at 9:00 AM and was not administered. Aspirin Tablet Give 81 mg by mouth one time a day, scheduled at 9:00 AM and was not administered. Finasteride Tablet (a medication used for urinary retention) 5 MG Give 5 mg by mouth one time a day, scheduled at 9:00 AM and was not administered. Flomax Capsule (a medication used for urinary retention) 0.4 MG Give 0.4 capsule by mouth in the morning, scheduled at 8:00 AM and was not administered. Furosemide (Lasix - a medication used to treat fluid retention/edema in people with CHF) 80 MG Give 1 tablet by mouth one time, scheduled at 9:00 AM and was not administered. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Hydrocodone - Acetaminophen Tablet (a narcotic pain medication) 7.5 -325 MG Give 2 tablet orally every 6 hours for Moderate Pain, scheduled at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM and not administered on 8/29/22 at 12:00 PM. Further review of R58's MAR on 8/30/22 revealed the 6:00 PM dose was not administered. Insulin Glargine Solution 100 UNIT/ML Inject 6 unit subcutaneously one time a day, scheduled at 8:00 AM and was not administered and R58's blood sugar was not monitored. Insulin Regular Human Solution Inject as per sliding scale .subcutaneously before meals, scheduled at 6:30 AM, 11:30 AM and 4:30 PM and not administered on 8/29/22 at 11:30 AM and 4:30 PM. Nifedipine ER (a medication used to treat cardiac and circulatory disorders) Tablet Extended Release 24 Hour 90 MG Give 1 tablet by mouth one time a day, scheduled at 9:00 AM and was not administered. Potassium Tablet (Potassium - a medication used for low potassium) Give 10 mEq (milliequivalents) by mouth one time a day, scheduled at 9:00 AM and was not administered. Carvedilol Tablet (a medication used to treat high blood pressure and heart failure) 12.5 MG Give 1 tablet by mouth two times a day, scheduled at 9:00 AM and 9:00 PM and not administered on 8/29/22 at 9:00 AM. Levetiracetam Tablet 500 MG Give 500 mg by mouth two times a day, scheduled at 9:00 AM and 9:00 PM and not was not administered on 8/29/22 at 9:00 AM. Quetiapine Fumarate Tablet (a medication used to treat psychotic disorder with hallucinations) 25 MG Give 1 tablet orally every 12 hours, scheduled at 8:00 AM and 8:00 PM and not administered on 8/29/22 at 8:00 AM. Hydralazine HCl Tablet (a medication used to treat high blood pressure) 50 MG Give 50 mg by mouth three times a day, scheduled at 6:00 AM, 1:00 PM and 9:00 PM and not administered on 8/29/22 at 1:00 PM. Salonpas Pain Relieving Patch 4% (Lidocaine) Apply to Right shoulder topically one time a day for pain, scheduled at 9:00 AM and was not administered. Review of the clinical record revealed R58 was admitted into the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus, benign prostatic hyperplasia with lower urinary tract symptoms, long term use of insulin, anal fistula, acute kidney failure, psychotic disorder with hallucinations, and functional quadriplegia. According to the MDS assessment dated [DATE], R58 had intact cognition. R268 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of R268's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Parkinson's Disease, Heart Failure, Unspecified Dementia, Chronic Pain, Anxiety and Post Traumatic Stress Disorder. A review of the resident's MDS indicated the resident was cognitively intact. Review of R268's Physician's Orders and MAR/TAR was conducted on 8/29/22 at 3:30 PM. Review of the Physicians orders revealed R268 was scheduled to receive the following medications, treatments, and assessments: Amlodipine (a medication used for High Blood Pressure) 10 MG one time per day, scheduled at 9:00 AM and was not administered on 8/29/22. Furosemide 40 MG one time per day, scheduled at 9:00 AM and was not administered on 8/29/22. Glucotrol XL (a medication used to treat diabetes). 2.5 MG tablet, scheduled at 9:00 AM and was not administered on 8/29/22. A Blood Sugar check scheduled for 8:00 AM on 8/29/22 was not administered. Lidocaine Patch 5% (Apply to lower back topically one time a day for pain), scheduled at 9:00 AM and was not administered on 8/29/22. Toprol (a medication used to treat HTN) Release 24 Hour 25 MG, scheduled at 9:00 AM was not administered on 8/29/22. Wellbutrin (a medication used to treat depression) XL Tablet Extended Release 24 Hour 300 MG, scheduled for 9:00 AM and was not administered on 8/29/22. Apixaban (Eliquis) Tablet 5MG, scheduled for 8:00 AM and 5:00 PM. The 8:00 AM dose was not administered on 8/29/22. Further review on 8/30/22 noted that the 8/29/22 5:00 PM dose was not administered. Lisinopril Tablet (a medication used to treat high blood pressure) 5 MG, scheduled for 9:00 AM and 5:00 PM. The 9:00 AM dose was not administered. Further review of the MAR on 8/30/22 noted that the 5:00 PM dose on 8/29/22 was not administered. Alprazolam Tablet (a medication used to treat anxiety) 0.5 MG, scheduled for 9:00 AM, 3:00 PM and 9:00 PM. The 9:00 AM and 3:00 PM dose was not administered on 8/29/22. Further review of the MAR on 8/30/22 noted that the 8/29/22 9:00 PM dose was not administered. Carbidopa-Levodopa (a medication used for Parkinson's Disease) Tablet 25-100MG, scheduled for 9:00 AM, 3:00 PM and 9:00PM. The 9:00 AM and 3:00 PM doses were not administered on 8/29/22. Gabapentin Capsule (a medication used to treat nerve pain) 300 MG, scheduled for 6:00 AM, 4:00 PM and 10:00 PM. The 4:00 PM dose was not administered on 8/29/22. Tylenol Tablet (pain medication) 325 MG, scheduled for 9:00 AM, 3:00 PM and 9:00 PM. The 9:00 AM and 3:00 PM dose was not administered on 8/29/22. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Pred Forte Suspension 1% -Instill 1 drop in both eyes four times a day for post-op eye surgery. The drops were schedule for 9:00 AM, 3:00 PM and 5:00 PM. The 9:00 AM and 3:00 PM doses/drops were not administered on 8/29/22. Further review of the MAR on 8/30/22 noted that the scheduled 5:00 PM dose on 8/29/22 was not administered. Left Lower leg treatment (xeroform to open area on anterior leg). Wrap with kerlix and Coban every day shift every other day, scheduled for 8/29/22 day shift. The treatment was not administered on 8/29/22. It should be noted that the treatment was also not administered on 8/27/22. Right lower leg: wrap with kerlix and Coban for edema every day shift every other day. The treatment was not administered on 8/29/22. It should be noted that the treatment was also not administered on 8/27/22. Further review of R268's MAR revealed medications for constipation, dermatitis, and supplements were also not given on 8/29/22, per physician's orders. R36 A review of R36's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Diffuse Traumatic Brain Injury, Seizures, Acquired Deformity of Head, Traumatic Subdural Hemorrhage, and Dysphasia. Review of R36's MDS noted the resident was severely cognitively impaired. Review of R36's Physician's orders and MAR/TAR was conducted on 8/29/22 at 3:30 PM. Review of the Physician's orders revealed R36 was scheduled to receive the following medications, treatments, and assessments: Amantadine (a medication used to treat Parkinson's Disease) 10ml via PEG-Tube, scheduled for 9:00 AM and 9:00 PM. The 9:00 AM dose was not administered on 8/29/22. Ivabradine (a medication related Diffuse Traumatic Brain Injury) 5 MG- Give 1 tablet via G-Tube, scheduled for 9:00 AM and 5:00 PM. The medication was not administered at 9:00 AM on 8/29/22. Keppra (Levetiracetam) Solution Give 10 ml via G-Tube for seizure precaution, scheduled for 9:00 AM and 9:00 PM. The medication was not administered at 9:00 AM on 8/29/22. Oxycodone (a narcotic pain medication) HCL Tablet 5 MG, scheduled for 8:00 AM and 8:00 PM. The medication was not administered at 8:00 AM and R36's pain level was not assessed at that time on 8/29/22. Topiramate (a medication used to prevent seizures) Tablet 25 MG, scheduled for 9:00 AM and 5:00 PM. The medication was not administered at 9:00 AM on 8/29/22. R61 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R61's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Huntington's Disease, Parkinson's Disease, Myocardial Infarction, Bi-Polar Disease, Schizoaffective Disorder and Anxiety Disorder. Review of the MDS revealed the resident had moderately impaired cognition. Review of R61's Physician's orders and MAR/TAR was conducted on 8/29/22 at 3:30 PM. Review of the Physician's orders revealed R61 was scheduled to receive the following medications, treatments, and assessments: Ativan (an antipsychotic medication) 2 MG, scheduled for 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM. The medication was not administered at 12:00 PM on 8/29/22. Further review of the MAR on 8/30/22 noted the resident additionally did not receive that medication on 8/29/22 at 6:00 PM. Haloperidol (an antipsychotic medication) 2MG/ML, scheduled for 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM. The medication was not administered at 12:00 PM on 8/29/22. Further review of the MAR on 8/30/22 noted the resident did not receive that medication on 8/29/22 at 6:00 PM. R59 Review of R59's Physician's Orders and MAR/TAR was conducted on 8/29/22 at 3:30 PM. Review of the Physician's orders revealed R59 was scheduled to receive the following medications, treatments, and assessments: Oxybutynin Chloride ER (extended release) 5 MG (milligrams) by mouth one time a day for UI (urinary incontinence) which was scheduled for 11:00 AM. The 11:00 AM dose and was not administered on 8/29/22. Benztropine Mesylate (a medication used to treat tremors) 0.5 MG two times a day, scheduled at 10:00 AM and 5:00 PM. The 10:00 AM dose was not administered on 8/29/22. Clonazepam (a medication used to treat anxiety) 0.5 MG two times a day, scheduled at 10:00 AM and 5:00 PM. The 10:00 AM dose was not administered on 8/29/22. Depakote ER (a medication used to treat seizure disorder or bipolar disorder) 500 MG two times a day. The 10:00 AM dose was not administered on 8/29/22. Further review of R59's clinical record revealed R59 was admitted into the facility on [DATE] with diagnoses that included: bipolar disorder, neuromuscular dysfunction of bladder, and schizophrenia. Review of a MDS assessment dated [DATE] revealed R59 had intact cognition. R64 Review of R64's Physician's Orders MAR/TAR was conducted on 8/29/22 at 3:30 PM. Review of the Physician's orders revealed R64 was scheduled to receive the following medications, treatments, and assessments: Aldactone (a diuretic) 25 MG one time a day, scheduled at 9:00 AM and was not administered on 8/29/22. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Jardiance (a medication used to treat diabetes) 10 MG one time a day, scheduled at 9:00 AM was not administered on 8/29/22. Metoprolol Succinate ER 24 Hour Sprinkle (a medication used to treat high blood pressure) 100 MG one time a day, scheduled at 9:00 AM, was not administered on 8/29/22. Zoloft (a medication used to treat depression) 100 MG one time a day, scheduled at 9:00 AM, was not administered on 8/29/22. Blood sugar monitoring two times a day, scheduled at 6:00 AM and 8:00 PM, was not completed at 6:00 AM (or any time between 7:00 AM and 7:00 PM) on 8/29/22. Eliquis 2.5 MG two times a day, scheduled at 9:00 AM and 9:00 PM. The 9:00 AM dose was not administered on 8/29/22. Entresto 24-26 MG two times a day, scheduled at 9:00 AM and 9:00 PM. The 9:00 AM dose was not administered on 8/29/22. Lasix 40 MG two times a day, scheduled at 9:00 AM and 9:00 PM. The 9:00 AM dose was not administered on 8/29/22. Further review of R64's clinical record revealed R64 was admitted into the facility on [DATE] with diagnoses that included: CHF, atherosclerotic heart disease, dementia, pulmonary embolism, hypertension, and chronic obstructive pulmonary disease (COPD). Review of a MDS assessment dated [DATE] revealed R64 had severely impaired cognition. R266 Review of R266's Physician's Orders and MAR/TAR was conducted on 8/29/22 at 3:30 PM. Review of the Physician's orders revealed R266 was scheduled to receive the following medications, treatments, and assessments: Lisinopril 2.5 MG in the morning, scheduled at 10:00 AM, was not administered on 8/29/22. Olanzapine (a medication used to treat psychosis) 5 MG give 0.5 tablet one time a day, scheduled at 10:00 AM, was not administered on 8/29/22. Metoprolol Tartrate 50 MG two times a day, scheduled at 10:00 AM and 5:00 PM. The 10:00 AM dose was not administered on 8/29/22. Tylenol Extra Strength 1000 MG three times a day, scheduled at 10:00 AM, 2:00 PM, and 6:00 PM. The 10:00 AM and 2:00 PM doses were not administered the resident's pain level was not assessed. Carbamazepine (a medication used to treat seizures and bipolar disorder) 200 MG four times a day, scheduled at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. The 9:00 AM and 1:00 PM doses were not administered. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/29/22 at 3:42 PM, an interview was conducted with the DON. When queried about why R29, R35, R36, R58, R59, R61, R64, R266, and R268 did not receive medications, treatments, and nursing assessments that day, the DON reported she was unaware they did not receive medications or treatments. When queried about who the assigned nurse was for R29, R35, R36, R58, R59, R61, R64, R266, and R268, the DON reported it was Nurse 'J'. When queried about whether Nurse 'J' was still at the facility, the DON reported she was. At that time, the DON was asked to locate Nurse 'J'. On 8/29/22 at 4:00 PM, the DON returned with Nurse 'K' and the Unit Manager, Nurse 'A'. Nurse 'K' was queried about who she provided nursing services to that day (medication administration, treatments, assessments) and reported room numbers from the [NAME] Hall and did not include R29, R35, R36, R58, R59, R61, R64, R266, and R268 who resided on the Gold Hall. When queried about where Nurse 'J' was, Nurse 'A' reported Nurse 'J' arrived at the facility at approximately 12:00 PM and was assigned to the Gold Hall medication cart. Nurse 'A' reported she tried to locate her about 20 minutes later and could not find her. Nurse 'A' reported at that time she notified Scheduler 'S' so that she could find someone to replace Nurse 'J'. Nurse 'A' reported she did not notify the DON. At that time, the DON was asked when they were observed counting narcotic medication with Nurse 'K' on the morning of 8/29/22 at approximately 9:45 AM, who received the keys to that medication cart. The DON reported she did (the DON). When asked who the nurse was on the midnight shift, they reported that was Nurse 'H'. When asked who took control of the medication cart for the Gold Hall and [NAME] Wing when Nurse 'H' left, the DON reported they did not take control, but received the keys. The DON was asked what time they took the keys and they stated, Took the keys around 8:30 or 8:45 (AM). When asked about what time Nurse 'H' left, the DON reported, Left little after 9 or 9:30 (AM). On 8/29/22 at 4:16 PM, an interview was conducted with Scheduler 'S'. When queried about the nurses who worked in the facility that day (8/29/22) from 7:00 AM until the current time, Scheduler 'S' reported there were three nurses scheduled to work the 7:00 AM-7:00 PM shift. Two nurses scheduled called off according to Scheduler 'S' and she found replacements, Nurse 'K' who arrived at approximately 9:00 AM and Nurse 'J' who arrived at approximately 12:00 PM. Scheduler 'S' explained that around 1:00 PM, Nurse 'A' notified her that Nurse 'J' left the building and a replacement was needed. Scheduler 'S' further reported that she was unable to find a replacement for Nurse 'J' and notified Nurse 'A'. When queried about whether she notified the DON or Administrator, Scheduler 'S' reported she only told Nurse 'A'. On 8/29/22 at 5:13 PM, an interview was conducted with Nurse 'A'. When queried about the last time R29, R35, R36, R58, R59, R61, R64, R266, and R268 received any nursing services to include medication administration, treatments, and/or assessments, Nurse 'A' stated, Prior to 7:00 AM when the midnight nurse left. Nurse 'A' reported no nursing services were provided to R29, R35, R36, R58, R59, R61, R64, R266, and R268 between 7:00 AM and approximately 4:15 PM when she took control of the medication cart. When queried about whether Nurse 'J' provided any nursing services when she was in the building, Nurse 'A' reported she did not. On 8/30/22 at approximately 8:00 AM, the Administrator was asked to provide verification of Nurse 'H' and Nurse 'J"s time details for 8/28/22 and 8/29/22. On 8/30/22 at 8:20 AM, the Administrator reported Nurse 'H' was done with work at 7:42 AM. (continued on next page)

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	235664	A. Building B. Wing	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/30/22 at 8:50 AM, the Administrator provided the time details for Nurse 'J' which revealed on 8/29/22 they were logged into the agency application as working from 12:31 PM to 12:37 PM (6 minutes). On 8/30/22 at approximately 9:10 AM a phone interview was conducted with Nurse J. Nurse J reported that she responded to an electronic notification from her Agency employer that the facility needed a nurse for the day shift on 8/29/22. She entered the building at approximately 12:30 PM and started a medication count on a cart placed near the front of the nurse's station (herein after gold cart). When doing the count with another nurse (Nurse K) she determined that the narcotic count was off as there were supposed to be 34 narcotic packages, but only 27 were noted. Nurse K stated that she informed the DON and was told that Nurse A would reconcile the count with her. Nurse J reported that she waited for Nurse A, but she never came and then she left the building as she did not feel comfortable passing medication. Nurse J reported that she never contacted the Agency to report why she left the facility. On 8/30/22 at 9:34 AM, the Administrator, in the presence of the DON, was interviewed. When queried about her knowledge of multiple residents not having an assigned nurse and as a result did not receive medications, treatments, or assessments between the time of 7:42 AM and approximately 4:15 PM, the Administrator reported she heard Nurse 'J' left the building and did not return and Nurse 'A' assumed duties of those residents. The Administrator explained that Physician 'CC' was contacted early that day to let him know that medications would be administered late and he said it was okay to give the once-a-day medications late. When queried about who was assigned to R29, R35, R36, R58, R59, R61, R64, R266, and R268 from 7:42 AM (when Nurse 'H' left) until 12:31 PM (when Nurse 'J' arrived), the Administrator reported she was not sure. When queried about how the Administrator became aware of the set of residents who did not have an assigned nurse and did not receive nursing services between 7:42 AM and 4:15 PM, the Administrator responded by saying Physician 'CC' was aware and she witnessed Regional Clinical Director of Operations 'U' contact him. On 8/30/22 at 1:51 PM, a telephone interview was conducted with Physician 'CC', the facility's Medical Director. When queried about when he was made aware that R29, R35, R36, R58, R59, R61, R64, R266, and R268 did not receive medications, treatments, or assessments on 8/29/22, Physician 'CC' checked his phone and reported that Regional Clinical Director of Operations 'U' contacted him at 4:00 PM on 8/29/22 (after it was identified by the survey team that the residents were not receiving nursing services and did not have an assigned nurse), approximately eight hours after the residents did not receive nursing services. When queried about when he should be contacted if it was known that a resident was not going to receive medications or treatments, Physician 'CC' stated, Facilities seem to call me after a concern is identified instead of when it actually happens. On 8/30/22 at approximately 10:43 AM, the DON was asked if she contacted the Agency that Nurse J was employed by to report that she had left the building without performing her assignment. The DON stated that never talked with the Agency but was waiting for a follow-up call from an e-mail that was sent. The DON was not able to provide a phone number for the Agency representative but indicated her name (herein after Agency Representative (AR) UU. On 8/30/22 at approximately 12:08 PM, an interview was conducted with the DON and the Administrator. When asked again if she had ever contacted AR UU, the DON then stated that she contacted her at approximately 12:45 PM on 8/29/22, only to ask the Agency i [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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on interview and record review, the facility failed to report an allegation of neglect to the abuse coordinator for one resident, (R267) of ten residents reviewed for abuse. Findings include: A review of a facility provided policy titled, Abuse, Neglect and Exploitation revised 6/2022 was conducted and read, VII. Reporting/Response A. The facility will implement the following: 1. Reporting of all alleged violations to the Administrator . On 8/28/22 at 1:06 PM, an interview was conducted with R267. They said they called 911 around 11:00 AM because they had been lying in their own urine for hours. R267 said, The nurse just changed me. It was noted a strong urine odor was present in the room at the time of the interview. On 8/28/22 at 1:51 PM, Licensed Practical Nurse (LPN) 'EE' was overheard talking with Certified Nurse Aide (CNA) 'G' about an incident earlier in the day where R267 called the local police and they came to the building. On 8/28/22 at 1:54 PM, an interview was conducted with CNA 'G' about their knowledge of R267 calling the police. CNA 'G' said R267, always calls them and said they (police) have been out to the building in the past for her. On 8/28/22 at 2:20 PM, an interview was conducted with LPN 'C' (R267's assigned nurse) regarding any knowledge of R267 calling the police. LPN 'C' said the police came to the building around 11:00 AM because R267 called them and alleged she had been laying in urine for hours. When asked if they reported to the facility's Administrator R267's allegations and the police responding to the building, they said they had not and, needed to figure out how to contact the Administrator. On 8/28/22 at 3:30 PM, a follow-up interview was conducted with LPN 'C' and they were asked if they knew if anyone had informed the Administrator of R267's allegations and the police reporting to the building. LPN 'C' said the charge nurse, LPN 'B' had contacted the Administrator. On at 8/28/2022 at 7:19 PM, a review of a late entry progress note entered into the record and created on 8/28/22 at 4:49 PM with an effective time of 11:41 AM, by a staff member only identified as Agency23 (no person's name was provided as to who Agency23 was) was reviewed and read, .The resident dialed 911 and the officers came out to address her concern, the resident was upset, stating that she has been sitting in her urine for 3 hours. I asked the CENA why that happened and she explained to me that at 0800 this morning she woke theresident <sic> up so that she can change her. The CENA said that the resident refused because she was asleep. After the officers left I went into the room listened to her concerns and then cleaned the urine off of her, changed her brief and linen .I told the unit manager and the administrator. A request was made on 8/30/22 at approximately 5:30 PM for the staff member's name who was documenting as Agency23, however; the name was not provided by the end of the survey. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/22 at 7:30 PM, an interview was conducted with LPN 'B', who LPN 'C' identified as the Charge Nurse. LPN 'B' was asked if they contacted the Administrator regarding R267 and said they did not, and they weren't even aware the police had been called to the building. At that time, the third nurse in the building, LPN 'EE', was also asked if they contacted the Administrator regarding R267's allegations and the police response to the building, and said they did not. LPN 'C' then apologized, said they thought LPN 'B' reported it but since they had not, they were going right then to the Administrator's office to report the situation. LPN 'C' was then observed to proceed to the Administrator's office. It was noted the progress note entered into the record by Agency23 on 8/28/22 with an effective time of 11:41 AM had already documented the Administrator had been contacted. On 8/29/22 at approximately 9:00 AM, a second interview was conducted with R267. They were asked if they had called the police during their stay prior to 8/28/22 and said they had not. On 8/30/22 at 2:48 PM, a review of R267's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: major depressive disorder, left below the knee amputation, chronic pain, and adjustment disorder. R267 was documented to have intact cognition. A review of R267's progress notes was reviewed and did not indicate they had any history of contacting the police, nor did their care plan have any indication they exhibited any such behavior. On 8/31/22 at 12:02 PM, the facility's Administrator was asked if they had been made aware of R267's allegations and the police response to the building and said they had been made aware on the evening of 8/28/22.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34208 Based on interview and record review, the facility failed to thoroughly investigate an allegation of misappropriation for one resident, (R267) of ten residents reviewed for abuse. Findings include: A review of a facility provided policy titled, Abuse, Neglect, and Exploitation with a revision date of 6/2022 was conducted and read, .V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Investigations may include but not limited to 1. Identifying staff responsible for the investigation; .3. Investigating different types of alleged violation; 4. identifying and interviewing all involved persons, including the alleged victim, perpetrator, witnesses, and others who might have knowledge of the allegations; .6. Providing a completely and thorough documentation of the investigation . On 8/28/22 at 7:19 PM, a review of a progress note entered into the record by Licensed Practical Nurse 'PP' on 7/31/22 at 7:22 AM read, .Resident complained she could not find her $100 she had in her pulse <sic>. She stated she is not sure if someone took the money because her purse is always by her. Administrator and DON notified. On 8/29/22 approximately 9:00 AM, an interview with R267 was conducted regarding their stay in the facility. R267 said they had been, ripped off twice since their admission to the facility. R267 said when they first admitted to the facility, they had sixty dollars come up missing and another time it was eighty-five dollars. R267 said their family brought them in money and they kept it in their fanny pack purse. They were asked if they reported the missing money to staff and said they did. R267 said they reported it the first time to LPN 'PP', but believed they didn't tell anyone else. R267 said the second time, staff had interviewed her about it and offered her the ability to lock her money in the nurse's medication cart. R267 also said the facility had told her they would reimburse her money, but they had not done so yet. On 8/31/22 at 8:27 AM, a facility provided investigation for R267's allegation of missing money on 8/19/22 was received and reviewed. At that time, the facility's administrator/Abuse Coordinator was asked if there was an investigation into R267's alleged missing money as documented in LPN 'PP's note on 7/31/22. The Administrator said it had not been reported to her and she had only found out about it while she was investigating the current allegation, despite LPN 'PP's note that indicated the Administrator had been notified on 7/31/22. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/31/22 at 11:08 AM, a second review of the facility's investigation file for R267's missing money reported on 8/19/22 was conducted. It was noted the investigation file contained only a summary of the incident, R267's progress notes, an interview statement from Unit Manager 'A' (who was the first staff aware of R267's missing money on 8/19/22) and ten statements from other residents dated 8/30/22 that indicated they did not have any valuables needing locked up, they weren't missing any money, and they felt safe in the facility. It was noted the file did not contain any interviews with any other staff who worked on or around the time of the allegation, or an interview with R267's roommate. It was further noted this file did not include any investigation into the first allegation of missing money on 7/31/22 that was referenced in the summary reading, .On 8/19/22 (Nurse Manager 'A'), informed the Administrator that (R267) states she was missing $80. Administrator .interviewed the resident on 8/19 and she stated she noticed her money was missing on 8/19/22 .(R267) also states that this is the second occurrence. She noted that she was missing money when she first admitted to the facility as well, in the amount of $60 .(R267) has been discharged from the facility. The Allegation of missing funds is inconclusive. A perpetrator could not be identified and like residents denied any missing funds . On 8/31/22 at 12:02 PM, a follow-up interview was conducted with the facility's Administrator. They were asked if anyone ever looked for R267's money and said, Someone did. They asked why this information was not provided in the file, and had no explanation. They were then asked why they only interviewed Unit Manager 'A' and no other staff that worked at the time of the allegation, or why there was no investigation into the alleged missing money documented in LPN 'PP's progress note on 7/31/22. The Administrator replied, I don't have an answer.

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed ensure orders for Total Parenteral Nutrition (TPN - all nutrition is received intravenously) were obtained and implemented for one (R216) of one residents reviewed for admission. This resulted in an immediate jeopardy (IJ) to the health and safety of the resident when R216 had not received TPN since their admission into the facility five days prior, resulting in the likelihood of serious harm due to malnutrition and electrolyte imbalance. Findings include: On 8/28/22 at 12:50 PM, R216 was observed seated at the side of the bed. R216 was pleasant and able to participate in conversation. An IV (intravenous) pole was observed at the resident's bedside with a bag of dextrose (a form of sugar solution infused intravenously to provide fluids and carbohydrates) hung, but not infusing at that time. An IV port was observed in the left side of R216's chest. When queried about their care in the facility, R216 reported she was admitted into the facility the previous Thursday and was supposed to receive TPN for nutrition, but had not received it since admission. When queried about the reason she had not received TPN, R216 reported the TPN was formulated based on laboratory results and blood had not been drawn yet. On 8/28/22 at 4:09 PM, R216 was further interviewed. When queried about whether she ate anything by mouth, R216 reported she took medications by mouth, but no food. R216 explained her medical condition which included multiple surgeries and an abdominal fistula (connection of two body cavities that do not typically connect) and that the TPN was required in order to heal the opening in her abdomen. R216 reported concern that in the hospital her blood was drawn weekly to formulate the TPN. R216 reported at the moment she felt okay, but would go to the hospital if she started to decline, but hoped that would not occur. Review of R216's clinical record revealed R216 was admitted into the facility on [DATE] with diagnoses that included: necrotizing fasciitis (flesh-eating bacteria), enterocutaneous (EC) fistula (abnormal connection that develops between the intestinal tract or stomach and the skin which causes contents of the stomach or intestines to leak through to the skin), anemia, and type 2 diabetes mellitus. Review of a Discharge Summary from the hospital revealed the following documentation: Physician Discharge Summary .Primary Discharge Diagnosis: Enterocutaneous fistula .Current Medications .Parenteral Nutrition Continuous 3-in-1 by total volume (QS base) Intravenous Continuous (HS - at night) .65 mL/hr (milliliters per hour) .Active Issues Requiring Follow-Up: Enterocutaneous fistula output .TPN .Discharge instructions: .Diet: TPN .Sips of water for medications and ice chips .Medication List Given to patient as of 8/25/22 8:38 AM .Amino Ac Elect-Calc in D10W (Parenteral Nutrition Infusion for discharge) See most recent Parenteral Nutrition formula . Review of an After Visit Summary (with missing pages) from the hospital revealed R216 was admitted in the hospital from 6/3/22 through 8/25/22 at which time they were placed at the facility. The summary documented, Diet Instructions .Nutrition Recommendations: Ice chips and sips with meds .TPN via CVC (central venous catheter - tunneled catheter). The Medication List documented to TAKE these medications: . Parenteral Nutrition Infusion for discharge .See most recent Parenteral Nutrition formula . (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Continuity of Care Document provided by the hospital revealed the following: .Active Lines .CVC Single Lumen Tunneled 5 Right Subclavian .Dressing change due 8/30/22 .Wound Care Instructions .Wound Location .Abdominal Fistula .Cleanse Normal Saline .Prep with skin prep and allow to dry .Cover Wound Management System (a pouch that adheres to the skin and ensures skin is protected from drainage from the fistula) .Change/PRN (as needed): Dressing no longer intact .Dressing damp, moist or saturated . Review of a section titled, TPN Medication Recent History which was continued from a previous page that was not included in the medical record revealed R216 received the following dose of TPN Continuous 3-in-1 by total volume on 8/24/22 at 10:00 PM in the hospital (the last dose given prior to admission into the facility) and documented all ingredients included in that dose which included macro ingredients (amino acids, dextrose), electrolytes, additives (insulin regular), sterile water, lipids (fats), and proteins. Review of R216's Admission/Readmission assessment dated [DATE] and completed by Nurse 'Y', documented See Diet Order in chart in the Nutrition section and it was checked that R216 received TPN. The admission skin assessment noted R216 had an implanted port (IV) in her chest and an abdominal fistula. It was documented R216 had a colostomy. Review of R216's physician's orders revealed no order for TPN. There was an order dated 8/25/22 for CBC (complete blood count) CMP (comprehensive metabolic panel) TSH (thyroid-stimulating hormone) A1C (glycated hemoglobin test - blood test that measures your average blood sugar levels over a three month period of time) Lipids B12 (Vitamin B12) Folate and Magnesium lab draw STAT (immediately) ordered by Physician 'CC'. There was an order dated 8/26/22 for cmp/cbc/tsh/hba1c next draw ordered by Physician Assistant (PA) 'NN'. No laboratory results were located in R216's medical record. Review of R216's progress notes revealed the following: A Practitioner Progress Note dated 8/25/22, written by Physician 'CC' that noted, .Adm (admit) for subacute rehab (rehabilitation)/wound care .Adm (admit) at (facility) from (inpatient rehab hospital), where pt (patient) was sent from Hosp (hospital) after intervention for recurrent enterocutaneous fistula - currently being treated with TPN to allow bowel rest and helping the closer <sic> of fistula - Has tunneled Central line in RT (right) SCV (subclavian) or IJ (internal jugular) vein for TPN. Colostomy is functional and she also has a bag for collection of the EC fistula discharge .Assessment and plan .Enterocutaneous fistula - recurrent - currently being treated conservatively with TPN to give 'bowel rest' - avoiding any food debris, load to intestines to help heal/close the fistula .May require surgical closure once nutritionally improved .TPN - orders to be filled by TPN pharmacy - start <sic> labs to be ordered to guide the pharmacy and then labs to be done weekly . A Practitioner Progress Note dated 8/26/22, written by PA 'NN' noted, .seen for eval (evaluation) pain control . on TF (tube feeding), NPO (nothing by mouth) due to fistula with ice chips .to start TPN on IVF today .abd (abdominal) pain/large fistula .TPN/NPO with ice chips, local care .check labs . As of 8/29/22 at 8:00 AM, there were no progress notes that explained why R216 had not yet received TPN. (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/29/22 at 9:49 AM, Registered Dietitian (RD) 'X' was interviewed. When queried about why R216 had not yet received TPN when she was admitted on [DATE], RD 'X' reported he did not know and explained the pharmacy dosed TPN backed on blood work, but was not sure why R216 had not received it. Regional Dietician 'Z' was interviewed at that time and reported the dietary department would not enter an order for TPN due to the complicated nature of the formulation. Regional Dietician 'Z' reported what would typically happen was the hospital order would be faxed to the pharmacy so that it could be formulated specifically for that resident. When queried about what could happen if a resident did not receive TPN for five days, Regional Dietician 'Z' reported it would be an emergent situation and would require an emergency order from the pharmacy. On 8/29/22 at 10:13 AM, the Director of Nursing (DON - started working in the facility on 8/18/22) was interviewed. When queried about the facility's protocol for residents newly admitted into the facility, the DON reported the facility received a referral through the admissions department that would be communicated to the DON and Administrator, the resident would be assigned to a nurse to do the admission. The DON further explained the assigned nurse assessed the resident, added medications into the electronic medical record that were obtained from the orders that came from the hospital. When queried about any other information reviewed besides medications, the DON reported the nurse reviewed the entire discharge summary from the hospital and contacted the physician to approve the orders and receive any clarifications. The DON reported nursing management double checked all admission orders, the discharge summary, diagnoses, and conducted a full clinical review to compare with what the admitting nurse entered, and ensured care plans were implemented. When queried about whether she reviewed R216's admission from 8/25/22, the DON reported she did not start the process to double check admissions yet. The DON reported Unit Manager, Nurse 'A' would be able to answer questions regarding R216. On 8/29/22 at 10:24 AM, Nurse 'A' was interviewed. Nurse 'A' explained they were the unit manager for the whole facility. When queried about why R216 was not receiving TPN, Nurse 'A' reported the admitting nurse should have put an order in and gone over the medications with the physician for any clarification. When queried about whether R216's provider was aware she had not yet received any doses of TPN since her admission on 8/25/22, Nurse 'A' reported the physician was not notified to her knowledge. On 8/29/22 at 10:56 AM, Physician 'CC' was interviewed via the telephone. When queried about why R216 had not yet received TPN, Physician 'CC' reported he put an order in for STAT labs the day of R216's admission. Physician 'CC' reported he was unaware that she had not yet received TPN. Physician 'CC' reported R216 received dextrose while waiting for the labs to be drawn and the TPN to arrive at the facility, but he would have expected to be notified within 24 hours if the resident could not receive the TPN in that frame. When queried about what should be done if TPN was unable to be obtained, Physician 'CC' reported he should be contacted so that the resident could be sent back to the hospital or other plans/orders be made. Physician 'CC' reported STAT labs typically were done and results received within one night or day and then they would be sent to the pharmacy for TPN formulation. On 8/29/22 at 11:06 AM, PA 'NN was interviewed via the telephone. When queried about whether she was aware on 8/26/22 that R216 had not yet received TPN, PA 'NN' reported she saw R216 on 8/26/22 but did not review all of her medical records. PA 'NN' reported she was aware R216 was receiving IV fluids and dextrose because it would take 24 hours to get the TPN from the pharmacy, but was unaware that the TPN never came. PA 'NN' reported a provider should have been contacted. PA 'NN' explained the nurses reported to her that TPN was going to arrive that day (8/26/22). (continued on next page)

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	235664	A. Building B. Wing	09/06/2022

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/29/22 at 12:18 PM, Nurse 'Y' (the nurse who completed R216's admission assessment on 8/25/22) was interviewed via the telephone. When queried about the facility's admission process, Nurse 'Y' reported when the resident arrived at the facility, an assessment was completed, admission paperwork was reviewed, diet orders were reviewed, orders were entered into the electronic medical record, and the provider was contacted to inform of the resident's admission and orders confirmed. Nurse 'Y' reported sometimes Physician 'CC' requested to do a video call so that he could see the resident. When queried about R216's admission on 8/25/22, Nurse 'Y' reported she was not R216's assigned nurse, but helped out another nurse who was overwhelmed and behind. Nurse 'Y' reported the other nurse (Nurse 'C') entered the orders and she (Nurse 'Y') assessed R216. When queried about R216's TPN orders, Nurse 'Y' reported herself nor Nurse 'C' could figure out the TPN orders so Physician 'CC' was contacted. Nurse 'Y' explained Physician 'CC' instructed them to provide the pharmacy with R216's most recent laboratory results from the hospital if they were drawn within the past 48 hours so the pharmacy could formulate the TPN. Nurse 'Y' reported she called the pharmacy who instructed her to contact a third-party company that compounded TPN. Nurse 'Y' explained she left a message with the specialty pharmacy and did not receive a call back. Nurse 'Y' reported Nurse 'C' contacted Physician 'CC' to inform him about the TPN and he instructed her to continue giving IV fluids and dextrose and ordered STAT labs. Nurse 'Y' entered the STAT lab order and instructed Nurse 'C' to follow up. Nurse 'Y' explained she did not enter a progress note because she was not the assigned nurse and Nurse 'C' said she would document what occurred. On 8/29/22 at 12:30 PM, any laboratory tests completed and any associated results since R216 was admitted into the facility were requested from the DON. On 8/29/22 at 1:15 PM, the DON reported she had to contact the laboratory to have them send the lab results to the facility. DON had to call the laboratory to get the labs. When queried about who was responsible to follow up on ordered labs, the DON reported the nurse who was assigned to the resident and the provider who initiated the order. If they were not completed on that shift, then it would be endorsed to the next shift. The DON reported that any communication should be documented in a progress note. At that time, the laboratory results for R216 were requested from the DON. The DON reported Nurse 'A' had them and would provide them. On 8/29/22 at 1:36 PM, Nurse 'A' was interviewed. Nurse 'A' reported she contacted the pharmacy and they said they did not receive any lab results for R216 and therefore they did not make the TPN. When queried about whether the STAT labs ordered by Physician 'CC' on 8/25/22 were drawn, Nurse 'A' reported she did not know and that the pharmacy did not have any record of labs for R216. Review of a Prehospital Care Report Summary from EMS (Emergency Medical Services), dated 8/29/22, revealed EMS contacted R216 at 11:28 PM, and included the following documentation: .PT (patient) requires EMS transport due to monitoring required due to 5 days of no nutrition administration by facility .Pt states she was admitted 5 days prior to EMS arrival. EMS crew confirmed the pt admitted [DATE]. She reports in that time, she has received absolutely no TPN. She has only received dextrose 10% (D10). In the last almost 14 hours since she last had any D10. She reports her last treatment (of D10) was 450ML approximately 45 grams of dextrose .Pt states she has had to resort to sneaking candies and graham crackers because he <sic> has been so hungry for the last 5 days and received nothing of nutritional value in the last 5 days .Pt was placed on cardiac monitor and 12 lead performed. 12 lead showed sinus rhythm with suppressed and prolonged T waves indicative of hypokalemia (low potassium) and hypocalcemia (low calcium) likely due to the fact the pt has received nothing with any nutritional value in the last 5 days . (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R216's Medication Administration Record (MAR) revealed R216 was not administered Dextrose on 8/29/22 at 4:30 PM as ordered by the physician (Dextrose Solution 10 percent 200 mL every 24 hours for TPN interruption) and their last administration was on 8/28/22 at 6:03 PM. A policy regarding the facility's admission process was requested from the Administrator on 8/30/22 at 12:03 PM. The following was received: A document titled, (Facility name) New Admission/Readmission Checklist. Review of the document revealed the following information: Admission Process: .Verify orders printed on the 'Discharge Instructions' with physician/extender .Enter eMAR (electronic medication administration record)/eTAR (electronic treatment administration record) applicable and standing orders .Fax .full medication list to the pharmacy asap (as soon as possible) upon entry .Enter diet order and communicate new order with dietary department . .Within 24 Hours: .Schedule ordered and standing order labs. NOTE: It is acceptable in most cases to utilize recent hospital labs as admission labs [unless indicated otherwise] .Ensure order/tasks present for catheter, wound IV, splint, contracture, fistula, and post-op cares, etc. as applicable . The IJ began on 8/25/22, it was identified by the survey team on 8/29/22 and the facility was notified of the IJ on 8/29/22. On 8/29/22, the State Agency completed onsite verification that the Immediate Jeopardy was removed on 8/30/22, however the facility remained out of compliance at a scope of isolated and severity of potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance that has not been verified by the State Agency. The immediacy was removed on 8/29/22 based on the facility's implementation of an acceptable plan of removal as verified on-site by the survey team, as follows: One resident residing in the facility is on TPN. The resident ' s admission TPN medication orders were reviewed and processed. The TPN medication orders were sent to the pharmacy for processing. The physician has been notified of the delay of TPN administration. No further orders were given. All resident's admission orders from 8/25-8/29 have been audited for accuracy and completion.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to complete quarterly Minimum Data Set (MDS) assessments in a timely manner for two (R2 and R19) of five residents reviewed for resident assessments. Findings include: According to the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual v1. 17.1, effective 10/1/2019, .An OBRA assessment (comprehensive or Quarterly) is due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between OBRA assessments . The facility was requested for their policy, but it was reported they did not have one. R2: Review of the clinical record revealed R2 was admitted into the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary disease with exacerbation, hypertensive chronic kidney disease, hypo-osmolality and hyponatremia, paroxysmal atrial fibrillation, acute kidney failure, and bipolar disorder. Review of the most recent completed assessment had an Assessment Reference Date (ARD) of 4/20/22. The electronic clinical record indicated a warning highlighted in red that read as of this review (9/6/22), the quarterly for 7/21/22 was overdue. Further review of the MDS data revealed the quarterly that was due on 7/21/22 was never initiated. R19 Review of R19's clinical record revealed R19 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, seizures, major depressive disorder, heart failure, expressive language disorder, hemiplegia, aphasia, cerebral infarction, chronic obstructive pulmonary disease (COPD), dysphagia, CHF (congestive heart failure), hypothyroidism, psychotic disorder, nontraumatic subdural hemorrhage, and pseudobulbar affect. Review of R19's MDS assessments revealed R19 was due to have a quarterly MDS assessment 8/2/22. It was highlighted in red and documented, ARD 8/2/22 14 days overdue. On 8/30/22 at 3:50 PM, an interview was conducted with the MDS Coordinator (Nurse 'VV'). Nurse 'VV' reviewed the clinical records and confirmed the missed/late assessments. When asked if they were aware of any concerns with the MDS assessments not being completed timely prior to this discussion, they reported that they were but offered no further explanation. 32568

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review the facility failed to transmit Minimum Data Set (MDS) assessments to the Centers for Medicare and Medicaid Services (CMS) within 14 days after completion for one (R1) of two residents reviewed for resident assessment tranmission, resulting in potential for inaccurate tracking of resident assessment, admission and discharges. Findings include: According to the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual v1. 17.1, effective 10/1/2019, .Submission files are transmitted to the QIES (Quality Improvement and Evaluation System) ASAP (Assessment and Submission and Processing) system using the CMS wide area network .Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirement .must be submitted with 14 days of the MDS Completion Date (Z0500B + 14 days) .For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by the QIES ASAP system. This confirmation information includes the files submission identification number (ID), the date and time the file was received for processing as well as the file name . The facility reported there was no actual policy for MDS transmitting. R1 Review of the clinical record revealed R1 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included: heart failure, chronic obstructive pulmonary disease, arthritis, congestive heart failure, bulbous pemphigoid, morbid obesity, obstructive sleep apnea, type 2 diabetes mellitus, and pressure ulcers of sacral region and left heel, unstageable. R1 discharged on [DATE] and has not returned to the facility. According to the MDS (discharge return not anticipated) assessment dated [DATE], the current status indicated this assessment had been completed, however there was no indication it had been transmitted. The computerized warning read, Assessment was never added to a batch. 32568

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on interview and record review, the facility failed to develop and implement a baseline care plan for one resident (R317) reviewed for new admission. Finding include: Findings include: A review of the Facility Policy titled, Care Planning (revised 2/22) documented, in part: Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provided effective and person-centered care of the resident that meets professional standards of quality care .The baseline care plan will: a. be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: Initial goals based on admission orders .Physician orders .Dietary orders .Therapy services .Social services .PASARR recommendations, if applicable. The admitting nurse .shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative .Interventions shall be initiated that address the resident's current needs including: Any health and safety concerns to prevent decline or injury, such as elopement, fall or pressure injury risk .Any identified needs for supervision, behavioral interventions and assistance with activities of daily living .A written summery of the baseline care plan shall be provided to the resident and representative . On 8/28/22 at approximately 2:00 PM, R317 was observed lying in bed on their back wearing only a hospital gown that was covered with food. The resident had dirty hair and nails. A floor mat was next to the resident's bed. The resident was alert, but not able to answer any questions asked. On 8/28/22 at approximately 8:33 PM, R317 was observed lying on their back wearing the same hospital gown that was covered with food. Again, the resident was not able to answer questions asked. On 8/31/22 at approximately 12:33 PM, R317 was observed lying on a floor mat next to their bed. The resident was undressed, with long nails and a wet brief. The resident's lunch tray was lying on the mat next to the resident. The resident was not able to reach the meal tray. The Director of Nursing (DON) was asked to observe the resident. The DON looked through the resident's door and stated that the positioning of the resident was not appropriate. A review of R317 clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: stroke, dementia with Lewy Bodies and behavioral disturbance and cocaine induced psychotic disorder. A Brief Interview for Mental Status (BIMS) form noted the resident was severely cognitively impaired. Further review of the medical record failed to reveal that a baseline care plan had been developed and implemented. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/22 at approximately 4:31 PM, an interview was conducted with the Director of Nurse (DON) and Unit Manager Nurse A. When asked about R317's baseline care plan, Nurse A reported that the MDS coordinator is responsible for the Base Line Care Plans and they should be in the resident's clinical record. The MDS coordinator revealed that she was only responsible for the care plans, and it was their understanding that either the Unit Manager or Admitting Nurse was responsible for the completing a baseline care plan. UM A noted that she could not locate a Base Line Care Plan and was not aware that it was her responsibility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to develop and/or implement comprehensive care plans to address mood, behaviors, use of antianxiety medication, smoking, falls and activities of daily living (ADLs) for three (R47, R62, and R19) of 29 residents reviewed for care plans. Findings include: According to the facility's policy titled, Care Planning dated 2/2022, .The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care .In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes shall be incorporated into an updated summary provided to the resident and his or her representative .The comprehensive care plan .is reviewed and revised by the IDT (Interdisciplinary Team) as necessary . R47: On 8/28/22 at 1:35 PM, R47 was observed seated in a wheelchair in their room. When asked about whether they smoked, R47 reported they used to have cigarettes that were kept in the nursing cart and recently had their family provide them with a CBD pen (Cannabidiol - vaping pen) recently. When asked if anyone had ever evaluated them for safe smoking, they reported the Administrator said they had to take the CBD pen and that no-one had assessed them for anything like that. Review of the clinical record revealed R47 was admitted in the facility on 6/30/22 with diagnoses that included: paraplegia, major depressive disorder recurrent, neuromuscular dysfunction of bladder, anxiety disorder, acquired absence of right and left leg below knee, assault by shotgun and retained metal fragments. Further review of the clinical record revealed there was no assessment for safe smoking completed until 8/28/22 (during the survey) by Nurse Manager 'A'. This assessment identified the resident may smoke with supervision. Review of the care plans revealed there was no care plan developed for R47's for smoking upon admission, or following the most recent safe smoking assessment completed on 8/28/22. On 8/30/22 at 3:40 PM, the Administrator was asked about who was responsible for completing the smoking assessments and care plans for the residents and they reported those should be done by the floor nurses upon admission into the facility. R62: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/22 at 1:30 PM, R62 was observed lying in bed with a hospital gown loosely tied and hung down to their waist. R62 was holding their feeding tube and stated, Hi repeatedly. On 8/30/22 at 2:40 PM, an interview was conducted with Certified Nursing Assistant (CNA 'G') who was assigned to R62. When asked about R62's behaviors, they reported R62 wheeled themselves all over once they were up in the wheelchair and can hit out at times. When asked where resident behaviors were documented, they reported in the task section of the electronic medical record (EMR). When asked to view the EMR, CNA 'G' reviewed and confirmed there were no documented behaviors for the past 30 days (maximum look back period available for review). Review of the clinical record revealed R62 was admitted into the facility on [DATE] and was readmitted on [DATE] with diagnoses that included: epilepsy, pervasive developmental disorder, severe intellectual disabilities, and adjustment disorder with disturbance of conduct. Review of R62's physician orders and Medication Administration Records (MARs) revealed the resident had been prescribed multiple orders for PRN Lorazepam (antianxiety medication) since 7/6/22. Further review of the MARs and clinical record revealed R62 received 13 PRN administrations of the Lorazepam medication since July 2022 without identifying the specific behavior or what non-pharmacological approaches were implemented at the time of medication administration. Review of R62's care plans revealed there was no care plan for the resident's use of PRN antianxiety medication, or for monitoring and providing interventions for behaviors. 32568 R19 On 8/28/22 at 12:33 PM, R19 was observed seated in a wheelchair near the nurse's station on the East Wing with a family member. At that time, the family member was concerned about R19 being lethargic and a call was made to the physician who evaluated R19 via a video call and reported she appeared over sedated. On 8/28/22 at 1:08 PM, R19 remained seated in a wheelchair near the nurse's station calling another resident vulgar names. R19 stated, We call each other [expletives] for fun. On 8/28/22, multiple observations were made of R19 between approximately 1:30 PM and 6:00 PM seated in the same spot near the East Wing nurse's station with minimal interaction from the staff. R19 remained tearful with almost continuous sobbing, crying, and yelling out for her family throughout this time frame, repeating the phrase, Let me go! On 8/29/22 at 9:01 AM, the door to R19's room was observed to be closed (it would not stay open). R19 was observed positioned poorly in bed, slouched down under an over the bed table that contained a breakfast tray. Food was observed to be all over R19's clothing and bed sheets and she was having difficulty eating it. R19 was sobbing and said she wanted to be up in the wheelchair outside of the room. When queried about whether she was able to eat her breakfast on her own, R19 started crying and stated, No. R19 appeared to be struggling to feed herself and was not positioned in a way that encouraged independent eating. R19 started screaming and crying, stating, Just let me go! (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/22 between 1:58 PM and 3:24 PM, R19 was heard yelling and sobbing loudly while seated near the nurse's station on the East Wing. On 8/30/22 from 5:00 PM until 5:18 PM, R19 was observed seated in a wheelchair inside her room with the door open only a crack (the door would not stay open). R19 was near the door and was yelling and sobbing. At 5:30 PM, R19 was observed in her room in a wheelchair yelling and sobbing. R19's dinner plate was observed to be placed on the bed. On 8/31/22 at 2:42 PM, R19 was observed lying in bed sobbing. The door was closed and the television was on. A mattress was observed on the floor next to R19's bed. R19 could be observed from the hallway crying while in bed. Review of R19's clinical record revealed R19 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, seizures, major depressive disorder, expressive language disorder, hemiplegia, aphasia, psychotic disorder, nontraumatic subdural hemorrhage, and pseudobulbar affect. Review of R19's Minimal Data Set (MDS) assessments revealed the most recent MDS due on 8/2/22 had not yet been completed. Review of the last MDS assessment completed on 5/2/22 revealed R19's cognition and behavior symptoms were not assessed. Further review of R19's clinical record, incident reports, and post-fall assessments revealed R19 had seven falls between 7/6/22 and 8/11/22. Review of R19's care plan conducted on 8/29/22 revealed the falls care plan was initiated on 5/23/22 and documented, I am at an increased risk for falls r/t (related to). No root cause was identified on the care plan. The care plan documented the following interventions: 1:1 as needed initiated on 8/8/22 - This intervention was not observed throughout the survey when R19 was observed to be restless and in emotional distress. R19 was observed on multiple occasions in their room, in bed, with the door closed, while crying and distressed. Encourage me to participate in activities that promote exercise, physical activity for strengthening and improved mobility, initiated on 6/28/22. This intervention was not observed. Frequent monitoring, initiated on 8/8/22. There were multiple observations throughout the survey of R19 in a restless, distressed state both in the hallway by the nurse's station and in their room with the door closed for extended periods of time. I need strategies that minimize the potential for falls while providing diversion and distraction, initiated on 7/28/22 and revised on 7/28/22. This intervention did not include any individualized or specific strategies to attempt with R19. Place in high traffic area for monitoring when up in wheelchair, initiated on 7/12/22 and revised on 7/25/22. R19 was observed multiple times throughout the survey in their room with the door closed or near the nurse's station in a restless and distressed state with minimal engagement from the staff. (continued on next page)

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	235664	A. Building B. Wing	09/06/2022

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident to remain in bed for safety, initiated on 8/11/22. There were multiple observations of R19 in bed with the door closed, crying and in distress. It should be noted that R19 had multiple unwitnessed falls in their room from their bed in the months of July 2022 and August 2022. Further review of R19's care plans revealed the following: A care plan initiated on 6/3/22 and revised on 6/23/22 that documented, I use anti-psychotic medications r/t (related to) Behavior management, DX: psychotic disorder with delusions, resident yells out, and will place self onto floor . Documented interventions included: Administer medications as ordered .AIMS per policy . Educate .about risks, benefits and the side effects and/or toxic symptoms of the medication I am on .I am followed by (behavioral health provider) for psychoactive medication management) .keep resident from obtaining a major injury .Mattress placed at bedside . A care plan initiated on 6/3/22 that documented, I use Antidepressant or Mood Stabilizer medication r/t Depression. Documented interventions included: Document on (CNA electronic documentation system) and report to social work PRN (as needed) s/sx (signs and symptoms) of depression (initiated 6/3/22), Give antidepressant medications ordered by physician . There was no care plan that included individualized specific goals and interventions for R19's mood and behaviors. On 8/31/22 at 3:00 PM, Social Services Assistant (SSA) 'AA' was interviewed. When queried about what care planned interventions were in place to address R19's mood and behaviors, SSA 'AA' reported there was currently nothing in place to address R19's mood and behaviors and stated, There is one staff person, but I'm not sure of her name, who can calm her down. On 8/31/22 at 3:34 PM, the DON was interviewed and reported there should be individualized interventions in place to address and monitor R19's mood and behaviors symptoms. When queried about care planned interventions to prevent falls, the DON reported they should be implemented by the staff.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to provide timely activities of daily living (ADLs) including nail care, dressing, and bathing or shower/bathing for eight (R15, R31, R62, R19, R38, R61, R268, and R317) of eight residents reviewed for ADLs. Findings include: R15 On 8/28/22 at 2:13 PM, R15 was observed lying in bed slightly on their left side with a large mattress on the floor next to the bed. The resident's gown was pulled down, and food was observed down the front of their body and collected in the crook of their left arm. The resident's hair and skin had a greasy appearance. On 8/29/22 at 8:50 AM, R15 was observed laying in their bed with a full mattress on the floor next to the bed. The resident was wearing a hospital gown and their hair and skin remained greasy. When asked about how often they received showers, R15 reported they were not. Review of the clinical record revealed R15 was admitted into the facility on [DATE], and readmitted on [DATE] with diagnoses that included: encephalopathy, acute kidney failure, psychotic disorder with delusions due to known physiological condition, seizures, neuromuscular dysfunction of bladder, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and major depressive disorder. According to the Minimum Data Set (MDS) assessment dated [DATE] (the assessment for 8/12/22 was not complete as of this review) R15 had intact cognition, was totally dependent upon two or more people for physical assistance with bathing. On 8/29/22 at approximately 8:30 AM, the Administrator was asked about how the facility documented its showers and they reported they were all electronic in the task section of the electronic medical record (EMR) and that they no longer used the paper bathing/shower sheets. On 8/29/22 at 2:15 PM, an interview was conducted with Certified Nursing Assistant (CNA 'G' and CNA 'O'). When asked about how often residents were showered or offered baths, they both reported difficulty due to staffing and at least once a week. According to R15's Kardex: I am totally dependent on 1 staff to provide Bed bath/shower per schedule and as necessary or requested. Shower/Bath/Bed Bath-PRN (as needed) Shower/Bathing/Bed Bath Scheduled Showers are on Wednesdays and Saturdays (afternoon shift). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R15's bath/shower documentation on 8/30/22 at 9:29 AM revealed the task section of the EMR for the past 30 days only had one bed bath documented as provided on 8/13/22. R31 On 8/28/22 at 1:20 PM, the resident was observed seated in a motorized wheelchair with a lunch tray placed in front of them. R31 reported they had been at the facility since 2016 and felt there needed to be more staff. When asked if there were concerns that care was not being provided due to this, R31 reported routine care like showers were not always done. Review of the clinical record revealed R31 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Parkinson's disease, a neuromuscular dysfunction of bladder. According to the MDS assessment dated [DATE], R31 had intact cognition and required extensive assistance of one person for personal hygiene. The section for bathing was noted as Activity itself did not occur. The documentation used for this look back period of seven days read, No Data Found. Review of R31's shower/bathing documentation for the past 30 days (as of 8/30/22 at 12:30 PM and 9/6/22 at 8:20 AM last shower/bed bath was a bed bath on 8/26) documented bed bath on 8/5, 8/16, 8/19 and 8/26 and a shower on 8/23. No documented refusals. and none on prn bathing documentation. There was no documentation on the prn shower/bath/bed documentation as of 9/6/22. R62: On 8/28/22 at 1:30 PM, R62 was observed lying in bed, wearing a loosely tied gown that hung down to their waist. The resident was holding their feeding tube near their stomach and holding it up to look at. The resident repeatedly stated Hi very loudly. The resident's appearance was very disheveled with uncombed hair and long fingernails with dark debris underneath the nail tips. When asked simple questions, R62 only responded very loudly and repeatedly, Hi. The resident's tube feeding was not connected or running at this time. Further observations through 7:00 PM revealed R62 remained in the same manner as observed earlier. Review of the clinical record revealed R62 was admitted into the facility on [DATE] and was readmitted on [DATE] with diagnoses that included: epilepsy, pervasive developmental disorder, and severe intellectual disabilities. According to the MDS assessment dated [DATE], R62 had significant communication limitations, had short- and long-term memory impairment and severely impaired cognitive skills for daily decision making, and was totally dependent upon one person for dressing, personal hygiene, and bathing. Review of R62's shower/bathing documentation for the past 30 days in the task section of the EMR revealed there was no documentation any showers or bed baths were provided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/22 at 2:15 PM, CNA 'G' and CNA 'O' were asked about why the resident was not up and dressed yesterday and today and CNA 'O' reported they were doing a lot of running around an didn't get R62 up because he was still receiving tube feeding. When asked if he was offered to get up once the tube feeding was completed, they offered no response. CNA 'G' ([NAME]) reported R62 was able to indicate when he wanted to get up and his sign to get up is pulling out and showing the feeding tube and will also say Hi. Both were informed that was what the resident had been doing earlier and offered no further response. 32568 R19 On 8/28/22 at approximately 1:08 PM, R19 reported she wanted a shower in the presence of Nurse 'B' and R19's family member. R19's family member told R19 that she knew she got a shower because she assisted with it. R19 explained that she was just washed in the bed and wanted a full shower. Nurse 'B' told R19 that she could have a shower. On 8/28/22 at approximately 1:30 PM, R19 was interviewed about showers. R19 reported she only received bed baths and wanted a shower. R19 stated, They will lie to you and say I got a shower, but I didn't. Review of R19's clinical record revealed R19 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, seizures, major depressive disorder, heart failure, expressive language disorder, hemiplegia, aphasia, cerebral infarction, chronic obstructive pulmonary disease (COPD), dysphagia, congestive heart failure (CHF), hypothyroidism, psychotic disorder, nontraumatic subdural hemorrhage, pseudobulbar affect. Review of R19's MDS assessments revealed R19 was due for a quarterly MDS assessment on 8/2/22. However, it was not completed. Review of R19's last completed MDS assessment dated [DATE] revealed R19's cognition and behavior symptoms were not assessed. According to the assessment on 5/2/22, R19 was totally dependent on at least two staff members for transfers and it was documented that bathing did not occur during the seven day look back period for the assessment. Review of the previous Significant Change MDS assessment dated [DATE] revealed R19 had severely impaired cognition and bathing did not occur during the seven day look back period. Review of the CNA task (CNA documentation) for Shower/Bathing/Bed Bath Scheduled for R19 for the past 30 days revealed only one documented bed bath on 8/29/22. There was no documentation that indicated R19 refused showers. 34208 R61 On 8/28/22 at 1:02 PM, R61 was observed in their bed. R61 was not responsive to attempts of verbal communication or an interview. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/31/22 at 10:21 AM, a review of R61's clinical record was conducted and revealed they admitted [DATE] with diagnoses that included: Huntington's disease, bipolar disorder, schizoaffective disorder, major depressive disorder, and protein calorie malnutrition. It was noted R61 transferred from a sister facility and admitted with Hospice Services. A review of R61's Minimum Data Set assessment dated [DATE] indicated they had moderate cognitive impairment and required total assistance from one or two staff members for all activities of daily living. A review of a 30-day look-back for the Certified Nursing Aide (CNA) task for showers was completed and revealed R61 had not been provided a shower or a bed bath in a 30-day look-back period. R268 On 8/28/22 at 12:49 PM, R268 was observed in their room sitting in their recliner. R268 was asked about their stay in the facility and said they had been requesting a shower for three days. They said they were supposed to have on Wednesday (8/24/22) but declined because they didn't feel well. They went on to say they had been requesting a shower and was supposed to have received their scheduled shower on Saturday (8/27/22), but was not given one. On 8/29/22 at 8:51 AM, R268 was asked if they received a shower and said they had not. On 9/6/22 at 9:38 AM, a review of R268's clinical record revealed an admitted [DATE] with diagnoses that included: Parkinson's disease, heart failure, lymphedema, dementia without behaviors, post-traumatic stress disorder, and anxiety disorder. R268's most recent MDS dated [DATE] indicated intact cognition, documented it was Very Important for R268 to choose between a tub bath, shower, bed bath, or sponge bath, required set up assistance for activities of daily living and was documented ADL Activity itself did not occur as a response to self performance and support provided for bathing. A review of a 30-day look-back period for the CNA task for bathing was conducted and revealed no documentation R268 had received a shower. 34275 R38 On 8/28/22 at approximately 1:44 PM, R38 was observed sitting in their wheel chair. The resident had un-combed greasy hair and long nails with dirt underneath them. A review of R38's clinical record was conducted and revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease, COPD, depression, and mood disorder. A review of R38's MDS indicated the resident needed extensive one person assist for most ADLs and was cognitively impaired. A review of a 30-day look-back for the CNA task for showers was completed and revealed R38 had only been provided one bed bath in the 30-day look-back period. R317 On 8/28/22 at approximately 1:56 PM, R317 was observed lying flat on his back in his room, his gown was dirty and covered with food, his hair was greasy and unkempt. The resident was alert, but not able to answer questions asked about ADL care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R317's clinical record was conducted and revealed the resident was admitted to the facility on [DATE] with diagnoses that included: dementia with Lewy Bodies, cerebral infarction, and cocaine abuse. An initial assessment noted that the resident needed extensive one to two person assist for all ADLs and had a BIMS score of 3/15 (severely cognitively impaired). A review of a 14-day look back completed on 8/29/22 noted the resident has not been provided either a shower or bed bath. On 8/29/22 at approximately 8:03 AM, an interview was conducted with CNA SS. CNA SS was asked how they documented when a shower/bed bath and nail care was given. CNA SS reported they believed a paper sheet was to be filled out and placed at the nurses' station. There were no documents available at the nurses' station. At approximately 8:30 AM, the DON was interviewed and CNA SS was present. The DON reported that all ADL care including showers would be found on the resident's electronic record and if not documented, it was not completed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to provide a meaningful, diverse, and engaging activity program for four (R19, R37, R47, and R54) of four residents reviewed for activities, and six of six residents that attended the confidential resident council interview, resulting in feelings of boredom, decreased quality of life and potential for social isolation and loss of autonomy. This deficient practice affects all residents that reside in the facility due to no activities on the weekends. Findings include: According to the facility's policy titled, Activities dated 01/2021, .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as encourage both independence and interaction within the community . On 8/28/22 at 12:30 PM, observation of the activity calendar revealed there were no weekend activities. Resident Council: On 8/29/22 at 11:00 AM, during the confidential resident council interview, six of the six residents in attendance verbalized ongoing concerns with lack of activities. Responses included: (Staff 'AA') is by herself and can't do it all by herself. Never been activities on the weekend. We asked for things like going out of the facility. Would love to go to the casino. I can understand gotta have volunteers but we are the ones that live here. We in here 20 hours a day only time is outside when you smoke. We be bored cause we don't have nothing to do. Watch tv and smoke cigarettes. Been locked up before with four walls and I don't want that again! A lot of time (R19) hollering in hallway and cause she's tired. Most time acting like that she's sleepy. She's sitting there for a long time. They should have more staff to be able to lay her down. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/29/22 at 11:46 AM, an interview was conducted with the Activity Director (Staff 'AA'). Staff 'AA' reported they had worked at the facility for two years and been in the role as Activity Director since March 2022. When asked about their role in activities, Staff 'AA' reported they were the only activity staff currently and also provided social services. When asked about the lack of weekend activities, Staff 'AA' reported that was correct and there had not been any weekend activities in the two years they've been at the facility. R47: On 8/28/22 at 1:35 PM, an interview was conducted with R47. When asked about what activities were offered at the facility, they reported No activities scheduled on the weekend, there's nothing to do. Review of the clinical record revealed R47 was admitted in the facility on 6/30/22 with diagnoses that included: osteomyelitis of vertebra sacral and sacrococcygeal region, attention to colostomy, paraplegia, anemia, opioid dependence, major depressive disorder recurrent, neuromuscular dysfunction of bladder, anxiety disorder, protein-calorie malnutrition, other chronic osteomyelitis, essential hypertension, acquired absence of right and left leg below knee, assault by shotgun with retained metal fragments. According to the Minimum Data Set (MDS) assessment dated [DATE], R47 had no communication concern, had intact cognition, and did not have any mood or behavior concerns. Review of the activity care plan initiated 7/5/22 documented, I am here for long term care and will be invited to participate in the activity program. Interventions included: I have indicated that the following items are important to me: These items are available to me through Resident likes a social setting in his room watching tv/movies and playing on his phone. Review of the activity documentation in the task section of the electronic medical record (EMR) revealed there were no activities noted and read, No Data Found. R54: From 8/28/22 to 8/31/22, multiple observations of R54 revealed they were not engaged in any meaningful activities and was in their room lying in bed for all but one observation. Review of the clinical record revealed R54 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Huntington's disease, dysphagia following other cerebrovascular disease, gastrostomy status, GERD, other secondary hypertension, conversion disorder with seizures or convulsions, tremor, anxiety disorder, mood disorder due to known physiological condition with major depressive-like episode, dementia in other diseases classified elsewhere without behavioral disturbance, and memory deficit following other cerebrovascular disease. According to the MDS assessment dated [DATE], R54 had unclear speech but was usually able to make themselves understood and usually understands others, had severe cognitive impairment, had mood concerns for feeling down, depressed, or hopeless, for 2-6 days, and was totally dependent upon staff for most aspects of care. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the activity care plan initiated 11/10/20, revised on 2/7/21 documented, I have little activity involvement due to limited cognitive impairment. Interventions included: Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. I need a variety of activity types and locations to maintain interests. I need assistance/escort to activity functions. Review of a mood care plan initiated 3/7/21, revised on 10/1/21 documented, There are times when I may demonstrate sad effect/mood secondary to remaining in the nursing home currently and my medical condition . Interventions included: Offer small group, out of the room activities. Review of the activity documentation in the task section of the EMR revealed there were no activities noted and read, No Data Found. On 8/31/22 at 3:04 PM, an interview was conducted with Staff 'AA'. When asked about the type of activities provided to R54, they reported the resident gets haircut and special events like parties, also gets family visits and 1:1 in room visits. When asked what types of activities were done with the room [ROOM NUMBER]:1 visits, Staff 'AA' reported Just talk. When asked how often, they reported three times a week. When asked where these activities were documented, they reported they were just given access in the electronic clinical record last week. When asked where those were documented prior to that, they reported there was no process to document. 32568 R19 On 8/28/22 at 12:33 PM, R19 was observed visiting with a family member. R19 was seated in a wheelchair near the East Wing nurse's station. R19's family member assisted R19 with eating. On 8/28/22 at 1:08 PM, R19 remained seated in a wheelchair near the nurse's station calling another resident vulgar names. R19 stated, We call each other [expletives] for fun. On 8/28/22, multiple observations were made of R19 between approximately 1:30 PM and 6:00 PM seated in the same spot near the East Wing nurse's station with minimal interaction from the staff and no activities provided. R19 remained tearful with periods of sobbing and crying out for her family throughout this time frame. On 8/29/22 at 1:58 PM, R19 was heard yelling and sobbing from another hallway. R19 was observed seated in a wheelchair near the nurse's station of the East Wing. CNA 'QQ' was observed seated at the nurse's station while R19 screamed. On 8/29/22 from 9:01 AM until 9:20 AM, R19 was observed in bed eating breakfast. R19 was crying and stated, They leave me here alone over and over. R19 reported she wanted to be up on her wheelchair and out of her room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/29/22 at 2:10 PM, R19 was observed yelling, sobbing, and nonsensically repeating things. CNA 'RR' was asked what kind of activities R19 participated in. CNA 'RR' stated, I can get her some crayons. CNA 'RR' placed crayons, coloring books, and a word puzzle book on the table in front of R19. R19 continued to cry uncontrollably and yell for another staff member (R19 called CNA 'SS' a different name than her actual name, but referred to her as that name). On 8/29/22 at 2:24 PM, R19 continued to yell out for CNA 'SS' and continued to cry. R19 was asked if she was able to do the word search puzzle that was placed in front of her and she responded, No! and continued to cry. On 8/29/22 at 2:35 PM, CNA 'SS' arrived on the unit. R19 continued to call out her name over and over. When CNA 'SS' approached R19, she asked the resident if she wanted to attend the birthday party and have some cake. R19 stopped yelling and stated, Birthday party? CNA 'SS' explained to R19 that she had to remain calm and she could attend the party located in the dining room. R19 remained calm at that time. At 2:37 PM, CNA 'SS' told R19 that she would go get her some cake and did not take her to the birthday party. No cake was provided to R19 and she was not taken to the birthday party. On 8/29/22 at 3:24 PM, R19 remained seated near the nurse's station on the East Wing, yelling, crying, and restless. Activities Director 'AA' was present nearby R19 on the East Wing and was not observed to engage with R19 or offer an activity. On 8/31/22 at 2:42 PM, R19 was observed lying in bed sobbing. The door was closed and the television was on. R19 could be observed from the hallway crying while in bed and was not engaged in watching television. Review of R19 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, seizures, major depressive disorder, expressive language disorder, hemiplegia, aphasia, cerebral infarction, psychotic disorder, nontraumatic subdural hemorrhage, and pseudobulbar affect. Review of the last MDS assessment completed on 5/2/22, R19's cognition was not assessed. Review of an MDS assessment completed on 1/30/22 revealed R19 had severely impaired cognition. Review of R19's Recreation Assessments revealed when she was assessed on 5/24/22 it was documented R19 was a former basketball coach and had current interested that included: TV/Movies, Talking/Conversing, and Family/Friends. It was documented that R19 liked to get her nails done, her hair done, and attend special events. It was documented that the following things comforted R19: personal tablet, music, outdoors time, and spending time talking to her family on her tablet. R19 was not observed to receive any of the above activities on 8/28/22, 8/29/22, and 8/30/22. Review of the CNA task documentation for R19 on 8/31/22 for the past 30 days revealed R19 did not attend any group activities, socialized with others in the facility one time on 8/6/22 as a self directed activity, and did not have any 1:1 activities documented. (continued on next page)

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	235664	A. Building B. Wing	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R19's care plans revealed a care plan initiated on 5/24/22 that documented, I am here for long term care and will be invited to participate in the activity program. One intervention that was initiated on 5/24/22 was included in the care plan that noted, Things that comfort me: Personal tablet, music, outdoors time and love spending time talking to her family on her tablet. R19's goal noted the following: I will participate in group activities of interest x a week (the goal did not include a number of times per week. On 8/31/22 at 2:56 PM, Activities Director 'AA' was interviewed. When queried about what activities were provided to R19, Activities Director 'AA' stated, I play music for her but I can't remember the name of the musician, she gets her nails and hair done. When queried about attending group activities, Activities Director 'AA' reported R19 sometimes attended but yells and they had to take her out. When queried about what activities were provided to R19 on 8/28/22, 8/29/22, and 8/30/33, Activities Director 'AA' reported there were no scheduled activities on weekends and she took her to a music activity on 8/30/22, but R19 started yelling. When queried about whether R19 attended the birthday party on 8/29/22, Activities Director 'AA' was unsure. When queried about where activities were documented and monitored for participation, Activities Director 'AA' reported there was nothing in place to document activities at that time. R37 On 8/28/22 at 2:30 PM, R37 was observed standing in her room. When asked about life in the facility, R37 reported she hated it there, did not need to be there, was bored, there was nothing to do, and she just wanted to live her life. Multiple observations were made on 8/28/22 and 8/29/22 of R37 standing in the mirror in the bathroom straightening up her shirt and hair. On 9/8/22 at 11:49 PM, the Administrator was interviewed about the facility's Quality Assurance program. When queried about the activities program, the Administrator reported she was aware there were no activities provided on the weekends, but they had not received any concern forms from residents. When queried about residents who were not able to complete a resident concern form or express dissatisfaction or boredom, the Administrator did not offer a response.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation has two deficient practice statements (DPS). DPS #1 Based on interview, and record review, the facility failed to ensure Hospice Services were provided per plan of care for one resident, (R61) of one resident reviewed for Hospice Services, resulting in R61 not receiving the provision of Hospice Care. Findings include: A review of a facility provided policy titled, Hospice Services Facility Agreement with a revision date of 12/2021 was conducted and read, Policy: It is the policy of this facility to provide and/or arrange for hospice services in order to protect a resident's right to a dignified existence .3. If hospice care is furnished in the facility through an agreement, the facility will: a. ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services . On 8/28/22 at 1:02 PM, R61 was observed in their room lying in a fetal position in a low bed. R61 had the covers pulled over their head, and was not responsive to attempts at verbal conversation. On 8/31/22 at 9:23 AM, a review of R61's Hospice Service binder was reviewed and a document that named R61's Hospice Team. The document named Registered Nurse (RN) 'WW' as the Primary Nurse, Social Worker 'XX', Chaplain 'YY, and RN 'ZZ' as the Team Director. It was noted no one had been named as R61's Certified Health Aide. It was also noted there was no schedule in the binder that indicated hospice staff visits. that A review of the progress notes in the binder was conducted and revealed the only visits documented were a one time weekly visit from RN 'WW'. A review of a HOSPICE TEAM VISIT CALENDAR was contained in the binder and noted to be blank. A review of a Plan of Care Update Report dated 7/27/22 was reviewed and read, Client Orders .HOME HEALTH AIDE SERVICE FOR ASSISTANCE WITH PERSONAL CARE, HYGIENE, AND ACTIVITIES OF DAILY LIVING . On 8/31/22 at 9:36 AM, it was reported the Director of Nursing (DON) was the staff member responsible for coordinating the care between the facility and the Hospice Company. At 9:39 AM, the DON was informed the only documented hospice visits were a one time weekly visit by RN 'WW'. They were asked if they knew about a Hospice Aide, Social Worker, or any Spiritual Care coming in and said they would reach out to the Hospice company to see if they had any additional information. On 8/31/22 at 9:51 AM, the DON reported R61 came from a sister facility on Hospice Services. They further reported the Nurse comes one time a week and the Hospice company would only send an aide if there were five or more patients receiving their services in the building. On 8/31/22 at 10:21 AM, a review of R61's clinical record revealed they admitted to the facility on Hospice Services on 7/21/22 from a sister facility. R61's diagnoses included: Huntington's disease, protein calorie malnutrition, bipolar disorder, schizoaffective disorder, and major depressive disorder. A review of R61's Minimum Data Set assessment dated [DATE] indicated R61 had moderately impaired cognition and needed total assistance from staff for activities of daily living. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/31/22 at 4:31 PM, the DON provided additional information faxed from the Hospice company. The Information provided included a document titled, FACILITY INTEGRATION TOOL that indicated R61 was to have a Hospice nurse visit once weekly and a Hospice aide visit once weekly. The additional documentation also indicated a Hospice Aide had been in the facility on 8/30/22, but no evidence was provided the aide had seen the patient between their admitted [DATE] and 8/30/22. It was further noted the document provided indicated a Social Worker had seen the resident on 8/11/22, but no progress note addressing the visit was provided. DPS #2 Based on observation, interview, and record review, the facility failed to ensure wound care treatments and leg wraps were provided per physician's order for one resident (R#268) of one resident reviewed for wound care, resulting in verbalized complaints and fear for the worsening of lymphedema (tissue swelling caused by an accumulation of fluid that's usually drained through the body's lymphatic system). Findings include: On 08/28/22 at 12:49 PM, R268 was observed in their room in their chair. R268 was asked about their stay in the facility and verbalized complaints about staff not changing the dressings on their legs and not knowing how to properly wrap their legs. R268 said they had lymphedema and wounds. With R268's permission their legs were observed. The right leg was observed wrapped with a white bulky wrap and the left leg was observed wrapped with a flesh-colored self-adherent wrap. It was observed neither wrap was dated. R268 was asked the last time the wraps had been changed and said it had been three days. On 8/29/22 at 8:51 AM and 8/30/22 at 11:30 AM, R268's leg wraps were observed. It was observed the right remained with undated white bulky wrap and the left with undated self-adherent wrap. R268 was asked if the dressings had been changed and said they had not. On 8/29/22 at 2:15 PM, a review of R268's clinical record was conducted and revealed an admitted [DATE] with diagnoses that included: Parkinson's disease, heart failure, dementia without behaviors, post-traumatic stress disorder, and anxiety disorder. R268's Minimum Data Set assessment dated [DATE] had not yet been completed but Section C. Cognition had been completed and documented intact cognition. On 8/30/22 3:52 PM a review of R268's physician's orders and treatment administration record (TAR) for August 2022 was conducted and revealed an order for R268's left leg to be cleansed with wound cleanser, xeroform (wound care treatment) to be applied to the open area and the leg wrapped with bulky dressing and self-adherent wrap every other day. It was noted the treatment had not been documented as completed on 8/27/22 or 8/29/22. Continued review of the TAR revealed an order for R268's right leg to be wrapped with white bulky dressing and self-adherent dressing for edema (swelling) every other day. It was noted the treatment to the right leg had also not been signed off as completed on 8/27/22 or 8/29/22. On 8/30/22 at approximately 4:00 PM the facility's Director of Nursing was made aware of the concerns with R268 and acknowledged the concern.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation has two deficient practices. Deficient Practice #1 Based on observation, interview, and record review, the facility failed to implement care planned interventions and develop effective and timely interventions based on accurate root cause analysis to prevent falls for one (R19) of two residents reviewed for falls, resulting in R19 falling seven times between July 6, 2022 and August 11, 2022 and sustaining injuries including abrasions to the chin and lip, a hematoma to the forehead, swelling of the hand, bruising to the arm, and a skin tear to the forearm. Findings include: On 8/28/22 at 12:33 PM, R19 was observed seated in a wheelchair near the nurse's station on the East Wing visiting with a family member. R19 appeared lethargic and her family member helped her eat. On 8/28/22 at approximately 1:00 PM, an interview was conducted with R19's family member. R19's family member reported R19 was supervised less and received less attention during the weekends, was paralyzed on the left side of her body, and experiences strong emotional reactions due to a head injury. R19's family member explained R19 had a seizure disorder, but seizures were under control at that time. On 8/28/22, multiple observations were made of R19 between approximately 1:30 PM and 6:00 PM seated in the same spot near the East Wing nurse's station with minimal interaction from the staff. R19 was tearful, sobbing, and restless, crying out to Let me go! On 8/28/22 at 5:09 PM, R19 was seated near the East Wing nurse's station which was also near the Director of Nursing's (DON) office. R19 was screaming loudly and crying and plate of food was observed on the table in front of the resident. Nurse 'B' walked by R19 without addressing her. R19 repeated, They just leave me. They leave me alone. I can't do it!. The DON and a Certified Nursing Assistant approached R19 and said, Let's eat (R19) and walked away. R19 began crying when the staff walked away and continued to yell, I can't do it! I can't do it! I want to go! At 5:12 PM, the DON told R19 to let the staff finish passing meal trays and the CNA told R19 she would be right back. R19 continued screaming and sobbing and stated, I can't do it! I can't do it! Help me! Help me! At 5:16 PM, Nurse 'B' was observed seated behind the nurse's station desk and the DON was inside her office. At 5:20 PM, Nurse 'B' sat down next to R19, 20 minutes later, and assisted her with eating and R19 calmed down. On 8/29/22 at 9:01 AM, R19 was observed in bed with a breakfast tray. The door to the room was closed. R19 was sobbing and said she wanted to be up in the wheelchair outside of the room. R19 started screaming and crying. At 9:09 AM, the DON entered R19's room (the door remained closed) and asked R19 to eat her breakfast and left the room. R19 continued to yell, They leave me! They leave me alone! At 9:20 AM, a CNA entered R19's room and R19 calmed down. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/29/22 at 1:58 PM and 3:24 PM, R19 was seated in a wheelchair across from the nurse's station yelling, sobbing, and restless with minimal interaction from the staff. CNA 'SS' was observed to tell R19 that she would get her some cake or take her to a birthday party that was being held in the main dining room, but did not do either task. On 8/30/22 from 5:00 PM until 5:18 PM, R19 was observed seated in a wheelchair inside her room with the door open only a crack. R19 was near the door and was yelling and crying. At 5:30 PM, R19 was observed in her room in a wheelchair yelling and crying. R19's dinner plate was observed to be placed on the bed. On 8/31/22 at 2:42, R19 was observed lying in bed with the door closed. R19 was crying. Review of R19's clinical record revealed R19 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, seizures, major depressive disorder, expressive language disorder, hemiplegia, aphasia (difficulty speaking), dysphagia (difficulty swallowing), psychotic disorder, nontraumatic subdural hemorrhage, and pseudobulbar affect. Review of R19's Minimum Data Set (MDS) assessments revealed the most recent MDS assessment was not yet completed and was due on 8/2/22. Review of the previous MDS assessment completed on 5/2/22 did not assess R19's cognition or behavior symptoms and revealed R19 required extensive assistance for bed mobility, was totally dependent on staff for transfers and eating, and was always incontinent of bowel and urine. It was documented R19 did not fall during the assessment period. Review of Fall Incidents (progress notes, incident reports, post-fall reviews, and care plans) for R19 from July 2022 and August 2022 revealed the following: 1. R19 fell on [DATE] at 4:00 PM and was observed laying on the floor on left side of her body. It was documented R19 complained of new pain to her left shoulder. There were no witnesses to the fall. A Post-Fall/Fall Risk Assessment completed on 7/6/22 documented R19's call light was not within reach and floor mats were in place. The assessment documented, State immediate intervention (new or revised) implemented to help prevent additional accidents: Floor mat in place . It should be noted that it was documented that the floor mat was in place at the time of the fall. A care plan initiated on 5/23/22 documented, I am at an increased risk of falls. Review of the care planned interventions for falls revealed the following interventions: Be sure my call light is within reach (initiated 5/23/22) (Please note that the post-fall assessment noted the call light was not in reach) and Floor mat was initiated on 6/27/22 and therefore was an intervention already in place at the time of the fall. Further review of the care plan revealed no new interventions. 2. R19 fell on [DATE] at 1:47, three days after the previous fall, and was observed on the floor in the hallway. R19 complained of pain in her left shoulder and head. There were no witnesses to the fall and R19 was not able to explain what happened. Review of a progress note written by Physician 'CC' revealed R19 sustained a small hematoma, complains of pain in the left shoulder from a previous fall and was more irritable than usual. R19 was later sent to the emergency room for an X-ray due to unrelieved pain and returned with negative results of the X-rays. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An Antigravity Team Note (Interdisciplinary Team Note for Falls) dated 7/11/22 documented, Root Cause(s) of Fall: Resident is very spontaneous and becomes agitated at times. Will yell out or moan for attention, repeating over and over .she attempts to rise from the chair on her own and is physically unable to do so . Prior Interventions: Mat at bedside, call light in reach, place in high traffic areas, offer diversional activities . New Interventions: (this was left blank) . Review of R19's care plans revealed a new intervention initiated on 7/12/22 to place in high traffic area for monitoring when up in wheelchair. However, R19 was in the hallway near the nurse's station when the fall occurred on 7/9/22. 3. R19 fell on [DATE] at 11:54 PM and was observed lying partly on the floor mat and the floor. Resident was observed lying partly on the floor mat and on the floor. R19 sustained a small abrasion on the chin according to an evaluation by Physician 'CC' on 7/19/22. It was documented on the incident report that R19 had increased agitation. A care plan intervention initiated on 7/19/22 noted, I need a specialty wheelchair High back to help reduce my risk for falls. It was not mentioned if R19 was previous up in a wheelchair or in bed in their room. Review of a Post-Fall/Fall Risk Assessment completed on 7/19/22 revealed R19's call light was within reach, the bed was in the lowest position and they had a low bed. The immediate interventions implemented to help prevent additional accidents were noted as bed in lowest position, call-light within reach, educated on how to use the call light to call. 4. R19 fell on [DATE] at 5:52 PM and was observed on the floor mat in their room. It was documented on the incident report that Resident stated she rolled on the mat .intentionally rolls onto mat. According to Physician 'CC's evaluation conducted on 7/23/22, R19 .fell again, tries to move and get off the bed leading to falls . restlessness/fall as a result, worsened by old left hemiparesis, poor bed mobility, PT (physical therapy) has not been of help. Continued fall precautions . A care planned intervention initiated on 7/25/22 noted, place in high traffic area when up in wheelchair. However, that intervention was initially added to the care plan on 7/12/22. Review of an Antigravity Team Note dated 7/26/22 to address R19's fall on 7/23/22 documented, .attempting to get out of bed .Prior interventions: move room near nurses station, place in active area, remind to ask for assistance, call light in reach .New Interventions: ask pharmacist to review meds . Review of R19's Pharmacy Progress Notes revealed the pharmacist did not review R19's medications until 8/23/22, one month later. Review of the Post-Fall/Fall Risk Assessment completed on 7/23/22 revealed n/a (not applicable was documented in the section to state immediate intervention . It was documented R19 was in bed prior to the fall and was agitated prior to the fall. 5. R19 fell on [DATE] at 4:45 PM and was observed on the floor in the hallway with a blister noted to the right hand. A progress note dated 7/29/22 noted R19 had a bruise on arm from fall. An evaluation documented by Physician 'CC' on 7/29/22 noted, screaming all morning, fell again, new right forehead hematoma, swelling to right hand, tender .blister .Xray .continue precautions Review of a Post-Fall/Fall Risk Assessment completed on 7/29/22 revealed R19 was agitated at the time of the fall and an evaluation by psychiatric services was ordered. R19 was seen by psychiatry on 8/4/22 and some medication changes were made. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	6. R19 fell on [DATE] at 6:50 PM. Nurse 'B' heard a loud noise when they were walking down the hallway and R19 was observed lying on the floor face down in front of her w/c (wheelchair) in the hallway. R19 complained of pain to their left knee, left eye, and mouth and an abrasion was noted to R19's upper lip and a skin tear to the left forearm. R19's pain level was documented to be nine out of 10 with 10 being the highest level of pain. It was documented there were no witnesses to the fall. A progress note written by Physician 'CC' on 8/5/22 documented, .Fall. Pain in forehead apparently 'jumped' off the bed sustained injury to upper lip/left upper arm . It should be noted that the incident report documented R19 was found face down in the hallway and that the incident was not witnessed. Review of an Antigravity Team Note dated 8/10/22 for R19's fall that occurred on 8/5/22 revealed, .prior interventions: call light w/in reach, mattress next to bed, place in common area, med review .new interventions: 1:1 as needed . Review of R19's care plan revealed 1:1 as needed was initiated on 8/8/22. 7. R19 fell on [DATE] at 7:13 PM while Nurse 'H' was standing at the medication cart counting medications with the oncoming nurse. The incident report documented R19 fell out of the wheelchair and onto the floor in the hallway. It was documented there were no witnesses to the incident. A progress note written by Physician 'CC' documented R19 reported to have fallen and found on the floor apparently has been trying to fall on purpose as per nursing reports .Fall recurrent likely because of left hemiparesis - trying to get out of bed and unable to control herself. Precautions to be maintained .steps in place with low bed and floor mattress . Review of an Antigravity Team Note dated 8/10/22 documented, .root cause, resident placed self on floor . prior interventions: perimeter mattress, mattress next to bed, proper foot wear, psych eval, med review, UA, bed in low position. 1:1 as needed . It should be noted that R19 fell while in the hallway in the presence of staff. A new intervention was initiated on R19's care plan on 8/11/22 for mattress next to bed. It should be noted that R19 did not fall in her room on 8/10/22. Review of a Post-Fall/Fall Risk assessment dated [DATE] revealed it was documented that R19 was up in a wheelchair and placed herself on the floor. It was documented the incident was witnessed and R19 was agitated and restless at the time of the fall. There was no documented evidence that R19 was placed on 1:1 when she was agitated and restless as that was the previous care planned intervention implemented on 8/8/22. It was documented that resident would remain in bed for safety as an immediate intervention and it was also initiated on the care plan on 8/11/22. On 8/31/22 at 3:31 PM, the Director of Nursing (DON) was interviewed. When queried about how residents who were at high risk for falls were prevented from falling, the DON reported if a resident was assessed to be at high risk for falling it was shared with staff and care planned interventions would be developed and implemented. The DON reported falls were discussed at the daily IDT meetings to determine the root cause of the fall and to figure out appropriate interventions to prevent future falls. When queried about who monitored residents to ensure staff were implementing the care planned interventions to prevent falls, the DON reported nurses, the unit manager, or the DON. When queried about what was in place to prevent falls for R19, the DON reported she did not know who that resident was. The above observations were discussed with the DON and the incident reports and care plans for R19 were discussed. The DON reported all care planned interventions should be implemented and appropriate interventions based on the root cause of the fall should be added after falls occurred. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R19's care plan conducted on 8/29/22 revealed the falls care plan was initiated on 5/23/22 and documented, I am at an increased risk for falls r/t (related to). It should be noted that there was no specific focus or root cause identified on the care plan when reviewed on 8/29/22. Review of the care plan on 8/30/22 revealed the care plan was updated and noted, I am at an increased risk for falls 2/2 (secondary to) hx (history) of falls with major injury, decreased awareness, incontinence. The care plan did not document that R19 jumped out of bed or threw self on floor. The care plan documented the following interventions: 1:1 as needed initiated on 8/8/22 - This intervention was not observed throughout the survey when R19 was observed to be restless and in emotional distress. R19 was observed on multiple occasions in their room, in bed, with the door closed, while crying and distressed. Encourage me to participate in activities that promote exercise, physical activity for strengthening and improved mobility, initiated on 6/28/22. This intervention was not observed. Frequent monitoring, initiated on 8/8/22. There were multiple observations throughout the survey of R19 in a restless, distressed state both in the hallway by the nurse's station and in their room with the door closed for extended periods of time. I need strategies that minimize the potential for falls while providing diversion and distraction, initiated on 7/28/22 and revised on 7/28/22. This intervention did not include any individualized or specific strategies to attempt with R19. Place in high traffic area for monitoring when up in wheelchair, initiated on 7/12/22 and revised on 7/25/22. R19 was observed multiple times throughout the survey in their room with the door closed or near the nurse's station in a restless and distressed state with minimal engagement from the staff. Resident to remain in bed for safety, initiated on 8/11/22. There were multiple observations of R19 in bed with the door closed, crying and in distress. It should be noted that R19 had multiple unwitnessed falls in their room from their bed in the months of July 2022 and August 2022. Review of a facility policy titled, Fall Reduction Policy, revised 8/2021, revealed, in part, the following: .Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care .Interventions will be monitored for effectiveness .The plan of care will be revised as needed .When any resident experiences a fall, the facility will: .IDT review of the resident's care plan and update as indicated .obtain witness statements as needed . 30675 Deficient Practice #2 Based on observation, interview and record review, the facility failed to ensure a timely safe smoking assessment for one (R47) of four residents reviewed for accidents, resulting in the increased likelihood for unidentified supervision needs. Findings include: (continued on next page)

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	235664	A. Building B. Wing	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/28/22 at 1:35 PM, R47 was observed seated in a wheelchair in their room. When asked about whether they smoked, R47 reported they used to have cigarettes that were kept in the nursing cart and recently had their family provide them with a CBD pen (Cannabidiol - vaping pen) recently. When asked if anyone had ever evaluated them for safe smoking, they reported the Administrator said they had to take the CBD pen and that no-one had assessed them for anything like that. Review of the clinical record revealed R47 was admitted in the facility on 6/30/22 with diagnoses that included: osteomyelitis of vertebra sacral and sacrococcygeal region, attention to colostomy, paraplegia, major depressive disorder recurrent, neuromuscular dysfunction of bladder, anxiety disorder, protein-calorie malnutrition, other chronic osteomyelitis, acquired absence of right and left leg below knee, assault by shotgun and retained metal fragments. According to the Minimum Data Set (MDS) assessment dated [DATE], R47 had intact cognition. Further review of the clinical record revealed there was no assessment for safe smoking completed until 8/28/22 (during the survey) by Nurse Manager 'A'. This assessment identified the resident may smoke with supervision. On 8/30/22 at 3:40 PM, the Administrator was asked about who was responsible for completing the smoking assessments for the residents and they reported those should be done by the floor nurses upon admission into the facility. When asked about R47's CBD pen, they reported they had just gotten approval from the physician and educated R47 about the facility's policy on use of cigarettes and smoking. When asked why the resident's safe smoking assessment was not completed until 8/28/22 (once survey started) and they reported they were not sure and were not aware other than the CBD pen that the resident smoked. The Administrator reported they were not aware R47 smoked cigarettes and would have to follow up. The Administrator was requested for a facility policy which addressed resident smoking, but there was no further documentation provided by the end of the survey.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00129973 and MI00130095. Based on observation, interview and record review, the facility failed to ensure a resident was provided timely incontinence care for one (R54) of four residents reviewed for bladder and bowel incontinence, resulting increased likelihood for feelings of embarrassment, loss of dignity, and skin breakdown. Findings include: On 8/28/22 from 12:00 PM to 7:10 PM observations of R54 included: At 12:00 PM, R54 was observed dressed and wearing a helmet while seated in a wheelchair (on top of a Hoyer lift sling) in the front dining room. From 12:00 PM to 6:30 PM, staff were not observed to offer to R54 to lay down, or to check for incontinence care needs. At 6:30 PM, R54 was observed to have a strong odor from a bowel movement (BM). At 6:53 PM, Nurse 'VV' was observed approaching R54 tell them they were going to take him to lay down. Upon moving R54's wheelchair backwards to turn around, the resident's lower extremities began shaking and trembling rapidly. Nurse 'VV' put their hands on the resident's shoulder and the resident's movements stopped. When asked about why the resident had been up in their chair since at least 12:00 PM without being changed or checked on by nursing staff, Nurse 'VV' reported they were not able to explain as they had only arrived at the facility at 4:00 PM. When asked who the assigned Certified Nursing Assistant (CNA) was, Nurse 'VV' reported they didn't know, but thought it was a male CNA from the agency. After a few more minutes, R58's assigned nurse (Nurse 'EE') came to the room. When asked why no one offered to check the resident for incontinence during the approximate seven or more hours, they reported there were issues with staff coming in and that once they got wind that State (health care surveyors) was in the building staff left, or called off. Nurse 'VV' acknowledged R54's strong BM smell and left the room to find the CNA. At 7:10 PM, R54 remained in seated in the wheelchair and remained incontinent of BM. Review of the clinical record revealed R54 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Huntington's disease, gastrostomy status, conversion disorder with seizures or convulsions, tremor, anxiety disorder, mood disorder due to known physiological condition with major depressive-like episode, dementia without behavioral disturbance, and memory deficit following other cerebrovascular disease. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Minimum Data Set (MDS) assessment dated [DATE], R54 had unclear speech, had severe cognitive impairment, was totally dependent upon one-person physical assist with toilet use and personal hygiene, was always incontinent of urine and occasionally incontinent of bowel and was not on a toileting program. On 8/29/22 at 8:54 AM, an interview was conducted with CNA 'O' (who had been assigned to R54 on 8/28/22 day shift. When asked about why the resident had not been toileted or checked for incontinence care on 8/28/22, they offered no explanation. When asked where documentation was maintained for the resident's bladder and bowel management, CNA 'O' reported that was in the task section of the electronic medical record (EMR). Review of R54's bowel and bladder section of the task documentation for the past 30 days (as of 8/29/22) revealed there was no documentation since 8/26/22. Review of R54's Kardex for Toileting/Bowel and Bladder documented, Monitor me for incontinent episodes @ (at) least Q (every) 2 hrs (hours) & prn (as needed) and provide me with incontinent care apply protective ointment to peri area with each brief change .Observe/document for s/sx (signs and symptoms) UTI (Urinary Tract Infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior .TOILET USE: Totally dependent on (X)1 staff for toilet use.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to ensure ongoing and timely monitoring and treatment/intervention for one resident (R54), of two residents reviewed for nutrition, resulting in a resident that received total nutrition via enteral feeding (delivery of nutrients through a feeding tube directly into the stomach, duodenum, or jejunum) having severe weight loss (8.83% in less than one month) and the potential for further clinical compromise. Findings include: According to the facility's policy titled, Nutrition at Risk and Review dated 2/2021, It is the practice of this facility to identify residents at nutritional risk and intervene to minimize decline in nutritional status .Residents at nutritional risk will be identified through the nutrition assessment, and observation .Residents reviewed will be a collaborated effort of an interdisciplinary team .Residents with unplanned significant weight changes . 5% in 30 days .7.5% in 90 days .tube fed residents that do not have stable weight .The dietary manager or dietitian with the support of the Director of Nursing or designee will be responsible for seeing that all residents meeting the above criteria are identified .The Physician will be notified if a resident is not responding to current interventions .The dietitian, dietary manager or designee will document the review of the IDT members. This policy did not address severe weight loss, or weight monitoring process. Review of the physician orders included: The current diet was NPO (nothing by mouth). The current enteral feed order dated 8/25/22 read, Enteral Feed Order two times a day Administer Jevity 1.5 @78ML/hr x 16 hrs = total 1248mL. Autoflush: 50ml/hr x 16 hrs = total 800mL/h2o. Up at 6PM, down at 10AM or until dose complete. On 8/31/22 at 9:43 AM, R54 was observed lying in bed with a thin bedsheet covering their body. The resident appeared thin and a tube feeding pump was on and administering tube feeding. Further observation revealed the tube feeding bag was labeled with a date of 8-30-22, a time of 1800 (6:00 PM), and a rate of 78. There was approximately 100 ml (milliliters) of tube feeding remaining in the bag that was in use. The tube feeding pump itself was set to a rate of 75 (not 78 - see physician order below). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 8/31/22 at 10:04 AM, Nurse 'Y' was asked about R54's use of tube feeding and reported that was due to come down at 10:00 AM. When asked to confirm R54's tube feeding rate, Nurse 'Y' reviewed the order via the electronic medical record (EMR) and reported the rate was to be set at 78. Nurse 'Y' was asked to observe R54's tube feeding pump and confirmed the rate on the pump was set to 75 and not 78. Nurse 'Y' was asked about the total ML's R54 should've received to be completed with their feeding and reported R54's tube feeding container held only 1000 ml total so a second bag should be hung to complete the total enteral nutrition of 1250 ml's. When asked about the incorrect tube feeding rate, Nurse 'Y' reported they were not sure why the previous nurse did that, but someone didn't put the rate high enough. Nurse 'Y' further reported that the order calls for the tube feeding to be down at 10 AM or until full dose completed, so they would need to hang another bag of tube feeding and whoever hung it on midnight shift should've put the correct rate in. Review of the clinical record revealed R54 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Huntington's disease, dysphagia following other cerebrovascular disease, gastrostomy status, conversion disorder with seizures or convulsions, tremor, and memory deficit following other cerebrovascular disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R54 had unclear speech, had severe cognitive impairment, required extensive assistance of one person for bed mobility, was total dependent upon two or more people for transfers, weighed 133 lbs, had no weight changes, and received 51% or more total calories from the tube feeding and 501 cc/day or more for fluid intake per day by IV or tube feeding. Review of the nutritional care plans revealed they were initiated on 5/3/21 and last reviewed/revised on 5/17/22. I have the potential for a nutritional/hydration problem r/t (related to) dx (diagnosis) of dysphagia, dementia, mood disorder, anxiety, HTN (Hypertension), GERD (Gastro-esophageal reflux disease), Huntington's disease, muscle weakness, subdural hemorrhage, conversion disorder. I am dependent on enteral feeding and hydration to meet 100% of my estimated nutrition needs. My diet order is NPO (nothing by mouth). Interventions included: Feeding Techniques I require: provide my TF (Tube Feeding) and water flushes as ordered. Monitor my weight. Report any significant weight changes I have to my physician and Me/DPOA/Guardian. Review of R54's documented weights revealed since February 2022 revealed the following: - 8/2/22 at 11:51 AM = 120.8 lbs (This was a severe loss of 11.7 lbs/8.83% in less than 30 days).) - 7/5/22 at 11:06 AM = 132.5 lbs - 6/7/22 at 10:47 AM = 133.8 lbs (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- 5/13/22 at 10:03 AM = 139.5 lbs - 2/15/22 at 2:59 PM = 125.1 lbs. There were no weights obtained for March, April, or upon R54's readmission on 7/15/22 following a peg-tube replacement. There were no additional weights obtained since 8/2/22 (such as a re-weight to determine accuracy or other factors). Review of the nutritional progress notes revealed: RD 'X' completed an assessment on 7/20/22 upon the resident's readmission which read, .My weight history is. <sic> Current BMI (Body Mass Index) of 21.4, indicating normal range, Wt (weight) stable x 180 days .I am at nutritional risk d/t (due to): S/p (status post) hospitalization ,d+[DATE] (secondary to) PEG replacement per phys (Physician) note 7/15 .CBW: 132.5 lbs (pounds), BMI 21.4 indicating normal range . per RN (Registered Nurse) staff is tolerating TF (Tube Feeding) .No reports of .TF intolerance, Current TF: Jevity 1.5 1000 ml @63ml/hr x 16 hrs .Current regimen likely meeting nutritional needs aeb (as evidenced by) wt stability x 180 days. Rec (Recommend) to continue w/POC (with plan of care). Monitor wt, skin, labs & TF tolerance, RD to follow . The next nutritional assessment was not until 8/25/22 which read, .CBW: 120.8 lbs, BMI 19.5 indicating normal range. Triggered for sig (significant) wt loss of -5% x 30 days (-11lbs) .Per RN, resident is tolerating TF .Res has hx (history) of wt fluctuating x 1 year: (approximately) 120-130lbs. Per RN, recommended increasing TF to 1250ML .Monitor wt .RD to follow. (The resident had severe weight loss, not significant as identified in this assessment.) There was no documentation of any evaluation of R54's severe weight loss from 8/2/22, until 8/25/22. Additionally, although the practitioner increased the resident's tube feeding rate on 8/25/22, their evaluation notes from 8/5/22 and 8/29/22 did not address the severe weight loss, or address any resident specific nutritional concerns. On 8/31/22 at 9:25 AM, an interview and record review were conducted with RD 'X'. When asked if there were any re-weights obtained that might not be in the EMR, RD 'X' reported there were none as R54's weights were done monthly. When asked about the delay in nutritional assessment and monitoring following the severe weight loss on 8/2/22, RD 'X' was unable to offer any explanation. When asked what their process was for weight discrepancies, RD 'X' reported they would have to follow up, but at a minimum should be once a month. When asked if weight changes or discrepancies were discussed in interdisciplinary meetings, they reported they had just done that on 8/25/22. When asked if they had been notified or aware of R54's weight loss on 8/2/22 and if there was any alert in the electronic record, they indicated there was an alert and they addressed it on 8/25/22. When asked why it took until 8/25 to address the resident's severe weight loss, especially for a resident that received all their nutritional via enteral feeding, they were not able to provide any explanation. When asked if the practitioner had addressed the weight/nutritional needs, RD 'X' reported they saw the resident on 8/29/22. Upon review of the physician note on 8/29/22, RD 'X' confirmed there was no mention of any nutritional concerns. RD 'X' was asked to obtain a current weight and reported they would arrange. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 8/31/22 at 9:45 AM, an observation of R54's weight was completed with Nurse 'Y' and Certified Nursing Assistant (CNA 'W'). R54's weight was obtained via use of a Hoyer lift that had a built-in weight scale. Prior to obtaining the weight, the nursing staff did not ensure the scale was set to zero (to ensure accurate weight was obtained). The weight observed was 124.9 lbs. When asked about the process for using the digital scale prior to getting the resident's weight, CNA 'W' reported it should have been completely zero' d out. On 8/31/22 at 10:37 AM, an interview was conducted with the Regional RD (RD 'Z') and RD 'X'. RD 'Z' reported they came to the facility on ce weekly to provide oversight. When asked about how the weights should be obtained, RD 'Z' reported an in-service would have to be done as the scale should've been set to zero to begin with. RD 'Z' also reported that the resident should have been placed on weekly weights and was unable to offer any explanation as to why this had not been done. Additionally, RD 'Z' was asked about if they were able to identify a severe weight loss if there was no documentation of any issues with the resident tolerating the tube feeding, and if it were possible the wrong rate of tube feeding could also contribute, they reported that could and confirmed they had concern with the delay in identification of the resident's weight loss, and delayed interventions and would have to follow up. A request was made for the facility's documentation on monitoring weights and nutritional status, however there was no further documentation provided by the end of the survey.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to ensure accurate administration of tube feeding formula in accordance with physician order for one (R54) of three residents reviewed for tube feeding, resulting in the increased potential for weight loss and clinical compromise. Findings include: According to the facility's policy titled, Care and Treatment of Feeding Tubes dated 12/2020, .Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush . Review of the physician order dated 8/25/22 read, Enteral Feed Order two times a day Administer Jevity 1.5 @78ML/hr x 16 hrs = total 1248mL. Autoflush: 50ml/hr x 16 hrs = total 800mL/h2o. Up at 6PM, down at 10AM or until dose complete. On 8/31/22 at 9:43 AM, R54 was observed lying in bed with a thin bedsheet covering their body. The resident appeared thin and a tube feeding pump was on and administering tube feeding. Further observation revealed the tube feeding bag was labeled with a date of 8-30-22, a time of 1800 (6:00 PM), and a rate of 78. There was approximately 100 ml (milliliters) of tube feeding remaining in the bag that was in use. The tube feeding pump itself was set to a rate of 75 not 78. On 8/31/22 at 10:04 AM, Nurse 'Y' was asked about R54's use of tube feeding and reported that was due to come down at 10:00 AM. When asked to confirm R54's tube feeding rate, Nurse 'Y' reviewed the order via the electronic medical record (EMR) and reported the rate was to be set at 78. Nurse 'Y' was asked to observe R54's tube feeding pump and confirmed the rate on the pump was set to 75 and not 78. Nurse 'Y' was asked about the total ML's R54 should've received to be completed with their feeding and reported R54's tube feeding container held only 1000 ml total so a second bag should be hung to complete the total enteral nutrition of 1250 ml's. When asked about the incorrect tube feeding rate, Nurse 'Y' reported they were not sure why the previous nurse did that, but someone didn't put the rate high enough. Nurse 'Y' further reported that the order calls for the tube feeding to be down at 10 AM or until full dose completed, so they would need to hang another bag of tube feeding and whoever hung it on midnight shift should've put the correct rate in. Review of the clinical record revealed R54 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Huntington's disease, dysphagia following other cerebrovascular disease, gastrostomy status, conversion disorder with seizures or convulsions, tremor, and memory deficit following other cerebrovascular disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R54 had unclear speech, had severe cognitive impairment, required extensive assistance of one person for bed mobility, was total dependent upon two or more people for transfers, weighed 133 lbs, had no weight changes, and received 51% or more total calories from the tube feeding and 501 cc/day or more for fluid intake per day by IV or tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nutritional care plans revealed they were initiated on 5/3/21 and last reviewed/revised on 5/17/22. I have the potential for a nutritional/hydration problem r/t (related to) dx (diagnosis) of dysphagia, dementia, mood disorder, anxiety, HTN (Hypertension), GERD (Gastro-esophageal reflux disease), Huntington's disease, muscle weakness, subdural hemorrhage, conversion disorder. I am dependent on enteral feeding and hydration to meet 100% of my estimated nutrition needs. My diet order is NPO (nothing by mouth). Interventions included: Feeding Techniques I require: provide my TF (Tube Feeding) and water flushes as ordered.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure a care was implemented and provided for a tunneled central venous catheter (CVC - an intravenous - IV line that is inserted into the chest, tunneled under the skin, and placed into a vein near or just inside of the heart to deliver medications) for one (R216) of one resident reviewed for IV lines. Findings include: On 8/28/22 at 12:50 PM, R216 was observed seated on the side of the bed. An IV pole with a bag of dextrose was observed in the room and was not infusing at that time. R216 reported she was supposed to receive TPN (Total Parenteral Nutrition) but had not yet received it. R216 reported she had a central line (CVC) inserted in her chest and currently received dextrose through the IV. The date on the CVC dressing was dated 8/25/22. Review of R216's clinical record revealed R216 was admitted into the facility on [DATE] with diagnoses that included: necrotizing fasciitis (flesh-eating bacteria), enterocutaneous (EC) fistula (abnormal connection that develops between the intestinal tract or stomach and the skin which causes contents of the stomach or intestines to leak through to the skin), anemia, and type 2 diabetes mellitus. Review of a Continuity of Care Document provided by the hospital revealed the following: .Active Lines .CVC Single Lumen Tunneled 5 Right Subclavian (vein located under the clavicle) .Dressing change due 8/30/22 . Review of R216's Physician's Orders revealed there was no order for the CVC and no subsequent orders for care, monitoring, or assessment of the IV site. Review of R216's care plans revealed no care plan for care, monitoring, or assessment of the IV site. On 8/29/22 at 1:36 PM, Unit Manager, Nurse 'A' was interviewed. When queried about what should be in place for a resident admitted with a central venous catheter, Nurse 'A' reported there should be a physician's order for the IV and orders to monitor, care for, and assess the site. At that time Nurse 'A reviewed R216's clinical record and confirmed there was no physician's orders for the CVC. On 8/31/22 at 10:38 AM, the Administrator was asked to provide a policy regarding Central Venous Catheters. According to the Administrator, the facility did not have a policy.

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	235664	A. Building B. Wing	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00130095. Based on observation, interview, and record review the facility failed to provide sufficient nursing staff to meet the needs of residents dependent upon staff for care needs. This deficient practice has the potential to affect all 62 residents that reside at the facility. Findings include: On 8/28/22 at 12:00 PM, upon entry to the facility, the resident in room [ROOM NUMBER] was overheard yelling, I've been sitting in piss for five hours, I can't wait till I get the f*** out of here!. The gold hall medication cart was observed to be unlocked, with several containers of small clear medication cups filled with colored liquids. There was no nursing staff observed in the area and the survey team given access by a resident that reached around the nursing desk to unlock the front door. Nurse 'B' did not return to the gold hall medication cart until 12:18 PM. When asked about the delay in nursing staff's response to the survey team's entry and unsecured medications, Nurse 'B' reported the cart was likely longer than what was observed as they had another resident whose fistula needed immediate care and there were only agency nurses working at that time. Review of the Resident Council Meeting Minutes from 2/8/22 to 7/25/22 included the following staffing concerns: On 4/25/22, resident states staff too busy to get her up before smoke break. On 5/23/22, residents complained there was a need for more nurses. On 6/6/22, residents stated they needed more showers. On 7/11/22, residents stated they need more showers; not answering call lights for over an hour sometimes. The action taken by the former Director of Nursing (DON) documented: On 4/27/22, regarding the concern about staff being too busy, the DON's response read, Resident often requests to get up during meal time and is reminded that we will get to her after meal completed. Staff challenges also have played a part in her recent concerns . On 5/23/22, regarding the concern about staff being too busy, the DON's response read, Please remind resident we staff over what state requires & it is an ongoing process to keep staff. Resident Council: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/29/22 at 11:00 AM, during the confidential resident council interview, six of the six residents in attendance verbalized ongoing concerns with staffing and response to call lights. Responses included: We get some from different agencies and it's kinda a problem. Some agency people come in and say you gotta just sit and wait. I waited for one nurse 45 minutes to come out of a room. Then I waited another 25 minutes till she gave me my medication. My roommate hasn't gotten up in over a week! Had an incident with staffing just yesterday. I was supposed to get by feeding (tube feeding) at 5:30 PM and didn't get it until 2:30 AM because of staffing. It was a lady from an agency. A lot of time (R19) hollering in hallway and cause she's tired. Most time acting like that she's sleepy. She's sitting there for a long time. They should have more staff to be able to lay her down. 34275 On 8/29/22 at approximately 9:22 AM, a phone interview was conducted with the Complaint. The Complainant reported that staffing is short on the weekends and specified that on the Saturday 7/30/22 and Sunday 7/31/22, R25 was left wet and soiled and they changed and cleaned the resident on their own. A review of the nursing staff schedule for the day shift on 7/30/22 and 7/31/22 was conducted with Staffing Coordinator (SC) S and revealed the following: 7/30/22: The Daily Staffing Sheet noted that three nurses were scheduled to work from 7 AM to 7 PM and six CNAs were scheduled to work the day shift from 7AM to 3:30 PM. Review of the punch cards for that day noted only two nurses worked and three CNAs. The census on that day was reported as 67. 7/31/22: The Daily Staffing Sheet noted two nurses and two managers were scheduled to work and five CNAs. Review of the punch cards for the day noted only two nurses work and SC C reported that the UM were not in the building. Of the five CNA's scheduled only four worked. The census on that day was reported as 67. R268 On 8/29/22 at approximately 11:47 AM, R268 was heard yelling help from their room. Upon entry into the room, R268 reported that she needed a nurse as she was in pain and had not received her morning medications. CNA QQ entered the room and reported that she was unable to find a nurse to assist the resident. On 8/29/22 at approximately 2:58 PM, R268 was interviewed in their room. R268 stated that a nurse has not been in to see her and she still was having pain in her back.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 34275 Based on interview and record review, the facility failed to ensure that performance reviews and corresponding in-service education was provided within the required time period to four Certified Nursing Assistants (CNAs: G, I, P and BBB) out of five staff whose education files were reviewed. Findings include: On 8/31/22 at approximately 1:48 PM, an e-mail request was sent to the Administrator asking for the name of the Staff person responsible for ensuring competency evaluations and 12-hour CNA in-service training were completed. An e-mail response was sent on 8/31/22 at approximately 3:31 PM that noted the Director of Nursing (DON) was responsible and that all in-service/competency evaluations would be located in the staff employee file. On 8/31/22 at approximately 3:45 PM, the DON was queried as to nursing aides reviews and training. The DON reported that they were new to the facility and had not completed the 12 hours in-service training. On 8/31/22 at approximately 4:04 PM, an interview was conducted with the Human Resource Director (HR) CCC. HR CCC reported that to her knowledge the documents most likely would not be in the staff records, as the former DON did not complete all of them. HR CCC provided the following files to review: CNA G-hire date 8/26/21 CNA I - hire date 7/5/18 CNA O -hire date 3/25/22 CNA P - hire date 1/21/21 CNA BBB - hire date 4/20/17 *There were no documents in the employee files that noted the required 12-hour in-service training. On 9/6/22 at approximately 8:17 AM, a follow-up interview was conducted with the Administrator. The Administrator reported that the training might be located in a binder. Binders for 2021 and 2022 were provided and after review were not noted to have the number of training hours. The Administrator did provide some documentation as to CNA O and noted she was a fairly new hire, and they would continue with 12-hour in-service. A request was for the facility 12-hour in-service policy on 9/6/22 at approximately 9:10 AM. There was no policy provided by the end of the survey.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34275 Based on observation, interview and record review, the facility failed to display current nurse staffing information that was readily accessible for all 67 residents as well as visitors in the facility. Findings include: On 8/28/22 at approximately 12:00 PM, the daily staffing posting in the facility was observed to be posted for 8/26/22. On 8/29/22 at approximately 8:00 AM, the daily staffing posting was observed to still be posted 8/26/22. On 8/29/22 at approximately 2:45 PM., The Director of Nursing (DON) was queried regarding the facility's daily staffing posting. The DON reported that a current posting should always be posted. The facility was asked to provided policy(s) pertaining to staffing. No staffing policy(s) were provided before the end of the survey.

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to provide medically related social services to address behavior and mood management and coordinate ancillary services for two (R19 and R54) of three residents reviewed for Social Services, resulting in R19 being in a continuous state of distress, sobbing, and yelling; R54's documented statements of wanting to die being unaddressed, and a delayed audiology appointment for R19. Findings include: Review of a facility policy titled, Behavior Management Program, revised 12/2020, revealed, in part, the following: Residents who display mental disorder .psychosocial adjustment difficulty .should receive appropriate services as indicated to optimize the resident's overall wellbeing .Identified behaviors should be evaluated for frequency, duration, intensity and pattern .The Interdisciplinary Team should decide which residents need a behavior management program by evaluating the documented behaviors .The plan of care should be reviewed at least quarterly and as needed for continued need of behavior management and appropriate interventions .Behaviors should be identified and approaches for modification or redirection should be included in the plan of care . R19 On 8/28/22 at 12:33 PM, R19 was observed seated in a wheelchair near the nurse's station on the East Wing with a family member. At that time, the family member was concerned about R19 being lethargic and a call was made to the physician who evaluated R19 via a video call and reported she appeared over sedated. On 8/28/22 at 1:08 PM, R19 remained seated in a wheelchair near the nurse's station calling another resident vulgar names. R19 stated, We call each other [expletives] for fun. On 8/28/22 at 4:14 PM, R19 was observed seated in the same spot on the East Wing, sobbing uncontrollably with tears running down her cheek, yelling Let me go! Just let me go! Conversation was attempted with R19, but she was inconsolable. Staff were not observed to do anything to attempt to calm R19 down. On 8/28/22 at 5:09 PM, R19 was seated near the East Wing nurse's station which was also near the Director of Nursing's (DON) office. R19 was screaming loudly and crying and a plate of food was observed on the table in front of the resident. Nurse 'B' walked by R19 without addressing her. R19 repeated, They just leave me. They leave me alone. I can't do it!. The DON and a Certified Nursing (CNA) Assistant approached R19 and said, Let's eat (R19) and walked away. R19 began crying when the staff walked away and continued to yell, I can't do it! I can't do it! I want to go! Let me go! At 5:12 PM, the DON told R19 to let the staff finish passing meal trays and the CNA told R19 she would be right back. R19 continued screaming and sobbing and stated, I can't do it! I can't do it! Help me! Help me! At 5:16 PM, Nurse 'B' was observed seated behind the nurse's station desk and the DON was inside her office. Staff was not observed to address R19's distress. At 5:20 PM, Nurse 'B' sat down next to R19, 20 minutes later, and assisted her with eating and R19 calmed down. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	On 8/28/22, multiple observations were made of R19 between approximately 1:30 PM and 6:00 PM seated in the same spot near the East Wing nurse's station with minimal interaction from the staff. R19 remained tearful with almost continuous sobbing, crying, and yelling out for her family throughout this time frame, repeating the phrase, Let me go! On 8/29/22 at 9:01 AM, the door to R19's room was observed to be closed (it would not stay open). R19 was observed positioned poorly in bed, slouched down under an over the bed table that contained a breakfast tray. Food was observed to be all over R19's clothing and bed sheets and she was having difficulty eating it. R19 was sobbing and said she wanted to be up in the wheelchair outside of the room. R19 started screaming and crying, stating, Just let me go! R19 continued crying and reported various things about family members, that they were mean and she did not like them and to just let me go! At 9:09 AM, the DON entered R19's room (the door remained closed) and stated, Eat your breakfast sweetie. You are doing a good job. The DON left the room and did not address R19's crying. R19 continued to yell after the DON left the room stating, They leave me! They leave me alone! At 9:20 AM, a CNA entered R19's room and R19 calmed down while the CNA was in the room. On 8/29/22 at 1:58 PM, R19 was heard yelling and sobbing loudly (it was heard from another wing of the facility). Upon entrance to the East Wing, R19 was observed seated in a wheelchair near the nurse's station of the East Wing. CNA 'QQ' was observed seated at the nurse's station while R19 screamed. On 8/29/22 at 2:10 PM, R19 was observed yelling, sobbing, and nonsensically repeating, Let me go!. CNA 'RR' was observed on the unit. When queried about R19's distressing emotional behavior at that time, CNA 'RR' reported R19 just wanted to go home. When queried about what should be done to address her distressed mood, CNA 'RR' reported she would get her some crayons and the proceeded to place crayons, a coloring book, and word search puzzle book in front of R19. R19 continued to cry uncontrollably, yelling out for another staff member (CNA 'SS'). When queried about what should be done if R19 could not be consoled, CNA 'RR' reported she could report it to the nurse but she did not know where the nurse was. On 8/29/22 at 2:24 PM, R19 continued to yell out for CNA 'SS' and continued to cry. R19 was asked if she was able to do the word search puzzle that was placed in front of her and she responded, No! and continued to cry and state, Let me go! On 8/29/22 at 2:35 PM, CNA 'SS' arrived on the unit. R19 continued to call out her name over and over. When CNA 'SS' approached R19, she asked the resident if she wanted to attend the birthday party and have some cake. R19 stopped yelling and stated, Birthday party? CNA 'SS' explained to R19 that she had to remain calm and she could attend the party located in the dining room. R19 remained calm at that time. At 2:37 PM, CNA 'SS' told R19 that she would go get her some cake and did not take her to the birthday party. No cake was provided to R19 and she was not taken to the birthday party. On 8/29/22 at 3:24 PM, R19 remained seated near the nurse's station on the East Wing, yelling, crying, and restless. Activities Director 'AA' was present nearby R19 on the East Wing and was not observed to engage with R19 or offer an activity. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	On 8/30/22 from 5:00 PM until 5:18 PM, R19 was observed seated in a wheelchair inside her room with the door open only a crack (the door would not stay open). R19 was near the door and was yelling and sobbing. At 5:30 PM, R19 was observed in her room in a wheelchair yelling and sobbing. R19's dinner plate was observed to be placed on the bed. On 8/31/22 at 2:42 PM, R19 was observed lying in bed sobbing. The door was closed and the television was on. R19 could be observed from the hallway crying while in bed. Review of R19's clinical record revealed R19 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, seizures, major depressive disorder, expressive language disorder, hemiplegia, aphasia, psychotic disorder, nontraumatic subdural hemorrhage, and pseudobulbar affect. Review of R19's Minimal Data Set (MDS) assessments revealed the most recent MDS due on 8/2/22 had not yet been completed. Review of the last MDS assessment completed on 5/2/22 revealed R19's cognition and behavior symptoms were not assessed. On 8/31/22, a review of R19's progress notes was conducted. There was no documentation from nursing, social services, or a medical provider regarding the distressing emotional symptoms R19 had on 8/28/22, 8/29/22, 8/30/22, and 8/21/22. Review of the last documented social services progress note revealed on 8/2/22 R19 expressed wanting to die and wanting to go home. On 8/31/22 at 3:00 PM, Social Services Assistant (SSA), who was also the Activities Director in the facility, SSA 'AA', was interviewed. When queried about what was in place to address R19's mood and behaviors, SSA 'AA' reported there was currently nothing in place to address R19's mood and behaviors and stated, There is one staff person, but I'm not sure of her name, who can calm her down. Review of R19's care plans revealed the following: A care plan initiated on 6/3/22 and revised on 6/23/22 that documented, I use anti-psychotic medications r/t (related to) Behavior management, DX: psychotic disorder with delusions, resident yells out, and will place self onto floor . Documented interventions included: Administer medications as ordered .AIMS per policy . Educate .about risks, benefits and the side effects and/or toxic symptoms of the medication I am on .I am followed by (behavioral health provider) for psychoactive medication management) .keep resident from obtaining a major injury .Mattress placed at bedside . A care plan initiated on 6/3/22 that documented, I use Antidepressant or Mood Stabilizer medication r/t Depression. Documented interventions included: Document on (CNA electronic documentation system) and report to social work PRN (as needed) s/sx (signs and symptoms) of depression (initiated 6/3/22), Give antidepressant medications ordered by physician . There was no care plan developed that included individualized specific goals and interventions for R19's mood and behaviors. Review of CNA documentation for the past 30 days revealed one documentation on 8/6/22 of R19 being Verbally Aggressive. There was no additional documentation of any mood or behavior symptoms for R19. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Review of a Behavior Management Program Review and Symptoms Analysis assessment dated [DATE] revealed, .Behavior Review Necessity .Does this Resident have any targeted behaviors and/or symptoms of depression that require being on the Behavior Management Program or Receiving ANY psychoactive medications, including PRN doses? Yes .Behavior Assessment Behavior #1 .Type of Behavior: yelling out . daily .Possible root cause: Disease process .Identified patterns/comments: Dx: psychotic disorder with delusions, mood disorder (It should be noted that the assessment did not document any identified patterns) . Behavior #2 .throwing self on floor .quantity: 0 .identified patterns/comments: Dx: psychotic disorder with delusions, mood disorder .Mood symptoms: .Mood swings .Crying .Statements of depression . Quantity/Frequency: Sometimes .Interventions: Varies .Possible Root Cause: Disease Process .Identified patterns/comments: Dx: psychotic disorder with delusions, mood disorder . It was documented the antipsychotic medication and antidepressant medication effectiveness was very good and that care plans were in place. Review of the CNA Kardex revealed the following interventions for Behavior/Mood: keep resident from obtaining major injury, psych eval. On 8/31/22 at 3:35 PM, the DON was interviewed. When queried about what was in place to address R19's distressed mood and behaviors, the DON initially reported she did not know who the resident was (she began working in the facility approximately one week prior). When the above observations were shared with the DON and SSA 'AA's explanation that there was no plan in place to address R19's mood and behavior symptoms, the DON reported that was unacceptable and there should be individualized interventions in place. At that time, the DON was given an opportunity to provide any additional information. No additional information was provided prior to the end of the survey. Further review of R19's clinical record revealed an active Physician's Order dated 8/5/22 for an audiology consult. Review of R19's progress notes revealed the following: A Practitioner Progress Notes dated 8/5/22, written by PA 'NN', documented, .seen per request for ear pain and decreased hearing .abrasion noted to back of right ear .left ear pain/abrasion/decrease hearing . audiologist to see . On 8/31/22 at 3:00 PM, SSA 'AA' was interviewed. When queried about whether R19 had been seen by the audiologist, SSA 'AA' reported they only came to the facility every few months. SSA 'AA' was not sure if R19 was on the list to be seen. When queried about whether any arrangements were made for R19 to go to an audiologist outside of the facility, SSA 'AA' reported none were made. On 9/6/22 at 1:04 PM, Regional Clinical Director of Operations 'LL', who was filling in for the DON on that day, was interviewed. When queried about why R19 had not yet seen an audiologist, Regional Clinical Director of Operations 'LL' reported he would look into it. Regional Clinical Director of Operations 'LL' followed up and reported no appointment had been made for R19 and she should have been sent to an outside audiologist since she had pain. A policy regarding ancillary services was requested from the Administrator on 8/31/22 at 3:24 PM. The policy was not received prior to the end of the survey. 30675 (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	R54: On 8/31/22 at 9:43 AM, R54 was observed lying in bed with a thin bedsheet covering their body. The resident did not respond upon approach. Staff in the hallway outside the room reported this was common for the resident to pull the sheet up over their face. Review of the clinical record revealed R54 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Huntington's disease, anxiety disorder, mood disorder due to known physiological condition with major depressive-like episode, and dementia in other diseases classified elsewhere without behavioral disturbance. According to the MDS assessment dated [DATE], R54 had unclear speech, had severe cognitive impairment, had mood concerns such as feeling down, depressed, or hopeless, for 2-6 days during this assessment period of seven days. Review of the care plans included a mood care plan initiated 3/7/21, last revised on 10/1/21 which read: There are times when I may demonstrate sad effect/mood secondary to remaining in the nursing home currently and my medical condition. I receive psych meds for my DX (Diagnosis): anxiety, mood disorder, major depression. Review of the most recent social service assessment included a quarterly review dated 8/1/22 which read, . What is their Mood? .feels down .Behaviors .anxiousness, depressed .Areas <sic> Social Services will be monitoring mood and behavior . Review of the most recent social services assessment was on 8/1/22 from former Social Services Staff (SS 'II') which noted, .Statements of depression .varies .DX: mood disorder with major depressive like episodes, Anxiety . The section for review of behaviors only noted care plans in place. Review of the most recent psychiatric note included an entry on 7/28/22 at 11:19 AM which included, .Has history of depression and self injurious actions due to confusion and agitation .He was awake but confused an overall though process reduced from baseline. He mumbled a brief single word in response to simple questions. Otherwise he was confused and offered no spontaneous comments. Mood was bland with dull affective range . Review of R54's progress notes included an entry from an unidentifiable agency nurse (only noted as RN/LPN Agency 2022) on 8/28/22 at 7:12 AM which read, .resident verbalized wanting to die. states, I am sorry for what i did. (The earlier entry noted the resident pulled out their feeding tube.) Review of the behavior documentation in the clinical record (which was noted as being a behavior for Question 1 in most resident records asked staff, Did the resident exhibit signs or symptoms of wishing for death/wanting to die? revealed there was no documentation. The review noted No Data Found. There was no documentation that social services, or a practitioner had been notified of R54's expression of wanting to die as noted in the progress notes. (continued on next page)

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	235664	A. Building B. Wing	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0745 Level of Harm - Actual harm Residents Affected - Few	On 8/31/22 at 10:30 AM, Social Services Assistant (Staff 'AA') was asked if they had been notified that R54 was making statement about wanting to die on 8/28/22 and they reported no one had mentioned anything to them. When asked what should've happened, they reported they should've been notified immediately and followed up. When asked if they were aware of the resident's history of self-injurious actions, they reported they were not.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34208 Based on observation, interview, and record review, the facility failed to accurately record and reconcile narcotic medications and ensure appropriate waste and destruction of narcotic medications for one resident (R61), and ensure narcotic counts were accurate in one of three medication carts reviewed, resulting in the potential for narcotic diversion. Findings include: A review of a facility provided policy titled, PREPARATION AND GENERAL GUIDELINES IIA6: CONTROLLED SUBSTANCES dated June 2019 was reviewed and read, .D. Accurate accountability of the inventory of all controlled substances is maintained at all times . R61 On 8/28/22 at 5:25 PM, Licensed Practical Nurse (LPN) 'C' was observed preparing medications for R61. Among the medications prepared was 0.5 mL (milliliters) of liquid morphine. A review of the morphine bottle prior to LPN 'C's administration revealed 24.5 mL remained in the bottle. LPN 'C' then entered R61's room and administered the medication. After the administration of the medication, LPN 'C' exited the room and signed out the morphine on the CONTROLLED SUBSTANCE PROOF-OF-USE RECORD. On 8/29/22 at 9:42 AM, a review of the CONTROLLED SUBSTANCE PROOF-OF-USE RECORD for R61's morphine was conducted and revealed the following: On 8/28/22 at 6 AM, Nurse 'H' gave 0.5 mL of morphine, and recorded 24.5 mL remaining, then on 8/28/22 at 5:20 PM, LPN 'C' recorded they gave 0.5 mL of morphine and recorded 20.0 mL remaining. It was further noted morphine 0.5 mL had been given next by Nurse 'H' on 8/28/22 at 9 PM and it was documented 19.5 mL remained, 0.5 mL was then next given on 8/28/22 at 6 AM by Nurse 'H', and they documented 19.0 mL remained. It was noted Nurse 'H' did not recognize the discrepancy upon shift change with LPN 'C' on 8/28/22 when the morphine amount in the bottle went from 24.5 mL to 20.0 mL. On 8/30/22 at 9:45 AM a second review of the CONTROLLED SUBSTANCE PROOF-OF-USE RECORD for R61's morphine was conducted and revealed a 0.5 mL dose given on 8/30/22 at 12 AM, by LPN 'PP' and it was recorded 18.5 mL remained. On 8/30/22 LPN 'PP' signed out another 0.5 mL dosage at 6 AM and documented 18.0 mL remaining. On 8/30/22 at approximately 10:00 AM an observation of R61's morphine bottle was observed with Registered Nurse (RN) 'N'. It was observed over 20 mL of morphine remained in the bottle. At that time, RN 'N' was asked if they looked at the bottle of morphine to confirm how much liquid was in the bottle when they took over for the midnight shift. They said they did. They were then asked why the bottle had over 20 mL remaining but the CONTROLLED SUBSTANCE PROOF-OF-USE log documented 18.0 mL. RN 'N' explained it was hard to tell how much morphine was left in the bottle. They were alerted to the discrepancy documented on 8/28/22 where the amount remaining was documented as 24.5 mL and after the next administration of 0.5 mL the amount remaining was documented as 20 mL. RN 'N' said they were going to alert the Director of Nursing (DON) of the discrepancy. Medication Cart Discrepancy (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/22 at approximately 9:10 AM a phone interview was conducted with Nurse 'J'. Nurse 'J' reported they responded to an electronic notification from their Agency employer for an open day shift position in the facility on 8/29/22. They said they entered the building at approximately 12:30 PM and started a narcotic medication count on the Gold unit medication cart with Nurse 'K'. Nurse 'J' further reported the narcotic count was off; there were supposed to be 34 total narcotic medications on the cart, but only 27 were counted. Nurse 'J' said Nurse 'K' informed the Director of Nursing (DON) of the discrepancy and the DON said Unit Manager 'A' would come to reconcile the medication cart. Nurse 'J' said Unit Manager 'A' never came to count the cart and so they left the building, citing their discomfort for taking responsibility of the medication cart. On 8/30/22 at 9:54 AM, a review of the Gold unit medication NARCOTIC COUNT SHEET' was conducted and revealed that on 8/29/22 at 7 AM the DON signed as the incoming nurse and Nurse 'H' signed off as the outgoing nurse with the total number of narcotics documented as 34. The next entry on the NARCOTIC COUNT SHEET' was dated 8/30/22 at 7 AM with Registered Nurse (RN) 'N' signed off as the incoming nurse and LPN 'PP' signed off as the outgoing nurse with the total number of narcotics documented as 28. It was noted there was no entry that showed the DON signed off the narcotic counts as the outgoing nurse and LPN 'PP' signed off as the incoming nurse. On 8/30/22 10:16 AM an interview was conducted with the facility's DON regarding the narcotic count of the Gold unit medication cart. The DON said they took possession of the cart from Nurse 'H' and said 34 was the accurate count when they took possession. The DON further reported an agency nurse (Nurse 'J') came in but did not stay for the shift and Unit Manager 'A' was given the assignment on the Gold unit, and was responsible for the cart. The DON was asked if they performed a narcotic count with Unit Manager 'A' when they turned over the cart and said they did not but they verified the count. When asked if they should have documented the verification of the count on the NARCOTIC COUNT SHEET, Unit Manager 'A' and Regional Clinical Director 'U' said they should have documented it. The DON said they would be looking into the discrepancy. On 8/30/22 at 11:15 AM, a review of the Gold unit medication cart was conducted with the assigned nurse, RN 'N' and the total number of narcotics contained on the cart was 28. At that time, a review of the NARCOTIC COUNT SHEET was conducted with RN 'N' and it was noted a new sheet had been started at 7 AM on 8/30/22 with RN 'N' as the incoming nurse, and LPN 'PP' as the outgoing nurse with a total number at the start of the shift documented as 28. RN 'PP' was asked if they compared the value of 28 to the previous value documented (34) on 8/29/22 at 7 AM, and they said they did not. RN 'N' said they and LPN 'PP' just counted the total number of narcotics, got 28 and recorded that value. It remained unclear how the narcotic count started on 8/29/22 at 7AM with a value of 34 and the next recorded value was 8/30/22 at 7 AM with a value of 28. There was no facility follow-up or information about the discrepancy reported by facility staff by the end of the survey.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on interview and record review, the facility failed to ensure the attending physician reviewed and acted upon recommendations and irregularities identified by the consultant pharmacist during medication regimen reviews, and failed to maintain documentation of the pharmacy recommendations in the medical record for two (R19 and R36) of five residents reviewed for unnecessary medications. Findings include: R19 On 8/31/22, a review of Pharmacy Progress Notes for R19 was conducted. The following was revealed: On 1/10/22, a Pharmacy Progress Note documented, Admission medication regimen review performed: ecrcl (estimated creatinine clearance) 1/4/22, lovenox (a medication used to prevent and treat blood clots), warfarin (a medication used to prevent and treat blood clots) recommendation/comment noted. On 1/26/22, a Pharmacy Progress Note documented, Admission medication regimen review performed: ecrcl 83 1/4/22, warfarin, lovenox, ergocalciferol, vimpat recommendation/comment noted. On 5/31/22, a Pharmacy Progress Note documented, Admission medication regimen review performed: ergocalciferol recommendation/comment noted. On 8/23/22, a Pharmacy Progress Note documented, Admission medication regimen review performed: Comments/Recommendation noted - please see report. On 8/31/22 at 3:35 PM, the Director of Nursing (DON) and Administrator were asked to provide the report the consulting pharmacist provided that documented the recommendation, irregularities, and/or comments to nursing and/or the attending physician for R19 for 1/10/22, 1/26/22, 5/31/22, and 8/23/22. On 9/6/22 at 12:56 PM, Regional Clinical Director of Operations (RCDO) 'LL', who was filling in for the DON on that day, was interviewed. When queried about the facility's protocol for medication regimen reviews, RCDO 'LL' reported the pharmacy sent the reports with recommendations to the facility, the DON or designee contacted the physician to get verbal instructions, then the report was placed in the physician's book to be signed, and once signed it was scanned into the resident's electronic medical record. RCDO 'LL' further reported the DON received a copy of the report, as well as the physician. At that time, RCDO 'LL' was asked for the pharmacy recommendation reports requested for R19 on 8/31/22 for the dates of 1/10/22, 1/26/22, 5/31/22, and 8/23/22. RCDO 'LL' provided unsigned reports for those dates and explained he had to have the pharmacy send copies to the facility and there were no copies in the facility that documented when the attending physician/provider reviewed them and what they did to act on the recommendations. At that time, a policy regarding medication regimen reviews was requested. A policy was not provided prior to the end of the survey. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of R19's clinical record revealed R19 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy, seizures, major depressive disorder, expressive language disorder, hemiplegia, aphasia, psychotic disorder, nontraumatic subdural hemorrhage, and pseudobulbar affect. 34275 R36 A review of R36's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: traumatic brain injury, cerebral infarction, traumatic subdural hemorrhage, and motor vehicle accident. A review of the residents MDS documented a BIMS score of 4/15 (severely cognitively impaired). Continued review of R36's clinical record revealed, in part, the following: Pharmacy Progress Note (7/21/22): Admission medication regimen review performed: Comments/Recommendations noted - Please see report . *There was no report and/or response found in R36's clinical record. On 8/30/22 at approximately 3:42 PM, a request was made to Regional Clinical Director U to provide a copy of the report and physician response. No document was provided by the end of the day. On 8/31/22 at approximately 9:30 AM, a second request was made to the Administrator asking for the report. An e-mail response was received on 8/31/22 at approximately 3:31 PM that noted the same statement dated 7/21/22 as noted above. It did not contain the report/response as requested. On 8/31/22 at approximately 1:00 PM, an interview and record review were conducted with Regional Clinical Director (RCD) LL who was filling in as the Director of Nursing (DON) on the date of the interview. RCD LL reported that he was able to obtain the Pharmacy report as noted 7/21/22. The form provided, documented, in part: Note to Attending Physician/Prescriber .R36 .Ordered 6/22/2022: Enoxaparin (anticoagulant medication) 40 mg Sub Q (injection) QD (daily) - please clarify the Stop Date. The Stop Date was blank. The Physician response (Agree/Disagree/Other) was left blank and there was no physician signature. RCD LL was asked as to the policy/protocol at the facility and stated that it should have been completed by the physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to ensure a resident who was prescribed as needed (PRN) psychotropic medication had adequate behavior monitoring and identification of the resident specific targeted behaviors and non-pharmacological approaches at the time of medication administration for one (R62) of six residents reviewed for unnecessary medications. Findings include: According to the facility's policy titled, Behavior Management Program dated 12/2020, .Behaviors should be identified and approaches for modification or redirection should be included in the plan of care .Psychoactive Medications .PRN orders for psychotropic medications are limited to 14 days. If the prescribing practitioner believes it is appropriate for the order to be extended beyond 14 days, then he/she should document their rationale in the medical record and indicated <sic> the duration for the order .Describe conditions regarding the behavior. Identify what preceded and what resulted from the behavior .Identify the interventions, attempted to date, that have and those that have not worked . On 8/28/22 at 1:30 PM, R62 was observed lying in bed with a hospital gown loosely tied and hung down to their waist. R62 was holding their feeding tube and stated, Hi repeatedly. On 8/30/22 at 2:40 PM, an interview was conducted with Certified Nursing Assistant (CNA 'G') who was assigned to R62. When asked about R62's behaviors, they reported R62 wheeled themselves all over once they were up in the wheelchair and can hit out at times. When asked where resident behaviors were documented, they reported in the task section of the electronic medical record (EMR). When asked to view the EMR, CNA 'G' reviewed and confirmed there were no documented behaviors for the past 30 days (maximum look back period available for review). Review of the clinical record revealed R62 was admitted into the facility on [DATE] and was readmitted on [DATE] with diagnoses that included: epilepsy, pervasive developmental disorder, severe intellectual disabilities, and adjustment disorder with disturbance of conduct. According to the Minimum Data Set (MDS) assessment dated [DATE], R62 had significant communication limitations, had short- and long-term memory impairment with severely impaired cognitive skills for daily decision making, and had no mood or behavior concerns. Review of R62's physician orders and Medication Administration Records (MARs) revealed the resident had been prescribed multiple orders for PRN Lorazepam (antianxiety medication) since 7/6/22. Further review of the MARs and clinical record revealed R62 received the following 13 PRN administrations of the Lorazepam medication being administered without identifying the specific behavior or what non-pharmacological approaches were implemented at the time of medication administration: July 2022: 7/24 at 7:44 PM; 7/29 at 9:30 AM; 7/30 at 9:00 PM; and 7/31 at 11:00 AM (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	August 2022: 8/3 at 7:40 PM; 8/6 at 11:07 AM and 8:00 PM; 8/12 at 8:39 PM; 8/15 at 9:33 PM; 8/17 at 7:24 PM; 8/20 at 8:00 PM; 8/21 at 7:40 PM; and 8/23 at 11:00 AM. Further review of the practitioner progress notes from 7/8/22 to 8/30/22 (most recent) revealed there was no identification or clinical rationale for R62's use of the PRN Lorazepam. The most recent psychiatric progress note dated 7/25/22 as a late entry for 7/14/22 indicated this was an evaluation for managing psychotropic medications, however this only addressed the resident's use of antipsychotic medication. Review of R62's care plans included a mood problem care plan initiated on 8/18/21 which read, I have a mood problem r/t (related to) Disease Process of cognitive and mental development they cause me to become frustrated and over excited at time. Interventions included: Attempt to re-direct me with diversion IE (that is) offer me something else that will not cause me or others harm, Foods appropriate for my diet, I enjoy bright colored objects. These had not been revised since 8/18/21. There was no care plan for the resident's use of PRN antianxiety medication. On 8/30/22 at 3:50 PM, an interview was conducted with the Administrator (the Director of Nursing was not available for interview). When asked about the facility's process for use of prn psychotropic medication and monitoring of mood/behaviors, the Administrator reported they were currently in transition for social services, but that behaviors and non-pharmacological approaches should be documented. The Administrator was informed of the concerns identified for R62. On 8/31/22 at 3:04 PM, an interview was conducted with the current Social Services Assistant (who also functioned as the Activity Manager - Staff 'AA'). Staff 'AA' reported they were unable to offer any explanation as they had just started taking over the social services role for a short time.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 34208 Based on observation, interview, and record review the facility failed to ensure a medication error rate less than five percent when six medication errors were observed from a total of 29 opportunities for three residents (R#'s 30, 2, and 217) of five residents observed during medication administration, resulting in a medication error rate of 20.69%. Findings include: A review of a facility provided document titled, PREPARATION AND GENERAL GUIDELINES with a revision date of January 2018 was conducted and read, .Policy Medications are administered as prescribed in accordance with good nursing principles and practices .The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions . R30 On 8/28/22 at 9:10 AM, Registered Nurse (RN) 'M' was observed preparing medications for administration to R30. RN 'M' prepared multiple oral medications including a losartan potassium (blood pressure medication). It was noted the pharmacy label dosage was for 100 milligrams (mg). It was observed the medication card contained two tablets of the medication in each section of the blister packaging bubble. RN 'M' was observed to dispense only one tablet from the blister package bubble and the second tablet remained in the bubble on the card. RN 'M' then proceeded to R30's room and administered the medications. After the administration, RN 'M' exited the room and signed the medications out in the electronic medication administration record (eMAR). RN 'M' was then asked if they had administered all of the medications that were due at that time, and said they did. On 8/30/22 at 11:32 AM, R30's medication orders were reconciled against the medications observed to be administered by RN 'M'. It was discovered R30's order for losartan potassium was to administer 100 mg; the medication provided was two 50 mg tabs in the same bubble on the blister pack. It was observed RN 'M' only gave half the prescribed dose when they administered one 50 mg tab on 8/28/22. R2 On 8/29/22 at 10:10 AM, Licensed Practical Nurse (LPN) 'K' was observed preparing medications for R2. LPN 'K' prepared multiple medications but said R2's oxybutynin (for overactive bladder) 5 mg was not in the medication cart and needed to be re-ordered. They also said they were not able to find the over-the-counter vitamin D3 in the medication cart and would be holding both the oxybutynin and the vitamin D3. LPN 'K' then entered R2's room and administered the medications. After the administration, LPN 'K' exited the room and documented the medication administration on the eMAR. LPN 'K' was asked if they administered all of the medications due at that time with the exception of the oxybutynin and the vitamin D3; and said they had. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/22 at 2:50 PM, a review of the 1 [NAME] medication storage area was conducted with Unit Manager 'A', it was discovered there were several bottles of vitamin D3 stocked in the room, but LPN 'K' did not check the supply in order to re-stock the medication cart and administer the medication on 8/29/22. After review of the 1 [NAME] medication storage area, an observation of the 1 East medication room was conducted with Unit Manager 'A'. Unit Manager 'A' checked the electronic back-up medication machine in the 1 East medication room and it was discovered oxybutynin 5 mg was stocked in the machine. Unit Manager 'A' was asked if staff should check the back-up medication supply for missing medications and said they should. R217 On 8/30/22 at 10:00 AM, RN 'N' was observed preparing medications for administration to R217. RN 'N' prepared multiple medications including a 25 microgram (mcg) or 1000 IU (international unit) tab of vitamin D3. RN 'N' entered R217's room administered the medications, exited the room, and signed the medications out on the eMAR. RN 'N' was asked if they administered all of the due medications for R217 at that time; and they said they had. On 8/30/22 at 12:58 PM, R217's medication orders and medication administration record was reviewed. During the review it was discovered R217's order for vitamin D3 was for 2000 IU, or 50 mcg. RN 'N' had only been observed to administer one 25 mcg or 1000 IU tab. It was further noted RN 'N' documented on the MAR they had administered a 1 mg anastrozole (for the treatment of breast cancer in post-menopausal women) tab due at 9 AM, and a 500 mg deferasirox (a medication used to treat high iron levels in patients who have received multiple blood transfusions) tablet due at 9 AM, however; during the observation at 10:00 AM, RN 'N' was not observed to prepare and administer those medications, and they had reported all due medications had been given. On 8/30/22 at 2:50 PM, an interview was conducted with Unit Manager 'A' regarding the medication errors observed and they acknowledged the concern.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review the facility failed to ensure appropriate medication storage and labeling in three of three medication carts, one of two treatment carts, one of two medication storage areas, and for R23, R61 and R36, resulting in the potential for misuse, contamination, and medication administration errors. Findings include: A review of a facility provided policy titled, MEDICATION STORAGE IN THE FACILITY dated June 2019 was reviewed and read, Policy .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .B Medications rooms, carts, and medications supplies are locked when not attended by persons with authorized access .C. Medications intended for internal use .are stored separately from medications intended for external use .F. Potentially harmful substances .and cleaning supplies are kept in a locked cabinet and stored separately from medications .H. Medication storage areas are kept clean, well lit, and free of clutter and extreme temperatures and humidity . On 8/8/22 at 12:00 PM and 1:52 PM, the treatment cart on the 1 [NAME] unit was observed unlocked. An observation of the contents of the cart revealed it contained resident's prescription creams, lotions, shampoos, powders, as well as various wound care supplies, and staple and stitch removal kits. On 8/28/22 at 3:30 PM, an observation of the medication cart on the 1 [NAME] unit was conducted with Licensed Practical Nurse (LPN) 'EE'. During the observation, an undated Levemir insulin for R23 was observed in the cart. It was also observed an open container of bleach cleaning wipes were stored in the bottom drawer with two Apokyn (a treatment for Parkinson's disease) injection medications. On 8/28/22 at 3:47 PM, a heparin lock flush (used in central IV lines to ensure clotting does not occur) syringe was observed on the 1 East nursing station counter. It was also observed a ring of keys were on top of the nursing station counter underneath a package of oxygen tubing. Upon inspection of the keys, an attempt to open the 1 East medication cart with the keys was successful. At that time, the Director of Nursing (DON) was requested from their office. They were made aware the keys were unsecured on top of the nursing station counter and the keys were then handed over to the DON. The DON was asked about the unsecured keys and said, The nurse told me she gave you the keys. The DON was asked what nurse told her they gave the surveyor the keys and the DON said she did not know the nurses name as they were agency staff. At that time, the DON was informed the surveyor did not, and would not request the keys from a nurse. At approximately 3:50 PM, The DON asked LPN 'B' (who was assigned to the 1 East medication cart) to show her medication cart keys, LPN 'B' was observed to have their keys on their person. The DON then requested LPN 'C' who was assigned to the Gold unit medication cart to show her medication cart keys. LPN 'C' admitted they did not know where their medication cart keys were and said they had lost them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/22 at approximately 3:55 PM, an observation of the 1 East medication cart was conducted with the facility's Director of Nursing. The observation revealed a Novolin insulin pen with no name or date of when it had been placed in the cart. Continued review of the cart revealed an open container of bleach wipes in the bottom right-side drawer stored with resident's inhalers and in the left side third drawer alcohol-based hand rub was observed stored with resident's oral medications. On 8/28/22 at 5:25 PM, LPN 'C' was observed preparing medications for R61. LPN 'C' prepared Ativan (a controlled substance, antianxiety medication), liquid morphine (controlled substance opioid pain medication), and Haldol (antipsychotic medication) at the medication cart. LPN 'C' entered R61's room, but was not observed to lock the medication cart upon leaving it and entering R61's room. On 8/30/22 at 2:20 PM, an observation of the medication storage area on the 1 [NAME] unit was conducted with Unit Manager 'A' . It was observed various food and drinks were stored in the area. The food included: an opened bottle of hot sauce, two opened bottles of soda pop, two foam cups of water, a half of plastic bottle of water, and a plastic grocery sack with snacks in were all stored on the counter of the medication storage area. An observation of a plastic three drawer storage bin in the area was observed with a large, dead, winged, bug with tentacles in the top drawer stored with enteral tube feeding supplies. Under the sink cabinet a large dried brown stain appeared under the sink pipes. It was further observed colostomy supplies were stored in the cabinet under the soiled sink area. At that time, Unit Manager 'A' was asked if food or drinks should be stored in the area and they said they should not. An observation of the refrigerator in the medication storage area revealed the three shelves in door of the refrigerator soiled with a yellow, sticky appearing substance. It was further observed an insulin pen was stored in the freezer section of the refrigerator. 30675 On 8/28/22 at 12:00 PM, the gold hall medication cart was observed unlocked without any nurse available and/or supervising the cart. There were multiple medications stored directly on top of the cart without any nurse present. The items stored on top of the cart included three clear one fluid ounce cups that contained liquid substances (one was blue, one was yellow, and one was clear with white powdery substance that sunk to the bottom of the liquid). Upon opening the medication cart drawers, there were multiple pills stored loosely throughout the top drawer which included: 1 brown pill labeled G2; 1 pink pill; 1 small yellow oval shaped tablet labeled GG 333; 2 small white round pills with no markings; and 1 light ([NAME] colored) blue capsule with no markings. At 12:18 PM, Nurse 'B' arrived at the medication art and reported they had been in a room with another resident. When asked about the unlocked med cart and medication stored on top, they reported that should not have been kept like that. Nurse 'B' was asked to identify the liquid substances stored on top of the cart and reported the yellow liquid was Lactulose, the blue liquid was chlorhexidine mouth rinse, and the clear liquid was magnesium for R36. Nurse 'B' was asked to identify the loose pills found in the medication cart and reported they were not able to identify all of them. Nurse 'B' then took the loose pills and discarded them in the full garbage bin attached to the medication cart (the pills were visibly seen on top of the garbage bin that did not have a lid to close and accessible to anyone that was near the cart). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse 'B' was then observed opening a bottle of vitamin D tablets in which the lid fell on the floor. Nurse 'B' then picked up the lid, placed back on the bottle and placed back into the medication cart. On 8/28/22 at 12:55 PM, Nurse 'B' further reported they were in a room for a resident and was probably gone longer than the 18 minutes you saw. That's my bad. I should've made sure the cart was locked and meds were put away before I left for that. On 8/29/22 at 2:05 PM, the medication cart on the 1 west hall was observed unlocked without any nurse around. On 8/29/22 at 2:09 PM, Staff 'T' was asked if they saw the nurse for the 1 west hallway and they reported the nurse went on a break about 10 minutes ago. There were several residents and other non-nursing staff observed walking by the unsecured medication cart. On 8/29/22 at 2:34 PM, the medication cart remained unsecured. On 8/29/22 at 2:40 PM, Nurse Manager 'A' was observed approaching the nursing desk and when asked about the unlocked medication cart, they asked Where's the nurse?. Nurse Manager 'A' was informed that this surveyor was told they were on break and had not returned yet. Nurse Manager 'A' then engaged the locking mechanism to the cart.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on interview and record review, the facility failed to timely provide radiology results to the attending physician for one resident (R25) of two resident's reviewed for hospitalization , resulting in a delay in treatment for R25 and having a four-day hospital stay for pneumonia. Findings include: A review of R 25's clinical record revealed the resident was initially admitted to the facility on [DATE] and had a recent readmission on 8/19/22 following a hospitalization for pneumonia. A review of the Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 4/15 (severely cognitively impaired) and required one person assist for most Activities of Daily Living (ADLs). Continued review of the resident's record documented, in part the following: 8/11/22 (Practitioner Progress Note): Patient was seen by video conferencing with the help of the nurse on duty Complaining of cough and shortness of breath and congestion of chest cough/chest congestion with underlying COPD (chronic obstructive pulmonary disease) possible mucus plugging -will give her a higher dose of guaifenesin (Mucinex) twice daily. (Authored by Dr. CC) 8/12/22 (Nursing Progress Note): C/O (complains of) congestion. Assigned nurse contacted Dr. CC with new orders for chest X-ray 2 View/DuoNeb via NEB q6 hours and prn noted (authored by Nurse UU) 8/15/2022 (Practitioner Progress Note): .Pt seen for f/u on chest XR 8/13 which shows complete opacification of L lung and RLL infiltrate .Pt reports ongoing cough for couple days .Acute resp failure with hypoxia 2/2 pneumonia and ? L-lung opacification .feels a bit more sob (shortness of breath) .Transfer pt to the ER for evaluation. Will most likely need CT chest and Abx (antibiotics) . (authored by Dr. CC) R25's electronic record noted that an X-ray was completed on 8/13/22. The results of the X-ray were not found in the electronic record. A request was made to the facility to provide a copy of the results. (Name redacted) Hospital records revealed: Admission Information: 8/15/22 8:41 PM .currently resides at ECF for long-term care was sent to ED .due to worsening shortness of breath and cough over the last week and abnormal CXR (chest radiography) done on 8/13 that revealed left lung opacification and possible RLL infiltrate .Plan: Given patient's symptoms and CXR findings start ABX for CAP (Community-Acquired Pneumonia) . (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/22 at approximately 10:57 AM, a phone interview was conducted with Dr. CC. Dr. CC was queried as to the order made for a chest X-ray for R25 and follow-up reviews. Dr. CC reported that X-ray results are forwarded/faxed to the facility when completed. Once obtained, the facility should report the results to him so that he can decide as to the resident's care and treatment. When asked if he was aware that the results were submitted to the facility on [DATE], Dr. CC stated that he was not aware and if he had been notified, he would most likely have sent her to the Hospital on 8/13/22 and/or made changes to her care. On 8/30/22 at approximately 2:12 PM, a phone interview was conducted with Nurse UU. Nurse UU was queried as to R25's status on 8/12/22. Nurse UU reported that she was not actually assigned to the resident, but a Nurse had left early, and she took over the care of R25 who complained of congestion. Nurse UU recalled contacting the Dr. CC and placed what she recalled a STAT order for the X-ray and then left her shift. On 8/30/22 at approximately 2:27 PM, Unit Manager (UM) A provided a paper copy of the Radiology Result Report for R25. The reported date was: 8/13/22 at 9:32am. Reviewed by UM A on 8/26/2022. UM A was queried as to the report and stated that she had reviewed the document after the fact. She indicated that Nurse on duty on 8/13/22 should have contacted the Doctor with the results and charted in the resident's record. UM A stated that the report is faxed to the facility and/or available on the portal. During a phone interview on 8/30/23 at approximately 3:43 PM with Nurse VV. Nurse VV reported that she worked the day shift on 8/13/22 from 7AM to 7PM and was assigned to R25's hall and had only worked at the facility one time. When asked if she received any education on how to review incoming radiology reports, Nurse VV said that she had no idea as to where to look for the results. On 8/30/22 at 3:58PM, a phone interview was conducted with Radiology Contact (RC) WW. RC WW reported that the Radiology/X-ray report was faxed to the facility on [DATE] at 9:36AM. The facility policy titled, Change in Condition (revised 7/20) was reviewed and documented, in part: Policy: It is the policy of this facility to inform residents/legal representatives, attending physician or designee of a change in resident's condition .The facility will .consult with the resident's physician .when there is a significant change in the resident's physical .status . The facility policy titled, Laboratory, Radiology and other Diagnostic Services (revised 12/20) was reviewed and documented, part: Policy: The facility must provide .radiology services when ordered .6. Staff will notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 30675 Based on observation, interview, and record review the facility failed to ensure lunch served to residents was palatable for two (R14 and R47) residents reviewed for food, and six residents that attended the confidential resident council interview, resulting in dissatisfaction during meals. This deficient practice has the potential to affect all residents that received food from the kitchen. Findings include: According to the facility's policy titled, Food Quality and Palatability dated 7/23/2021, .Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature .Food attractiveness: refers to the appearance of the food when served to the residents. Food palatability: refers to the taste and/or flavor of the food . On 8/28/2 at 12:25 PM, during an initial tour of the kitchen with Dietary Staff 'AAA', they reported that residents will complain that the food is cold but due to lack of staffing, the food was not able to get passed quick enough. On 8/28/22 at 1:30 PM, R14 was asked about the palatability of the food and they reported, Food is bad. They need some new cooks. It's been worse lately. On 8/28/22 at 1:35 PM, R47 was asked about the palatability of the food they reported, The food here is disgusting. It's usually so bad I don't eat it. A bunch of people order door dash. Review of the Resident Council Meeting Minutes from 2/8/22 to 7/25/22 included the following food concerns: On 4/25/22, Resident states more seasoning on food. Resident states we need better food. On 5/23/22, Resident states she wants more sandwiches; resident states we don't want cranberry juice. On 7/25/22, Resident want choices. On 8/29/22 at 11:00 AM during the confidential resident council interview, when asked about the palatability of the food served, six of the six residents reported concerns with cold food and poor quality/taste. Responses included: The biscuits and gravy, ewe. It's s***. We get it every week. On 8/29/22 at 11:30 AM, a test tray was conducted for the last remaining tray from the food cart with Dietary Manager (DM 'DD'). The following temperatures were obtained: Meat: 125; Mashed Potatoes: 129; Peas: 127; and Melon: 55 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 2013 FDA Food Code section 3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding, 1. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be maintained: (1) At 57 C (135 F) or above .may be held at a temperature of 54 C (130 F) or above .

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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. 34275 Based on observation, interview, and record review, the facility failed to provide sanitary conditions in the kitchen, resulting in the increased potential for foodborne illnesses. This deficient practice had the potential to affect all residents in the facility that receive food from the kitchen. Findings Include: On 8/28/22 at approximately 12:25 PM, an initial tour of the Kitchen was conducted with Kitchen Staff AAA. Staff AAA reported that they were employed as a kitchen aide/cook and noted that their supervisor was not in the building. In the large walk-in refrigerator and smaller reach in refrigerator the following was observed: 1. A large baking sheet had three large rolls of hamburger meat. The meat was not labeled or dated and red blood from the meat covered the baking sheet. 2. Three packages of shredded cheese were open and not dated 3. A bowl of salad was not labeled or dated. 4. A container of soup had a use by date of 8/27/22. 5. A block of creamed cheese had a use by date of 8/27/22. 6. A large jar of prepared jelly had a date of 8/14, Staff AAA was not able to determine if it was the date prepared or a date to discard. When asked as to facility policy for food storage, Staff AAA reported that all food must be labeled and dated and discarded accordingly. A facility policy titled, Food Storage (revised 1/2021) was reviewed and documented, in part: Policy: Food storage areas shall be maintained in a clean, safe and sanitary manner .Food stored in walk-in refrigerators . will be stored on shelves .Refrigerated food outside of original package shall be labeled, dated, and monitored by the use by date, frozen or discarded whichever is applicable .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 22960 Based on observation, interview, and record review, the facility failed to maintain the exterior trash refuse area in a clean manner, resulting in the increased potential for pest and rodent harborage. This deficient practice had the potential to affect all residents, staff, and visitors. Findings include: On 8/29/22 at 9:45 AM, the exterior dumpster area was observed with Maintenance Supervisor JJ. The refuse area was littered with numerous items (mattresses, refrigerator, a rolling cart with 3 inches of green, stagnant water, numerous chairs, a cabinet). Maintenance Supervisor confirmed the items needed to be removed from the area. A facility policy for maintaining the exterior refuse area was requested on 8/29/22 at approximately 2:30 PM, but was not provided by the end of the survey. According to the 2013 FDA Food Code section 5-501.115 Maintaining Refuse Areas and Enclosures, A storage area and enclosure for REFUSE, recyclables, or returnables shall be maintained free of unnecessary items, as specified under S 6-501.114, and clean.

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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. 32568 Based on interview and record review, the facility failed to develop and implement a QAPI (Quality Assurance and Process Improvement) Program Plan which described an organized approach to identifying issues and areas that needed improvement and how they would implement a process to correct identified issues. This had the potential to affect all 62 residents who resided in the facility. Findings Include: On 8/28/22 at approximately 3:30 PM, an entrance conference was conducted with the Administrator. At that time, the Administrator was asked to provide the QAPI Plan for the facility. The Administrator provided a document titled, Ad Hoc QAPI dated 7/13/22 and was for one specific identified issue regarding staff COVID-19 testing. Review of a facility policy titled, Quality Assurance and Performance Improvement, revised 4/2019, revealed, in part, the following: .The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI plan .The QAPI plan will address the following elements: a. Design and scope of the facility's QAPI program and QAA committee responsibilities and actions . b. Policies and procedures for feedback, data collection systems, and monitoring . c. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: Tracking and measuring performance; Establishing goals and thresholds for performance improvements; Identifying and prioritizing quality deficiencies; Systematically analyzing underlying causes of systemic quality deficiencies; Developing and implementing corrective action or performance improvement activities; and Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed . On 9/6/22 at 11:49 AM, the Administrator was interviewed. The Administrator was asked if the facility had a QAPI plan to track and measure performance, establish goals and thresholds of performance measurement, identify, and prioritize quality deficiencies, systematically analyze underlying causes of systemic quality deficiencies, develop, and implement corrective action or performance improvement activities, and monitor or evaluate the effectiveness of corrective action/performance improvement activities. The Administrator provided the Ad Hoc QAPI dated 7/13/22 for Staff COVID-19 testing a second time. No written QAPI plan was provided prior to the end of the survey. During the survey, systemic issues and substandard quality of care were identified in areas including neglect, activities, staffing, cleanliness of the environment, kitchen sanitation, and infection control. The Administrator reported no concerns with staffing, the environment, or infection control had been identified through the QAPI program. The Administrator reported she was aware that activities were not offered or provided on the weekends and did not currently have an action plan to address the issue.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 32568 Based on observation, interview, and record review, the facility failed to implement effective plans of action to correct identified quality deficiencies related to abuse reporting and investigating, admission orders, falls, intravenous (IV) care, social services, medication storage, and influenza and pneumococcal vaccines, resulting in the continuation of deficient practices. This had the potential to affect all residents who resided in the facility. Findings include: On 10/25/22 and 10/26/22, a revisit survey was conducted to determine compliance with deficiencies identified during the facility's recertification survey completed on 9/6/22. According to a CMS (Center for Medicare and Medicaid) 2567 form dated 9/6/22, the facility was found to be noncompliant with regulatory requirements related to admission orders, abuse reporting and investigating, falls, IV care, social services, medication storage, and influenza and pneumococcal vaccines. Review of the facility's Plan of Correction (POC) with an alleged compliance date of 10/4/22 revealed the facility would do the following to correct the deficient practice related to the failure to report an allegation of neglect to the abuse coordinator: .The Administrator re-educated staff on the Abuse, Neglect, and Exploitation policy with an emphasis on reporting an allegation of abuse timely .The interdisciplinary team will conduct weekly rounds .with the residents to identify concerns, which includes allegations of neglect. The interdisciplinary team will report allegations of neglect to the abuse coordinator immediately .The Administrator/Designee will audit the (rounds) weekly for 6 weeks to ensure allegations of neglect abuse have been reported to the abuse coordinator. The Administrator/Designee will report findings to QAPI (Quality Assurance Performance Improvement) for monitoring and recommendations until compliance is achieved .The Administrator is responsible for attaining and maintaining compliance . On 10/26/22, it was identified that the facility did not report an injury of unknown origin to the State Agency for R725 and an allegation of misappropriation of resident property to the Abuse Coordinator for R713. Review of audits conducted by the facility as part of their POC revealed the following: An audit conducted by the Administrator/Abuse Coordinator on 10/19/22 that documented there were no allegations of abuse reported by staff or residents, no injuries of unknown origin reported by staff or residents, and no allegations of abuse to report. However, R725's injuries including eye bruising, inner thigh bruising, and swelling to the hip, were documented on 10/19/22. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's POC documented the following would be done to correct the deficient practice related to the lack of a thorough investigation into an allegation of misappropriation of resident property with an alleged compliance date of 10/4/22: .The Administrator was re-educated by the Regional Director of Operations/designee on the Abuse, Neglect, and Exploitation policy, emphasizing conducting a thorough investigation, including interview individuals surrounding the date(s) of allegation .The Administrator will use an investigation checklist for all facility-reported incidents to ensure a thorough investigation, with an emphasis on interviewing individuals (staff and non-staff) surrounding the alleged event date(s) .The Administrator/Designee will audit grievance concerns from residents to ensure a thorough investigation process for facility reported incidents, as deemed necessary, weekly for 6 weeks. The Administrator will report findings to QAPI for monitoring and recommendations until compliance is achieved .The Administrator is responsible for attaining and maintaining compliance . On 10/26/22, it was identified that the facility did not investigate injuries of unknown origin, including eye bruising, inner thigh bruising, and hip swelling, for R725. The facility's POC documented the following would be done to correct the deficient practice related to the failure to obtain and implement physician orders for TPN (Total Parenteral Nutrition) upon admission with an alleged compliance date of 10/4/22 (It should be noted that immediate jeopardy was identified related to this deficiency on the annual recertification survey conducted on 9/6/22): .The Regional Clinical Director educated the Director of Nursing on the TPN Medication Review and Admission Process .The Director of Nursing /Designee educated the licensed nurses on the TPN Medication Review and Admission Process . Licensed nurses will utilize the admission checklist to ensure all admission medication orders are transcribed and completed .The Director of Nursing/Designee will audit new resident medication orders to ensure all medication orders are transcribed and completed weekly for 6 weeks. The Director of Nursing/Designee will report findings to QAPI for monitoring and recommendations until compliance is achieved .The Director of Nursing is responsible for attaining and maintaining compliance . On 10/26/22, it was identified that the facility failed to ensure admission orders for a central venous catheter, as well as orders to care and maintenance of the IV. This deficient practice involved R716, who was the same resident cited on 9/6/22. Review of audits conducted by the facility, did not identify the deficient practice related to R716's IVs. The facility's POC included education of staff to utilize an Admission Checklist. However, it was not in R716's electronic clinical record, and upon request was not provided by the facility before the end of the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235664	A. Building B. Wing	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's POC documented the following would be done to correct the deficient practice related to the failure to implement interventions and develop effective and timely interventions based on accurate root cause analysis to prevent falls resulting in harm to a resident, with an alleged compliance date of 10/4/22: . The Regional Clinical Director educated the Director of Nursing on the Fall Reduction Policy. The Director of Nursing/Designee educated the nursing staff on Fall Reduction Policy, with an emphasis on ensuring fall interventions are related to root cause analysis to prevent likelihood of a fall. Resident at risk for falls will be reviewed by the clinical management team, Mon (Monday)-Fri (Friday) during morning meeting. Interventions based on root cause analysis will be implemented and documented .The DON/designee will audit the fall incident reports, weekly for 6 weeks to ensure care plans are updated and interventions are implemented, to reduce the likelihood of falls for residents experiencing falls. The Director of Nursing/Designee will report findings to QAPI for monitoring and recommendations until compliance is achieved .The Director of Nursing/Designee is responsible for attaining and maintaining compliance . On 10/26/22, it was identified that the facility failed to conduct an accurate root cause analysis to develop and implement fall interventions for R718 resulting in harm to the resident. R718 was the resident who cited on 9/6/22, as well. Review of audits conducted by the facility revealed, on 10/21/22, it was documented there were no falls or accidents reported. On 10/11/22, it was documented that R725 and R718 were audited and had Fall Risk interventions in place and updated as needed. The facility's POC documented the following would be done to correct the deficient practice related to the failure to implement care and maintenance to a central venous catheter (IV) with an alleged compliance date of 10/4/22: .Resident (previous resident identifier) still resides in the facility and has received care for the central venous catheter (CVC), per physician order .There aren't any other resident with a CVC .The nursing staff were educated on the Managing Central Vascular Access Devices guidelines by (nursing guidelines manual) .A schedule has been developed to ensure residents with a CVC receive care per physician order . The Director of Nursing/Designee will audit residents with a CVC weekly for 6 to ensure care is being provided per physician order. The Director of Nursing/Designee will report findings to QAPI for monitoring and recommendations until compliance is achieved .The Director of Nursing is responsible for sustained compliance . On 10/26/22, it was identified that the facility failed to ensure there were physician orders for a central venous catheter to R716's chest and ensure the IV site was maintained and care provided. This resulted in an infection to the IV access site. According to the facility's POC, R716 was the only resident in the facility with a central venous catheter to the chest and was also the resident cited on 9/6/22. Review of audits conducted by the facility revealed R716 was included on the audit on 10/4/22, 10/14/22, 10/19/22 and was the only resident audited. The audit indicated CVC care rendered per physician order was done, as evidenced by Y (yes). However, review of R716's clinical record revealed there were no physician orders for the CVC to R716's chest, no orders for monitoring of the IV site to R716's chest until 10/11/22 (it should be noted that the order did not specify the site to be monitored in that order), no orders for flushes of the chest IV line until 10/21/22, and no orders for dressing changes to the chest IV site until 10/6/22. R716 was readmitted with a PICC Line to the left arm, but there was no order to remove the PICC and no documentation about when it was removed, and who removed it. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's POC documented the following would be done to correct the deficient practice related to the lack of social services, including behavior management and coordinating ancillary services, with an alleged compliance date of 10/4/2: .Licensed nurses and social services have been educated on the Behavior Management program policy with focus on documentation, evaluation, and plan of care review/adjustment for resident who display behaviors or mood/mental disorders .Concerns related to behavior and mood management .will be reviewed Mon-Fri during the clinical management meetings .Social Services/Designee will audit identified or documented behaviors or mood/mental disorders .weekly for 6 weeks, to ensure proper interventions and plans are implemented. Social Services/Designee will report findings to QAPI for monitoring and recommendations until compliance is achieved .The Director of Nursing is responsible for sustained compliance. On 10/26/22, it was identified that the facility failed to implement interventions for behavior management for R726. The facility's POC documented the following would be done to correct the deficient practice related to medication storage with an alleged compliance date of 10/4/22: .The Director of Nursing/Designee re-educated the nurses on the Medication Storage in the Facility policy. A schedule has been developed to ensure the proper storage, labeling and security of the medication carts and storage area .The DON/Designee will audit the medication storage areas and carts 3 times weekly for 4 weeks and 2 times weekly for 2 weeks, to ensure the proper storage, labeling and security of the medication carts and storage area. The Director of Nursing/Designee will report findings to QAPI for monitoring and recommendations until compliance is achieved .The Director of Nursing is responsible for sustained compliance. On 10/26/22, it was identified that there were concerns with medication storage, including issues with labeling and discarding medications. Review of audits conducted by the facility did not identify any concerns with medication storage. The facility's POC documented the following would be done to correct the deficient practice related to accurately tracking and administering pneumococcal vaccinations and influenza vaccinations, with an alleged compliance date of 10/4/22: .The Regional Clinical Director re-educated the Director of Nursing on Pneumococcal Vaccination Series and Influenza Vaccination policies. The Director of Nursing/Designee re-educated the licensed nurses on Pneumococcal Vaccination Series and Influenza Vaccination policies. Residents (and/or guardians) will be offered the opportunity to accept or decline the pneumonia and influenza vaccination within in the first week of admission. Administration of the vaccines, if accepted, will be occur upon receipt from the pharmacy .The Director of Nursing/Designee will audit influenza and pneumonia offerings and administration to ensure all residents have been offered, educated, and administered (if applicable) the influenza and pneumonia vaccine, 3 times weekly for 4 weeks and 2 times weekly for 2 weeks. The Director of Nursing/designee will report findings to QAPI for monitoring and recommendations monthly until compliance is achieved .The Director of Nursing is responsible for attaining and maintaining compliance. On 10/26/22, it was identified that the facility was not in compliance with providing pneumococcal and influenza immunizations. Review of audits conducted by the facility revealed the facility did not identify any concerns with providing pneumococcal and influenza immunizations. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/26/22 at 4:49 PM, the Administrator was interviewed regarding how the facility's Quality Assurance program ensured quality deficiencies identified during the recertification survey on 9/6/22 were corrected and compliance maintained after the alleged compliance date of 10/4/22. When queried about whether the facility identified any areas of non-compliance related to abuse reporting and investigating, admission orders, falls, IV care, social services, medication storage, and influenza and pneumococcal vaccinations, the Administrator reported the facility identified on 10/4/22 that some of the vaccinations were skipped. The Administrator reported no issues were identified with abuse reporting, abuse investigation, admission orders, falls, IV care, social services, or medication storage. The Administrator reported R725's injuries were discussed during an interdisciplinary team meeting, but reported she was not aware of the inner thigh bruising and therefore it was not reported or investigated. The Administrator reported clinical was responsible to oversee resident's admission orders, falls, IVs, social services, and medication storage and no concerns were brought to QA. The Administrator explained she was informed by the Regional Clinical Directors that everything was in compliance

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 32568 Based on interview and record review, the facility failed to ensure the required committee members attended the Quality Assessment and Assurance (QAA) meetings. This had the potential to affect all 62 residents who resided in the facility. Findings include: On 9/6/22 at 11:49 AM, an interview was conducted with the Administrator regarding the facility's QAA program. The Administrator reported the QAA committee met on the 3rd Friday of every month. The Administrator reported the following members attended each meeting at least on a quarterly basis: Director of Nursing (DON), Medical Director, Administrator, Activities Director, Social Services, and Medical Records. Review of sign-in sheets for the facility QAA meetings revealed the following: The Medical Director did not attend the QAA meetings from August 2021 until December 2021. At that time, the Administrator was asked about QAA meetings held from January 2022 through August 2022. The Administrator reported she had to go retrieve them. The Administrator returned with photocopies of QAPI Meeting sign in sheets that revealed the following: Each form listed five typed staff members names, their title, and a column for them to initial if they attended the meeting. On 1/21/22, attended was written in the initials space for the former DON, DON 'OO' and former Social Services staff (SS) 'Q'. When queried, the Administrator reported she wrote attended in those spaces. When asked why the staff members did not sign their initials, the Administrator reported they did not have to because she, as the Administrator attested that they were there. The Administrator further explained that because they did audits for that month that were present in the QA binder, that meant they attended the meeting. On 2/18/22, attended was written in the initials space for DON 'OO', Activity Director 'AA', and SS 'Q'. Activity Director 'AA' also signed her initials in the space, but DON 'OO' and SS 'Q' did not. When queried about why she did not have DON 'OO' and SS 'Q' go back and sign their initials, the Administrator reported that her attestation was enough to show they were at the meeting. Further review of the QAPI Meeting forms provided revealed, DON 'OO' and SS 'Q' did not sign that they attended the meetings on 3/18/22, 4/15/22, 5/20/22, and 6/30/22. On 7/15/22 it was documented that SS 'Q' was no longer present (no longer worked in the facility). Attended was documented in the initials space for the DON and the current DON's name was written in the Name space. It should be noted that the current DON's hire date was 8/18/22 and that meeting was held on 7/15/22. On 8/19/22, it was documented that DON 'OO' attended the meeting, as well as SS 'Q'. However, they no longer worked in the facility at that time. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was no evidence that a DON attended a QAA meeting between January 2022 and August 2022. There was no evidence that a third staff member (SS 'Q' or another staff member in her place) attended a QAA meeting between January 2022 and August 2022. There was no evidence that the Infection Control Preventionist attended the QAA meeting between January 2022 and August 2022. On 9/6/22 at 12:54 PM, the Administrator was further interviewed. When queried about how the DON attended a QAA meeting on 7/15/22 when she did not work in the facility yet and how DON 'OO' and SS 'Q' attended a QAA meeting on 8/19/22 when they no longer worked in the facility, the Administrator attempted to change the dates and said it was a mistake. When queried about when the sign-in sheets were signed off on, the Administrator did not offer a response. Review of a facility policy titled, Quality Assurance and Performance Improvement, revised 4/2019, revealed, in part, the following: .The QA Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. the director of nursing services; ii. The Medical Director or his/her designee; iii. At least three other members of the facility's staff, at least one of which must be the administrator, owner, a board member, or other individual in a leadership role: and iv. The infection control and prevention officer .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation has two deficient practices. Deficient Practice #1 Based on observation, interview and record review, the facility failed to maintain infection control practices, including, but not limited to the following: COVID-19 screening upon entry, hand hygiene, equipment cleaning, and implementing transmission-based precautions. Findings include: On 8/30/22 at 8:06 AM, an interview was conducted with the receptionist/screener (Staff 'T'). When asked to provide the documentation that Nurse 'J' had been screened upon arriving to the facility on [DATE], Staff 'T' reviewed the screening log and reported they were not able to find that documentation. At that time, the Director of Nursing (DON) offered to review the screening log as well and confirmed they were unable to locate any documentation that Nurse 'J' (who had been assigned to work on 8/29/22) had signed in on the screening log. There was no further documentation provided by the end of the survey. 34208 On 8/28/22 at 5:25 PM, Licensed Practical Nurse (LPN) 'C' was observed preparing medications for administration. LPN 'C' donned gloves and poured a liquid medication into a medication cup. LPN 'C' was observed to drop the medication cap onto the floor. LPN 'C' left the open medication on top of the cart and the cap on the floor under the cart and entered the resident's room and administered the medication. After the administration LPN 'C' exited the room with the gloves on, removed the cap from the floor, swabbed it with an alcohol swab and placed it back on the bottle and placed the bottle back in the medication cart. LPN 'C' then removed the gloves. On 8/29/22 at 9:25 AM, an observation of two clean linen carts on the 1 [NAME] unit was conducted. On the first cart it was observed an opened tube of barrier cream, a pair of blue jeans, and an abdominal binder were stored on the cart with the clean linens. On the second cart the plastic cover for the linen cart was soiled with brown, streak stains and a container of bleach wipes, a half bottle of skin and hair cleanser, a half bottle of body and face wash/peri-cleanser were stored with the clean linens. On 8/29/22 at 1:20 PM, Housekeeper 'E' was observed wearing a soiled, blue cloth face mask. On 8/30/22 at 8:05 AM, Licensed Practical Nurse (LPN) 'PP' was observed in the hallway at the medication cart, it was observed their surgical mask was pulled down under their chin, not covering their nose or mouth. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/22 at 10:10 AM, LPN 'K' was observed preparing medications for administration. LPN 'K' entered the resident's room and obtained their blood glucose, after obtaining the reading, they placed the glucometer in their uniform pocket. After the medications were administered, LPN 'K' exited the room, removed the glucometer from their pocket and placed it back in the medication cart. LPN 'K' was not observed to clean the glucometer prior to, or after use on the resident. 32568 On 8/28/22 from 12:00 PM until 9:00 PM, R216 was not observed to be on isolation precautions, as evidenced by no signage on the door to indicate they were and no personal protective equipment was available outside of R216's room. Throughout that time period, R216 left her room and smoked in the presence of other residents. On 8/29/22 at 9:40 AM, R216's door was observed with signage posted that R216 was on Enhanced Precautions and an N95 respirator mask, gown, gloves, and goggles. At that time, Unit Manager, Nurse 'A', who was also the facility's Infection Control Preventionist, was interviewed about why R216 was on isolation precautions. Nurse 'A' explained that R216 should have been placed on isolation precautions when she was admitted on [DATE] because she was a new admission and was not up to date with COVID-19 immunizations. Nurse 'A' reported R216 was still permitted to smoke, but now had to wear a mask when she left the room and smoke at times separate from the other residents. Review of R216's clinical record revealed R216 was admitted into the facility on [DATE] with diagnoses that included: necrotizing fasciitis (flesh-eating bacteria), enterocutaneous (EC) fistula (abnormal connection that develops between the intestinal tract or stomach and the skin which causes contents of the stomach or intestines to leak through to the skin), anemia, and type 2 diabetes mellitus. Review of R19's Physician's Orders revealed an order with a start date of 8/26/22 that read, Transferred <sic> Based Precautions. On 8/28/22 at 2:09 PM, CNA 'D' was observed exiting R27's room carrying a plastic bag of soiled linens. The bag was not closed and CNA 'D' was carrying some of the soiled linens outside of the bag. CNA 'D' stated, These bags are not big enough. CNA 'D' exited the room wearing gloves, grabbed the handle to open the door to the soiled linen room, then grabbed clean linen from a cart. CNA 'D' then entered R27's room and continued bagging dirty towels that were on R27's over the bed table. The towels were soiled with brown substance. CNA 'D' was not observed to clean and sanitize R27's over bed table and reported the towel was already on the table so she bagged it up. Review of a facility policy titled, Novel Coronavirus Prevention and Response, revised 2/2022, documented, in part, the following: .'Up to Date' means a person has received all recommended vaccines, including any booster dose(s) when eligible .All residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions/readmissions should be placed in quarantine [i.e. observation], even if they have a negative test upon admission . .Assess visitors and healthcare personnel for symptoms of COVID-19 or exposure to others with suspected or confirmed COVID-19 infection . .Staff will wear a facemask .at all times while in the facility . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled, Hand Hygiene, revised, 12/2020, documented, in part, the following: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . 39592 Deficient Practice #2 Based on observation, interview and record review the facility failed to ensure COVID-19 unvaccinated staff wore the required Personal Protection Equipment (PPE) while working at the facility for 2 unvaccinated staff. This deficient practice had the ability to affect all the residents at the facility. Findings include: Review of a facility policy titled, COVID-19 Vaccination Mandate revised 5/2022 read in part, .It is required that all employees working within the facility receive a COVID-19 Vaccination as a condition of employment unless a valid medical or religious exemption is granted . Until this provision of the policy is rescinded any employee who obtains an exemption will be required to wear PPE as a source control measure when in the facility which includes a N95 respirator . Review of a facility employee matrix revealed Certified Nursing Assistant (CNA) O and Cook R were granted exemptions from the COVID-19 vaccination. On 8/30/22 at 1:11 PM, CNA O was observed coming out of a resident's room wearing a surgical mask and side shields attached to her prescription glasses. CNA O was asked if she was exempted from the COVID-19 vaccine. CNA O explained she was. When asked what PPE she was required to wear while at the facility, CNA O explained she had to wear a mask and goggles. CNA O was asked if a surgical mask was acceptable. CNA O explained she could wear a surgical mask. On 8/30/22 at 1:42 PM, Cook R was observed in the kitchen with a surgical mask pulled below her chin and goggles pushed to the top of her head. When asked if she was exempted from the COVID-19 vaccination, Cook R agreed she was. Cook R was asked what PPE she was required to wear while in the facility. Cook R explained she had to wear a mask and goggles or a face shield if she was out with residents. When asked if a surgical mask was acceptable, Cook R agreed she could wear a surgical mask. On 8/31/22 at 8:44 AM, Licensed Practical Nurse (LPN) A, who was an Infection Control Preventionist (ICP) and served as the Infection Control Nurse (ICN) was interviewed and asked what PPE was required for unvaccinated staff. ICN A explained they should wear a N95 respirator and goggles. ICN A was asked who monitored that the staff were wearing the appropriate PPE. ICN A explained it was her. When told of the observation of two unvaccinated staff wearing surgical masks, and them saying they only had to wear surgical masks, ICN A explained she would have to start a log and monitor the unvaccinated staff.

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	235664	A. Building B. Wing	09/06/2022

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F 0883 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Deficient Practice #1 Based on interview and record review, the facility failed to implement their policy and ensure accurate tracking and adminstration of the pneumococcal vaccinations for residents residing in the facility for three (R66, R69 and R70) of ten residents reviewed for pneumococcal vaccinations resulting in facility acquired pneumonia and hospitalization . Findings include: Review of a facility policy titled, Pneumococcal Vaccine (Series) revised 12/2020 read in part, .It is our policy to offer our resident immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations . Each resident will be assessed for pneumococcal immunization upon admission . Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders . Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization .The individual receiving the immunization, or the resident representative, will be provided with a copy of CDC's current vaccine information statement relative to that vaccine .The resident/representative retains the right to refuse the immunization. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record. The type of pneumococcal vaccine (PCV13 - pneumococcal conjugate vaccine, PPSV23/PPSV - pneumococcal polysaccharide vaccine) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations .The resident's medical record shall include documentation that indicates at a minimum, the following: .The resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization .The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal. Review of the CDC publication titled, Pneumococcal Vaccination: What Everyone Should Know read in part, . Pneumococcal disease is common in young children, but older adults are at greatest risk of serious illness and death . CDC recommends pneumococcal vaccination for all children younger than 2 years old and all adults [AGE] years or older. In certain situations, older children and other adults should also get pneumococcal vaccines . PCVs (Pneumococcal conjugate vaccine): CDC recommends PCV13 for: All children younger than 2 years old; Children 2 through [AGE] years old with certain medical conditions. For those who have never received any pneumococcal conjugate vaccine, CDC recommends PCV15 or PCV20 for: Adults [AGE] years or older; Adults 19 through [AGE] years old with certain medical conditions or other risk factors . PPSVs (Pneumococcal polysaccharide vaccine): CDC recommends PPSV23 for: Children 2 through [AGE] years old with certain medical conditions; Adults [AGE] years or older who receive PCV15 . There are 4 pneumococcal vaccines licensed for use in the United States by the Food and Drug Administration . (continued on next page)

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	235664	A. Building B. Wing	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0883 Level of Harm - Actual harm Residents Affected - Few	On 8/31/22 at 8:44 AM, as part of a review of the facility's infection control program Licensed Practical Nurse (LPN) A, who was an Infection Control Preventionist (ICP) and served as the Infection Control Nurse (ICN) was interviewed and asked how it was determined which pneumococcal vaccine each resident received. ICN A explained she did not know, but would check the resident's chart and look at their policy to determine what vaccine should be given. When informed there were four different pneumococcal vaccines, and the vaccine given was dependent on the resident's age and medical conditions, ICN A explained she was not aware of the different pneumococcal vaccines or the requirements for each vaccine. ICN A was asked if any pneumococcal vaccinations had been given at the facility. ICN A explained did not know of any that had been given, but would check to see when any had been given to a resident. On 8/31/22 at 1:08 PM, ICN A provided documentation that the last pneumococcal vaccination had been given at the facility on 7/27/21. On 8/31/22 at 1:10 PM, three residents (R66, R69 and R70) were selected to review for screening and assessment for eligibility to receive the pneumococcal vaccination, education about risks and benefits of receiving the pneumococcal vaccination, and evidence of administration of the vaccination, if eligible and consent or refusal was given to be immunized. R66 Review of the clinical record revealed R66 was admitted to the facility on [DATE] with diagnoses that included: fibromyalgia, rheumatoid arthritis, and diabetes. Review of R66's progress notes revealed a Practitioner note dated 7/25/22 at 9:15 PM that read in part, .Pt seen for f/u (follow up) on . pneumonia . CXR (chest x-ray) showed RLL infiltrate. Pt reports worsening cough from baseline w/ yellowish sputum . A Practitioner note dated 7/26/22 at 8:45 read in part, .Assessment and plan: .To be sent to the ER at (Local Hospital) for evaluation . Review of R66's immunization record revealed no documentation of any pneumococcal vaccine. Review of R66's consents revealed no consent or refusal for any pneumococcal vaccine. R69 Review of R69's clinical record revealed R69 was admitted to the facility on [DATE] with diagnoses that included: stroke, immunodeficiency, and diabetes. Review of R69's progress notes revealed a Practitioner note dated 1/10/22 at 6:35 PM that read in part, .pt seen and examined for f/u on recent dx (diagnosis) of LLL (left lower lobe) pneumonia .On evaluation pt is tachycardic (elevated heart rate) . Pulse ox (measure of oxygen level in the blood) 74% (normal range 95-100%) on my exam, re-checked on different finger 75% . pt will be sent to the ER for hypoxia and respiratory failure and to R/O (rule out) sepsis . Review of R69's immunizations revealed no documentation of any pneumococcal vaccine. Review of R69's consents revealed no consent or refusal for any pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Actual harm Residents Affected - Few	R70 Review of R70's clinical record revealed R70 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included: pneumonia, kidney disease and heart failure. Review of R70's progress notes revealed a Practitioner note dated 3/30/22 at 5:11 AM that read in part, . Altered/ mental status and resp distress -recently started on antibiotics for right bronchopneumonia/ oxygenating adequately but breathing at a rate of 40 per minute (normal rate 8-16) . Respiratory distress - Pneumonia likely a urgent Iso [sic] now causing sepsis/ ? PE (pulmonary embolism) - needs more active interventions . To be transferred to (Local Hospital) ER immediately . Review of R70's immunizations revealed no documentation of any pneumococcal vaccine. Review of R70's consents revealed no consent or refusal for any pneumococcal vaccine. On 8/31/22 at 3:04 PM, ICN A was asked to confirm that no residents at the facility had received a pneumococcal vaccine since 7/27/21. ICN A confirmed the date. When asked why, ICN A explained she had no idea of why as she had only been the ICN for a couple of weeks. ICN A was asked how consents for vaccinations were obtained. ICN A explained it was the admitting nurse who got the consents, but it depended on the nurse doing the admission whether they got them or not. When asked who was responsible for ensuring consents were obtained and vaccines given, ICN A explained she did not know. On 8/31/22 at 3:47 PM, Regional Clinical Director of Operations (RCDO) U was interviewed and asked why no pneumococcal vaccinations had been given at the facility since 7/27/21. RCDO U explained it was a big concern that no vaccines had been given, but she could not say why they had not been given. When asked who was responsible for ensuring consents were obtained and vaccines given, RCDO U explained the admitting nurse gets the consent then gives the consent to the Director of Nursing (DON) who puts in the order for the vaccine. On 8/31/22 at 4:20 PM, the DON was interviewed and asked if she was aware no pneumococcal vaccines had been given since 7/27/21. The DON explained she had not known because she had only been DON for a week, but that it was a big concern especially due to the time of the year. It should be noted that pneumococcal vaccines can be given any time of the year, there is no season. On 8/31/22 at 4:47 PM, RCDO U provided a Vaccine Consent Form Influenza/Pneumonia/Covid-19 for R66 from their admission packet. The form was not filled out except for R66's name, birth date and admitted , all the choices were blank, nor was it signed. RCDO U explained it was not the admitting nurse, but the Admissions Department that would obtain the consents, but she had not even been physically at the facility, she had been in a different building. RCDO U was asked how someone who had no clinical background provided education of risks versus benefits of the vaccine and answer questions about vaccinations, and get a signed consent if they were not physically there. RCDO U had no answer. Deficient Practice #2 Based on interview and record review the facility failed to provide the influenza vaccinations to one (R15) of five residents reviewed for influenza vaccinations. Findings include: (continued on next page)

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F 0883 Level of Harm - Actual harm Residents Affected - Few	Review of a facility policy titled, Influenza Vaccination revised 12/2020 read in part, .It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza . Influenza vaccinations will be routinely offered annually during flu season unless such immunization is medically contraindicated . following assessment for potential medical contraindications, influenza vaccinations may be administered in accordance with physician-approved standing orders . Review of R15's immunizations revealed on 10/27/20, R15 had received the Influenza vaccination. There was no documentation for 2021. Review of R15's consents revealed a Pneumococcal and Influenza Immunization Consent Form marked Accept and dated 7/19/21. On 8/31/22 at 8:44 AM, ICN A was interviewed and asked why R15 did not receive their Influenza vaccination when there was a signed consent. ICN A explained she did not know and would look into the matter. On 8/31/22 at 1:08 PM, ICN A confirmed R15 did not receive an Influenza vaccine after signing the consent to get one. When asked why R15 did not get the vaccine, ICN A had no answer.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 41415 Based on interview and record review the facility failed to implement and maintain a contingency plan for the facility's staff who are not fully vaccinated for COVID-19 to adhere to additional precautions that are intended to mitigate the spread of COVID-19. Findings include: On 10/26/22 the Administrator was asked to provide the facility's contingency plan for the facility's staff who was not fully vaccinated for COVID-19. The Administrator provide a Staffing Strategy Action Plan and Emergency Staff policy, both were reviewed and neither addressed the facility's contingency Plan for their staff that are not fully vaccinated for COVID-19. On 10/26/22 at 1:38 PM, the Administrator was asked a second time if the facility had a contingency plan/policy in place for the facility's staff who are not fully vaccinated for COVID-19. At 2:53 PM, the Administrator replied the facility had adopted guidance from the new updates made by CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare & Medicaid Services) and the vaccination status no longer determines source control measures. On 10/26/22 at 5:17 PM, the Administrator was interviewed and asked for a third time if the facility had a contingency plan for the staff that are not fully vaccinated for COVID-19 the Administrator stated No, per the CMS and CDC regulations. At that time the Administrator offered to highlight the updates and provide it to the surveyor. The Administrator was asked if the facility staff who are not fully vaccinated for COVID-19 had to adhere to any additional precautions while working in the facility and the Administrator stated in part No, the unvaccinated staff does not have any additional precautions put in place to take . At 5:31 PM, the Administrator provided a policy that stated all of their staff who obtains an exemption must wear a N95 respirator and perform at minimum weekly rapid COVID testing. The Administrator was reinterviewed and when asked stated the contingency plan for their unvaccinated staff was to wear the N95 and weekly testing prior to 10/18/22, however on 10/18/22 the facility was informed by their corporate staff that the facility's staff who are not fully vaccinated for COVID-19 can now wear a surgical mask and no longer had to wear an N95. The Administrator was asked since 10/18/22 to current (10/26/22) if the facility staff who are not fully vaccinated with COVID-19 was allowed to wear surgical mask with no additional precautions implemented for them to take and the Administrator stated that was correct. The Administrator stated since the State Agency requested the contingency plan, they have now informed their staff who are not fully vaccinated for COVID-19 to wear N95 mask while in the facility.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22960 This citation pertains to intake #MI00130095. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure that the facility was free from flies. This deficient practice had the potential to affect all residents, staff, and visitors. Findings include: The exit door in the basement located next to the boiler room, and leading up into the courtyard, was observed with a large gap along the bottom edge of the door. In addition, the exit door near the 1st floor dining room was observed with a large gap at the bottom of the door. There was a heavy infestation of large, black flies in the 1 [NAME] Hallway. Maintenance Supervisor confirmed the presence of the flies, but provided no explanation. Review of the facility's pest control service reports noted the following: Date of Service: 12/10/21 Open Conditions: Door not rodent proof. Severity: High Action: Replace door sweep at the courtyard door next to the dining room to help prevent rodent entry. Date of Service : 2/11/22 Open Conditions: Door not rodent proof. Severity: High Action: Replace door sweep at the courtyard door next to the dining room to help prevent rodent entry. Date of Service: 5/13/22 Open Conditions: Door not rodent proof. Severity: High Action: Replace door sweep at the courtyard door next to the dining room to help prevent rodent entry. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Date of Service: 6/10/22 Open Conditions: Door not rodent proof. Severity: High Action: Replace door sweep at the courtyard door next to the dining room to help prevent rodent entry. Date of Service: 7/8/22 Open Conditions: Door not rodent proof. Severity: High Action: Replace door sweep at the courtyard door next to the dining room to help prevent rodent entry. Review of the facility's policy Pest Control Program dated 1/11/21 noted: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents .4. Facility will utilize a variety of methods in controlling certain seasonal pests, i.e. flies. These will involve indoor and outdoor methods, that are deemed appropriate by the outside pest service . 30675 On 8/28/22 at 1:15 PM, room [ROOM NUMBER]-B (occupied by R18) was observed to have many large black flies throughout the room. On 8/28/22 at 1:24 PM, room [ROOM NUMBER]-B (occupied by R3) was observed to have a large black fly on their bed linen near their head. R3 did not respond to questions asked. On 8/28/22 at 1:30 PM, room [ROOM NUMBER]-A (occupied by R14) was observed to have many large black flies throughout the room. On 8/28/22 at 2:07 PM, room [ROOM NUMBER]-A (occupied by R50) was observed to have large black flies throughout the room. Resident Council: On 8/29/22 at 11:00 AM, residents in attendance of the confidential resident council interview were asked about whether they were satisfied with their environment, or if there were any concerns. Six of the six residents in attendance reported concerns with pests. Responses included: My room needs more cleaning. The corners need to be cleaned, there are spider webs. There's lots of flies and spiders.