STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41415 This citation pertains to intake: MI00129376. Based on observation, interview and record review the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for one (R704) of two residents reviewed for quality of life, resulting in the resident being kept bed bound, and not being offered the opportunity to be up, out of bed into, an appropriate chair daily. Findings include: Review of a complaint submitted to the State Agency on 6/29/22 documented concerns of the facility staff failing to get the resident out of bed. Review of the clinical record revealed R704 was admitted to the facility on [DATE] with diagnoses that included: acute respiratory failure with hypoxia, type 2 diabetes mellitus, tracheostomy, and a Stage 4 sacral pressure ulcer. A Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognitive skills for daily decision making, required staff assistance for all Activities of Daily Living (ADLs) and used a wheelchair for mobility. On 7/5/22 at 4:00 PM, R704 was observed laying on their backside with their head positioned to the left side of the bed. A feeding tube pole was observed on the side of the bed. A urinary catheter bag hung on the lower right side of the bed. Registered Nurse (RN) C was observed administering a nebulizer treatment via the resident's tracheostomy. The resident was nonverbal and unable to answer any interview questions. There was no wheelchair or Geri chair observed in the resident's room. On 7/6/22 at 10:11 AM, R704 was observed lying on their back in bed sleeping. Review of the clinical record failed to document any indication that R704 was to remain confined to their bed. Further review of the medical record revealed no task, intervention or documentation instructing the staff to get the resident out of bed daily. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/6/22 at 11:50 AM, the Director of Nursing (DON), Administrator, and Regional Clinical Director (RCD) B was interviewed and asked if they had ever seen R704 out of bed since admission into the facility on [DATE]. The DON and RCD B did not reply. The Administrator stated no; however, they could have the Rehab Manager (RM) E come and talk about R704, their understanding was that RM E was working on this concern. On 7/6/22 at 12:13 PM, RM E was interviewed and asked if they had ever seen R704 out of bed. RM E stated they have never personally seen the resident out of bed. RM E explained that due to trunk instability the resident would only be safe in a Geri chair when out of bed. When asked, RM E stated the facility had a Geri chair, but would have to locate it. RM E stated the resident's husband spoke to them about this same concern and it's on their list to work on this concern today. On 7/6/22 at 12:21 PM, Licensed Practical Nurse (LPN) F (assigned nurse for R704) was interviewed and asked if they ever seen R704 out of bed and LPN F replied they had never seen the resident out of their bed. On 7/6/22 at 12:31 PM, Certified Nursing Assistant (CNA) G (assigned CNA for R704) was asked if they are supposed to get R704 out of bed daily and CNA G replied in part, the nurses told them to not get the resident out of bed. CNA G stated the resident does not have a wheelchair. When asked if they ever seen R704 out of bed, CNA G stated they never seen R704 out of bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	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** 39592 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect when they failed to provide necessary wound care, medical oversight, monitoring, antibiotics, and skilled nursing services for one (R705) of two residents reviewed for wounds, resulting in R705 receiving no accurate skin assessments, no wound care provided, and no antibiotics for five days after admission. Findings include: Review of a facility policy titled, Abuse, Neglect and Exploitation revised 6/2022, read in part, .Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Review of the clinical record revealed R705 was admitted to the facility on [DATE] with diagnoses that included: encounter for other orthopedic aftercare, pressure ulcer of right ankle, Stage 3 (Full-thickness loss of skin, in which subcutaneous fat may be visible), fracture of right patella, strain of other muscles and tendons at lower leg level. Review of a nursing admission assessment dated [DATE] revealed R705 was alert and orientated to person, place, time, and situation and required the extensive assistance to total dependence of staff for all activities of daily living (ADL's). The admission assessment also indicated R705 had a surgical incision to the right knee (front) and to the right lower leg (front). The nursing assessment failed to identify R705's Stage 3 Pressure Ulcer. On 8/2/22 at 10:35 AM, R705 was observed lying in bed sleeping. An external fixator (rods surgically screwed into bone, exit the body, and are attached to a stabilizing structure on the outside of the body) was observed with two pins in his right thigh and two pins in his right lower leg, connected to two external bars preventing the right knee from bending. A dressing was observed to be wrapped around R705's right knee. Review of medical recored revealed a physician progress note for R705 dated 7/30/22 at 9:03 AM that read in part, .recently in the hospital with a chief complaint of right knee pain . Apparently the patient also had a left upper extremity wounds that he was unable to care for . had I&D (incision and drainage) of both the right patella as well as left wrist. Apparently there was also some right knee patellar tendon reconstruction on July 22. He has a stage III pressure ulcer noted over the right Achilles tendon region . Hardware infection of the right knee - Patient to continue current antibiotic therapy. - Bactrim double strength to continue until September 16 per hospital records . Review of R705's care plans failed to reveal any interventions for the care and/or treatment of the surgical wounds, external fixator or the Stage III pressure ulcer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of hospital paperwork for R705 revealed in part, .Impression and Plan: Hardware infection of Right Knee. Status post I/D of right knee and left wrist on 7/1. Status post I/D of right knee on 7/7, 7/9, and 7/12, 7/18. Status post I/D irrigation debridement and right patellar tendon reconstruction 7/22. Plan: .ID (Infectious Disease) consulted, recommend Bactrim 2 double strength tablets twice daily with stop date on September 16. Patient to begin this on discharge . Review of R705's physician orders revealed no orders for wound care for the surgical incisions or the Stage 3 Pressure Ulcer, or for any antibiotic therapy. Review of R705's Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) for July and August 2022 confirmed R705's received no wound care or antibiotics. On 8/3/22 at 9:20 AM, a skin assessment on R705 was conducted by Licensed Practical Nurse (LPN C), who served as the wound treatment nurse. On the right lower leg over the Achilles tendon region was an approximately 3/4-1 inch diameter circular pressure ulcer with sutures at the top and bottom of the ulcer, no dressing was on the wound. R705's right leg had staples on the medial aspect of the leg from above the knee down to the middle to bottom of the lower leg. The external fixator was noted. An undated, unsigned dressing was observed around R705's right knee. R705 explained he had changed that dressing himself two days previously. On 8/3/22 at 10:36 AM, R705 was observed sitting in a wheelchair in the common area of the unit. R705 was asked where he had gotten the supplies to change his dressing. R705 explained a nurse had given them to him, that the dressing had become saturated and was getting his sheets wet, so he asked a nurse for the supplies to change his dressing. R705 explained he put on gloves, used wound cleanser to clean it and put the dressing on it. When asked if any staff had changed the dressing since he had been at the facility, R705 said no, only he had. On 8/3/22 at 11:00 AM, an observation of R705's right knee was done with LPN C. Once the kerlix bandage was removed, the gauze covering the wound had dry, crusted drainage and was adhered to the wound. LPN C had to use normal saline to soak the gauze to remove it. After the gauze was removed, it appeared to have been saturated with serosanguineous (mixture of blood and serum) drainage with some purulent drainage noted. Staples were observed on both sides of the knee, almost a complete oval. A skin graft over the top of the knee was observed with open areas at the top and bottom of the knee. Sutures were present at the top and bottom of the knee. R705 explained that was the first time he had seen his wound, as he had not taken the gauze off when he had changed the dressing because it was stuck down and it hurt to remove it. LPN C explained she would have to call the doctor to get orders for wound care. On 8/3/22 at 11:50 PM, an observation of wound care for R705 was observed with LPN C. During this observation a bottle of wound cleanser was seen on R705's window sill. LPN C was asked if that was the wound cleanser that was used at the facility. LPN C explained that was what was used at the facility. When shown the cleanser on the window sill, LPN C asked R705 where he got it from as he should not have had it in his room. R705 explained he used it when he changed his dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/3/22 at 3:14 PM, LPN S was interviewed and asked if they noticed R705 had a surgical wound and needed wound care. LPN S explained they remembered R705 having an external fixator and that at 3:00 PM (shift change), R705 had asked them to change his dressing. LPN S was asked how they knew what to do as there were no orders for wound care. LPN S explained first R705 said he would change it, but then LPN S just used wound cleanser and some gauze to clean it. LPN S was asked if they had called the doctor to get wound care orders. LPN S explained they had not. When asked to describe R705 wound on his right knee, LPN S explained they did not remember what it looked like. It should be noted, the knee wound was unique and distinctive in appearance and not easily forgotten. On 8/3/22 at 3:35 PM, Registered Nurse (RN) Q was interviewed and asked if he had noticed R705 had a surgical wound and had no orders for wound care. RN Q explained the treatment never popped up on the TAR so he did not know R705 had no orders for wound care, he assumed they were changed on another shift. When asked if he looked at the physician orders, RN Q explained he usually only looked at the MAR and TAR's. On 8/3/22 at 3:41 PM, LPN O was interviewed by phone and asked if she had noticed R705 had no orders for wound care. LPN O explained she had noticed a dressing on R705's knee, and had noticed he did not have a dressing on his ankle, so she put a dry 4 x 4 on it. When asked if she had called the doctor, LPN O explained she did not. LPN O was asked if she had changed the dressing on R705's knee. LPN O explained she did not. On 8/3/22 at 3:47 PM, LPN R was interviewed by phone and asked if she had noticed R705 had no orders for wound care. LPN R explained she did not know he had no orders; she just figured the wound care had been done on a different shift. On 8/3/22 at 4:35 PM, the Director of Nursing (DON) was interviewed and asked how a resident could be admitted with an obvious surgical wound, an external fixator, a Stage III pressure ulcer, and go five days with no wound care. The DON had no answer. The DON was asked how R705's Stage 3 Pressure Ulcer was not identified on the admission skin assessment, or by any of his assigned nurses. The DON explained R705 did not want to have his skin assessed when he was first admitted . The DON was asked why a second skin assessment was not done per their Plan of Correction for a F686 Pressure Ulcer citation with a compliance date of 7/21/22. The DON had no answer. When asked if nurses could provide wound care without physician orders, the DON explained it was never permissible for a nurse to do wound care without physician orders. On 8/3/22 at 4:50 PM, the Administrator, DON, Regional Clinical Nurse T and Regional Administrator U were interviewed concurrently and asked if R705 had been admitted to the facility for skilled nursing care. All responded in the affirmative. When asked if R705 had received skilled nursing care since he was admitted , no answer was given by anyone. It should be noted that until identified by the surveyor, R705 received no wound care to his Stage 3 Pressure Ulcer, no wound care to his surgical wounds, and did not receive any antibiotic therapy for five days after admission to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00129376. Based on observation, interview and record review the facility failed to complete accurate body assessments, timely identify skin changes, consistently implement wound interventions, notify the physician of skin changes and obtain treatment for one (R704) of one resident reviewed for Pressure Ulcers, resulting in the development of and/or worsening of multiple pressure ulcers to the left ear, proximal (posterior aspect under the toes) of right foot, right heel and in between the third, fourth and fifth toes of the right foot. Findings include: Review of a complaint submitted to the State Agency on 6/29/22 documented concerns of the facility not providing adequate and appropriate care to prevent and/or treat pressure sores for R704. On 7/5/22 at 4 PM, upon entering R704's room a feeding pole was noted at the right side of the bed. There was no enteral formula or bottles connected to the tubing or the resident. The enteral machine was off. Registered Nurse (RN) C prepared a Glucerna with carbsteady 1.5 cal formula bottle and a water bag and started the resident's feeding. At 4:19 PM, a skin audit of R704's feet, elbows, coccyx and left ear was conducted with RN C. R704 was observed laying on their backside with their head positioned to the left side of the bed. A pillow was wedged under the right side of the resident's body. A pressure pump device was observed hooked to the bed with two options noted on the device (normal pressure and low pressure) the device was set on the normal pressure setting. R704's feet was noted with multiple dark areas on both feet. Both feet were observed on the bed with no offloading devices applied to the feet. The right foot was observed swollen, all toes were dark in color, dry and flaky. Purulent discharge was noted between the third, fourth and fifth toes. RN C was asked to slightly separate each toe from one another. Between the third, fourth and fifth toes, open areas with purulent drainage were observed. The wound bed could not be visualized for either wound between the toes. Dark maroon/brown areas observed on the right foot. Two blisters filled with fluid was observed on the right heel and proximal posterior (under the toes) part of the right foot, both blisters noted to be larger than a quarter in size. Dried discharge and blood were observed on the white sheet under the resident's feet. These wounds were not identified by the facility staff and there was no treatment documented in the clinical record for these areas. At 4:24 PM, RN C lifted R704's head, an open wound was observed on the left ear, approximately an inch in length and a half inch in width, there was no dressing noted on the left ear. Review of the clinical record revealed R704 was admitted to the facility on [DATE] with diagnoses that included: acute respiratory failure with hypoxia, type 2 diabetes mellitus, tracheostomy, and a Stage 4 sacral pressure ulcer. A Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognitive skills for daily decision making and required staff assistance for all Activities of Daily Living (ADLs). Review of an Admission skin assessment dated [DATE] at 2:14 PM, documented in part . Skin is impaired . Coccyx . Pressure . It should be noted that no measurements were documented for this wound and the wound was not staged. This was the only wound identified by the facility staff upon admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a facility policy titled Wound Treatment Management and Documentation revised 7/21, documented in part . Wound assessments are documented upon admission . The following elements are documented as part of a complete wound assessment . Stage of the wound, if pressure injury (stage 1, 2, 3, 4, deep tissue) . Measurements: height, width, depth, undermining, tunneling . Review of the preadmission hospital documents provided to the facility on admitted d 5/26/22, documented in part . Heel Right Inferior . Wound Length: 5 . Wound Width: 4 . Heel Right Distal . Allewyn <sic> INTACT . Coccyx . Stage IV (4) Pressure Ulcer (Stage 4 Pressure Ulcer - Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) . Length: 9 . Width: 6 . Depth: 2 . Ear Left . Stage II Pressure Ulcer (Stage 2 Pressure Ulcer- Partial- thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) . Length: 1.2 . Width: 0.2 . The facility staff failed to identify the right foot, right heel, and left ear wounds, although documented by the transferring hospital on the discharge paperwork provided to the facility upon the resident's admission to the facility. Review of the medical record revealed no documentation that the physician was notified of the right foot and left ear wounds. Further review of the medical record revealed treatment was not implemented for the right heel and foot wounds. Treatment for the left ear was started on the day of survey 7/5/22. The facility failed to implement treatment to the right foot, heel, and left ear for more than a month. Review of the weekly body audits completed by the facility staff on 6/2, 6/9, 6/16, 6/23, and 6/30/22 failed to identify the wounds to the right foot, heel, and left ear. Review of wound consultations dated 5/27, 6/2, 6/10, 6/24 and 7/1/22, revealed no assessment or documentation of the right foot, heel, and left ear wounds. Further review of a facility policy titled Wound Treatment Management and Documentation revised 7/21, documented in part . The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition and changes in treatment . Wound treatments will be provided in accordance with physician orders . Review of the physician orders revealed the following: Enteral Feed Order, two times a day TF (Tube Feed) via pump; via PEG (Percutaneous Endoscopic Gastrostomy) tube Glucerna 1.5 at 55 ml (milliliters)/hr (hour) for 10 hours. On at 2 PM and off at 10 AM. On the day of observation, the feeding was put on for the resident 2 hours and 18 minutes past the ordered time. This potentially can cause the resident to not get their intended nutritional needs. Ensure Pressure Relieve Boots Apply To BLE (Bilateral Lower Extremities) Feet Q (every) Shift For Prevent Pressure Ulcer every shift for Prevention. These boots were not applied on the day of observation and preventative care was not effective as the resident was identified to have developed multiple wounds and the worsening of preexisting wounds to the right foot that was not identified by the facility staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a wound consultation dated 7/1/22, documented in part . has a history of protein calorie malnutrition . receives her nutrition parenterally (outside of the digestive tract) . It is imperative that this patient be pressure offload it <sic> frequently reposition and kept clean and dry as possible. Nutritional support is also an imperative . On 7/5/22 at 4:42 PM, Wound Nurse (WN) A was interviewed and asked to discuss all of R704 wounds. WN A replied the resident has a wound on their coccyx and a left ear wound was brought to their attention today by the resident's husband. WN A stated they applied treatment to the coccyx and left ear today and will be seen by the wound physician on Friday. WN A was asked why the facility did not identify the wound to the resident's left ear when it was documented on the discharge paperwork provided to the facility on admission by the transferring hospital, WN A stated they were not informed of the left ear wound by the facility staff. WN A was then asked about the multiple wounds observed on the resident's right heel, proximal posterior right foot and open areas noted in between the third, fourth and fifth phalanges on the right foot, noting that two of the right foot wounds were also identified on the discharge paperwork provided to the facility on admission. WN A stated they were not notified by the facility staff of those skin concerns. At 4:47 PM, the Regional Clinical Director (RCD) B joined the interview and was asked about the resident's right foot, heel and left ear wounds, the lack of identification of wounds, implementation of appropriate interventions, notification to the physician and treatment initiation for all of the observed areas. RCD B stated they were unaware of the resident wounds in question and will follow up immediately. On 7/6/22 at 7:43 AM, an additional review of the medical record was conducted. A Nursing Progress Note dated 7/5/22 at 6:26 PM, documented in part . Resident observed w (with)/opening to left ear lobe, Right toe 2, 3, 4, 5 w/fungi & opening sore between toes. Right heel stage 3 (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present). Telecommunication w/ (doctor name) new order in place . Wound Team w/assess resident on Friday . On 7/6/22 at 11:15 AM, Registered Dietician (RD) D was interviewed and asked if R704's current vitamins, minerals and nutritional needs were adequate to help in wound healing considering the fact the resident was only on a multivitamin and solely dependent on parenteral feeding that was observed not being infused as the physician ordered (infused two hours and 18 mins past the prescribed time) and the development of multiple identified pressure ulcers. RD D replied they were not notified of the residents newly identified pressure ulcers and will need to reevaluate the resident's regime. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/6/22 at 11:33 AM, the Director of Nursing (DON) was interviewed and when asked stated they were unaware of R704's right foot wounds until being informed this morning. When asked about the float foot devices that was observed not to be on the residents' feet, the DON acknowledged the concern and stated they started staff education regarding the boots. When asked how the facility did not identify the left ear, proximal right foot, and right heel wounds when the discharge documents from the receiving hospital documented the wounds on the discharge paperwork, the DON did not have a response. When asked how the facility ensures the resident is receiving their expected nutritional intake which helps with wound healing if the feeding is put on two hours and 18 minutes after the prescribed time, the DON did not offer a response. When asked how the dietician is informed of any new wounds or worsening of existing wounds, the DON stated they or the wound nurse would notify the dietician. The DON was asked about the accuracy of the weekly skin assessments completed by the facility staff, considering the unidentified wounds that was documented by the transferring hospital and the wounds found by the surveyor on 7/5/22 which were not identified by the facility staff and the DON did not offer a response.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to implement an effective Quality Assurance & Performance Improvement (QAPI) program that identified quality issues and implemented appropriate plans of action to correct quality deficiencies, resulting in inaccurate skin assessments, skin assessments not done, and wound treatments not provided. This had the potential to affect all residents newly admitted into the facility, including one (R705) of two residents reviewed for pressure ulcers. Findings include: During an abbreviated survey conducted 7/6/22, deficient practices were identified related to pressure ulcers. The facility developed a plan of correction with an alleged compliance date of 7/21/22 revealed the facility would do the following, .Licensed Nurses were re-educated . Nurses completed a hands-on in-service going over properly inspecting skin and presented a return demonstration to validate that they could perform the task. The Director of Nursing/designee will complete a second skin assessment Monday through Friday to validate that the skin assessments were completed correctly . The Director of Nursing is responsible for sustained compliance . Review of a facility audit titled, Transfer/Wound Audit revealed no issues were identified on 7/18/22, 7/22/22, 7/25/22 and 7/29/22. For Did a second nurse complete a skin assessment? Y/N section, Y was written, indicating it had been done. The audit form was signed by the Director of Nursing (DON). Review of the clinical record revealed R705 was admitted on [DATE], had not picked up on the audit tool, had an admission skin assessment that did not identify a pressure ulcer documented on hospital paperwork. R705 had no second skin assessment documented. No treatment orders for wounds were found. On 8/3/22 at 11:35 AM, the DON was interviewed and asked about R705's inaccurate skin assessment as R705 had a pressure ulcer, and it was documented in the hospital paperwork that R705 had a pressure ulcer. The DON explained she and another nurse had completed the first skin assessment, but R705 did not want to have his skin assessed. The DON was asked if she had documented that the resident had refused the assessment. The DON explained she had not. When asked why the second skin assessment had not been performed, the DON had no answer. On 8/3/22 at 12:16 PM, the Administrator and Regional Clinical Nurse (RCN) T were interviewed concurrently and asked about a Plan of Correction when there was no second skin assessment performed on R705 and the first assessment had inaccuracies, and R705 had not been identified on their audits. RCN T agreed they had not followed their POC, but were doing everything now. When asked to clarify that wound care and antibiotic therapy had begun after being identified by the surveyor as not being done, RCN T agreed that was so. Review of a facility policy titled, Quality Assurance and Performance Improvement revised 4/2019 read in part, .Develop and implement appropriate plans of action to correct identified quality deficiencies . Regularly review and analyze data . and act on available data to make improvements .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 39592 Based on observation, interview and record review, the facility failed to follow infection prevention and control standards for Methicillin-resistant Staphylococcus Aureus (MRSA) transmission based precautions (TBP) for one (R705) of two residents reviewed for wounds. This had the potential to affect all residents who resided on the first floor of the facility. Findings include: On 8/2/22 at 10:35 AM, an observation of room [ROOM NUMBER] revealed an isolation caddy on the door, empty except for gloves. There were three isolation three drawer bins observed in the hallway on the unit, none contained isolation gowns. When staff were asked where to find isolation gowns, one was found in an isolation caddy hanging from a door at the opposite end of the unit as 130. Upon entry to the room, R705 was observed lying in bed sleeping. An external fixator (rods surgically screwed into bone, exit the body, and are attached to a stabilizing structure on the outside of the body) was observed with two pins in R705's right thigh and two pins in R705's right lower leg, connected to two external bars preventing the right knee from bending. A dressing was observed to be wrapped around R705's right knee. R702 was observed sitting on his bed. A ridged plastic walking boot was observed on R702's left foot/leg. Review of the clinical record revealed R705 was admitted to the facility on [DATE] with diagnoses that included: encounter for other orthopedic aftercare, pressure ulcer of right ankle, Stage 3 (Full-thickness loss of skin, in which subcutaneous fat may be visible), fracture of right patella, strain of other muscles and tendons at lower leg level. According to a nursing admission assessment dated [DATE], R705 was alert and orientated to person, place, time, and situation and required the extensive assistance to total dependence of staff for all activities of daily living (ADL's). The admission assessment also indicated R705 had a surgical incision to the right knee (front) and to the right lower leg (front). No mention of a Stage 3 Pressure Ulcer. Review of the clinical record revealed R702 was admitted to the facility on [DATE] with diagnoses that included: encounter for orthopedic aftercare, fracture displaced fracture of left lower leg and difficulty in walking. According to the Minimum Data Set (MDS) assessment dated [DATE], R702 had intact cognition and required the limited assistance of staff for ADL's. R705 and R702 were roommates from 7/29/22, when R705 was admitted , until 8/2/22, when R702 was discharged . Review of R702's August 2022 Medication Administration Record (MAR) revealed an order for wound care that read, CLEANSE LEFT ANKLE W/NS (with normal saline) PAT DRY AND APPLY DRY DRESSING In the morning every Fri (Friday). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R705's progress notes revealed an admission note dated 7/30/22 at 9:03 AM by R705's physician that read in part, .recently in the hospital with a chief complaint of right knee pain . Apparently the patient also had a left upper extremity wounds that he was unable to care for . had I&D (incision and drainage) of both the right patella as well as left wrist. Apparently, there was also some right knee patellar tendon reconstruction on July 22. He has a stage III pressure ulcer noted over the right Achilles tendon region . Hardware infection of the right knee - Patient to continue current antibiotic therapy. - Bactrim double strength to continue until September 16 per hospital records . Review of hospital paperwork for R705 revealed in part, .Impression and Plan: Hardware infection of Right Knee. Status post I/D of right knee and left wrist on 7/1. Status post I/D of right knee on 7/7, 7/9, and 7/12, 7/18. Status post I/D irrigation debridement and right patellar tendon reconstruction 7/22. Pt (patient) is currently on vancomycin for MRSA, Corynebacterium and strep dysglalactiae found on cx (culture) 7/1 . At discharge, pt can . go on PO (by mouth) Bactrim . End date of abx (antibiotics) is 9/16/22 . Review of R705's physician orders revealed no orders for wound care for the surgical incisions or the Stage 3 Pressure Ulcer, or for any antibiotic therapy. Review of R705's Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) for July and August 2022 confirmed R705's received no wound care or antibiotics. On 8/3/22 at 9:20 AM, a skin assessment on R705 was conducted by Licensed Practical Nurse (LPN C), who served as the wound treatment nurse. LPN C did not have an isolation gown on during the skin assessment. On R705's right lower leg over the Achilles tendon region was an approximately 3/4-1 inch diameter circular ulcer with sutures at the top and bottom of the ulcer, no dressing was on the wound. R705's right leg had staples on the medial aspect of the leg from above the knee down to the middle to bottom of the lower leg. The external fixator was noted. R705's right wrist was noted to have a small opening on the inside aspect under the thumb area. An undated, unsigned dressing was observed around R705's right knee. R705 explained he had changed that dressing himself two days previously. LPN C informed R705 she would need to remove the dressing on his right knee. R705 explained before the dressing was changed, he needed his pain medication and to go smoke at the 10:00 AM smoking time. When asked how often he was allowed to smoke, R705 explained smoking times were 10:00 AM, 2:00 PM, 5:00 PM and 8:00 PM and he went to them all. On 8/3/22 at 10:33 AM, R705 was observed coming back from smoking, maneuvering his own wheelchair. There were several residents in the hall, both that had been smoking and other resident that had not. It should be noted the exit to the area where residents were allowed to smoke was on the opposite side of the facility, resulting in R705's potential exposure to all first floor residents. On 8/3/22 at 10:36 AM, R705 was observed sitting in a wheelchair in the common area of the unit. R705 was asked where he had gotten the supplies to change his dressing. R705 explained a nurse had given them to him, that the dressing had become saturated and was getting his sheets wet, so he asked a nurse for the supplies to change his dressing. R705 explained he put on gloves, used wound cleanser to clean it and put the dressing on it. When asked if any staff had changed the dressing since he had been at the facility, R705 said no, only he had. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. Building B. Wing	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/3/22 at 11:00 AM, an observation of R705's right knee was done with LPN C. Once the kerlix bandage was removed, the gauze covering the wound had dry, crusted drainage and was adhered to the wound. LPN C had to use normal saline to soak the gauze to remove it. After the gauze was removed, it appeared to have been saturated with serosanguineous (mixture of blood and serum) drainage with some purulent drainage noted. Staples were observed on both sides of the knee, almost a complete oval. A skin graft over the top of the knee was observed with open areas at the top and bottom of the knee. Sutures were present at the top and bottom of the knee. R705 explained that was the first time he had seen his wound, as he had not taken the gauze off when he had changed the dressing because it was stuck down and it hurt to remove it. LPN C explained she would have to call the doctor to get orders for wound care. On 8/3/22 at 11:50 PM, an observation of wound care for R705 was observed with LPN C. ExSept Plus skin & wound cleanser was used to clean R705's right knee, slight purulent drainage was noted. When LPN C informed R705 there was puss in the wound, R705 explained there should not be any puss as he was on antibiotics. It should be noted that R705 did not receive any antibiotics for the five days he had been at the facility. On the window sill in R705's room a bottle of ExSept Plus skin & wound cleanser was observed. LPN C was asked if that was the wound cleanser that was used at the facility. LPN C explained that was what was used at the facility. When shown the cleanser on the window sill, LPN C asked R705 where he got it from as he should not have had it in his room. R705 explained he used it when he changed his dressing. LPN C informed R705 he would not be allowed to leave his room, or go smoke. R705 questioned why he was restricted to his room now and explained some of the people that went out to smoke with him had PICC (peripherally inserted central catheter) lines and he was not more compromised than them. On 8/3/22 at 12:16 PM, the Administrator and Regional Clinical Nurse (RCN) T were interviewed concurrently and asked about R705 have MRSA in a wound with no order for contact isolation and having had a roommate with a wound. RCN T explained she did not know R705 had a roommate. When told R705's roommate had discharged on [DATE], RCN T had no answer, but explained R705 was on contact precautions now. When asked to clarify that wound care, antibiotic therapy and TBP had begun after being identified by the surveyor as not being done, RCN T agreed that was so. On 8/3/22 at 4:35 PM, the Director of Nursing (DON) was interviewed and asked how a resident could be admitted with an obvious surgical wound, an external fixator, have a documented MRSA infection that required antibiotic therapy and go five days without TBP, antibiotics and wound care. The DON had no answer. Review of a facility policy titled, Standard Transmission-Based Precautions revised 12/2020 read in part, . Transmission-based precautions refers to the actions (precautions) implemented, in addition to standard precautions, that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections . Contact precautions are measures that are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment . Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment .