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	01/18/2023

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00133578. Based on observation, interview, and record review, the facility failed to thoroughly investigate an injury of unknown origin for one (R801) of three residents reviewed for abuse. Findings include: Review of a Facility Reported Incident (FRI) submitted to the State Agency on 12/25/22 revealed R801 sustained an injury of unknown origin. Review of a facility policy titled, Abuse, Neglect, and Exploitation, revised on 6/2022, revealed, in part, the following: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .Investigations may include but not limited to .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and .Providing complete and thorough documentation of the investigation . On 1/18/23 at 8:30 AM, R801 was observed sleeping in their bed. On 1/18/23 at 9:30 AM, R801 was lying in bed. An interview was attempted with R801 who appeared to be in a considerable amount of pain. R801 was tearful and repeatedly reported that they did not 'feel well' and that they 'hurt all over'. R801 was very difficult to understand due to their expressions of pain. R801 did report they 'broke her leg', but it was unclear how it happened as they continued to request to go to the bathroom, moan in pain, and report they did not feel well. Review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: schizoaffective disorder, disorders of bone density and structure, osteoarthritis, age related osteoporosis with current pathological fracture, right femur (not diagnosed until after the fracture on 12/24/22). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 required extensive physical assistance from at least two staff members for transfers and rarely experienced pain. The highest level of pain experienced by R801 during the assessment period was 2 with 10 being the highest level of pain. Review of R801's progress notes revealed the following: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress Note dated 12/24/22 at 9:00 PM documented, Late Entry .Assigned CNA (Certified Nursing Assistant) noted resident had c/o (complained of) pain and facial grimaces to right upper leg during transfer. Assigned CNA notified writer, writer observed right upper leg swollen and painful upon touch. Limited ROM (range of motion). A Nursing Progress Note dated 12/24/22 at 9:00 PM documented, Writer observed resident right upper leg swollen and painful upon touch. ROM is limited to right leg. No discoloration is noted to right leg. (Physician 'E') is notified via telehealth new order to send resident to (hospital) . A Practitioner Progress Note dated 12/24/22, written by Physician 'A', documented, .Patient was seen by video-conferencing with help of the nurse on duty .Complaining of pain in the right thigh - patient felt the pain while getting transferred .nurse on duty observed the swelling of the right thigh .There was apparently no fall . appears in pain and uncomfortable .swelling of the right thigh .Swelling/pain of the right thigh deformity suggesting right femoral fracture, likely pathological fracture secondary to osteoporosis as no traumatic event ? happened during routing transfer/care (It should be noted that the facility's investigation was not complete at the time of the physician's evaluation to determine if it could have occurred during care/transfer) .Patient to be transferred to the hospital for further evaluation and x-rays and management likely requiring .surgery . Review of R801's hospital discharge summary revealed a diagnosis of Closed displaced fracture of right femoral neck (thigh bone) and it was documented R801 required intramedullary nailing (surgical repair) of the fracture. Review of an investigation conducted by the facility revealed the following: An Administrative Statement Investigative Analysis 5 Day Summary completed by the Administrator and Director of Nursing (DON) on 12/29/22 that documented, R801 .was a 1 person extensive assistance with transfers, bathing, and daily care .According to staff interviews, witness statements, and record review, (CNA 'F'), was assigned to the resident on 12/24/22 and states that she was transferring the resident back to bed from the wheelchair and that the resident did not complain of pain during the transfer, it was after the transfer that she started complaining of pain to her right leg. (CNA 'F') immediately notified (Nurse 'G') regarding the residents change of condition and complaints of pain to her right leg. (CNA 'F') was asked if anything happened during the transfer for example, did her leg hit an object or become twisted during the transfer and she stated no that 'I transferred her the same way I always do' . Further review of the facility's investigation revealed no further questions were asked of CNA 'F' when they said they transferred R801 'the same way I always do'. There was no evidence that R801 was interviewed about how they sustained the injury. On 1/18/23 at 3:05 PM, an interview was conducted with CNA 'F'. When queried about how staff knew a resident's transfer status, CNA 'F reported it was documented on the Kardex. When queried about R801, CNA 'F' reported they were assigned to the resident on 12/24/22. When asked if they assisted R801 with transferring on 12/24/22, CNA 'F' reported they did. CNA 'F' was asked to describe the technique they used when transferring R801. CNA 'F' stated, I pulled her wheelchair up to the bed like I normally do, locked the chair, grabbed the back of her pants, put my leg between her left and hoisted her up to the bed. CNA 'F' reported they did not use a gait belt to assist with R801's transfer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/18/23 at 4:40 PM, an interview was conducted with the Administrator, who was identified as the facility's Abuse Coordinator. When queried about the facility's investigation into R801's fractured femur and how R801 was transferred by CNA 'F', the Administrator stated, She said she transferred her how she always transferred her. When queried about what that meant and if CNA 'F' was interviewed further to determine if they transferred R801 properly, the Administrator reported the DON also conducted interviews. When queried about whether a gait belt should have been used for a resident who required extensive assistance, the Administrator reported a gait belt should have been used. On 1/18/23 at approximately 4:55 PM, an interview was conducted with the DON. When queried about how R801 was transferred by CNA 'F' on 12/24/22, the DON reported R801 was a one person assist and that was how CNA 'F' transferred them. When queried about whether CNA 'F' used the proper technique to transfer R801, the DON reported she did not inquire about that and only focused on whether R801 required one or two people for transfers. The DON reported no education was provided to CNA 'F' because it was only determined that she transferred with the right number of staff members, not the proper technique. When queried about whether residents should be transferred by the waste band of their pants and without a gait belt, the DON reported a gait belt should have been used.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to conduct a thorough and accurate skin assessment and implement treatment and interventions for multiple pressure ulcers to the foot, leg, and sacrum for one (R801) resident, resulting in pain and discomfort, and worsening of a sacral pressure ulcer. Findings include: Review of a facility policy titled, Skin and Pressure Injury Risk Assessment and Prevention, revised on 7/2021, revealed, in part, the following: A skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury .Documentation of skin assessment: . Document type of wound .Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain) .After completing a thorough assessment/evaluation, the interdisciplinary tear shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions .Evidence-Based interventions for prevention will be implemented for all resident who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: .Redistribute pressure .Minimize exposure to moisture and keep skin clean, especially of fecal contamination .Provide appropriate, pressure-redistributing, support surfaces . Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present .Treatment decisions will be based on the characteristics of the wound, including the stage, size, amount of exudate, and presence of pain, infection, or non-viable tissue . On 1/18/23 at 8:30 AM, R801 was observed lying in bed sleeping on a standard mattress. R801 was positioned on their back. R801's feet were not elevated and made direct contact with the mattress. On 1/18/23 at 9:30 AM, R801 was observed lying on their back in bed. Their feet were not elevated and made direct contact with the standard mattress on their bed. At that time, an interview was attempted with R801. R801 appeared to be in pain and had facial grimacing and was tearful and moaning. R801 reported they did not feel well and that they had pain all over. R801 was difficult to understand due to their moaning and expressions of discomfort. When queried about whether R801 had any wounds, R801 was not able to answer. R801 reported that she broke her leg and explained that it hurt. On 1/18/23 at approximately 10:00 AM, R801 was observed lying on their back in bed on a standard mattress. Their feet made direct contact with the mattress. R801 was moaning and tearful and stated, I don't feel well. R801 explained they had increased pain that started that day and that it hurts all over. At that time, R801 asked to used the bathroom. R801 reported they had not been out of bed or repositioned yet that day. At that time, Certified Nursing Assistant (CNA) 'B' entered the room and informed R801 that they could not get them out of bed without the assistance of therapy staff and left the room. R801 remained on their back in bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/18/23 at approximately 10:20 AM, an interview was conducted with Nurse 'C', R801's assigned nurse. When queried about whether R801 had any pressure ulcers, Nurse 'C' reported they were not sure. At that time, Nurse 'C' performed a skin assessment with the assistance of CNA 'B'. When R801 was rolled to the side, a balled up sheet was observed under the absorbent pad on R801's bed. Nurse 'C' indicated R801 had an open area to her sacrum. When asked to describe the area, Nurse 'C' stated there was an open sore and there was no dressing applied to the sacral area. At that time, R801's feet were assessed by Nurse 'C' and a dark area was observed covering R801's right heel. Nurse 'C' described R801's right heel as a blackened area. Nurse 'C' reported they had to contact the physician to get interventions and treatments in place. At that time Nurse 'C' contacted a practitioner via the telephone and told them R801 had a sacral and did not provide additional information. Nurse 'C' reported that no wounds were reported to them from the previous shift. On 1/18/23 at approximately 2:00 PM, R801 was observed up in a wheelchair, self propelling in the hallway, tearful and asking to go to bed. CNA 'B' and Therapy Staff 'H' were observed transferring R801 from the wheelchair to the bed using a mechanical lift. R801's mattress was observed to be a standard mattress. Once in bed, Therapy Staff 'H' and CNA 'B' rolled R801 to their left side. At that time, undressed open areas were observed on R801's right calf (back of lower leg) that appeared to have some drainage. R801 was placed onto their back and their right leg made direct contact on top of the tubing from their indwelling urinary catheter and a plastic component that was attached to the tubing. No heel protector boots were observed to be applied to R801's feet. At that time, Nurse 'C' was asked to explain what was going on with R801's right calf. Nurse 'C' looked at R801's right calf and said She has a mark there. R801 did not describe the skin impairment any further. Review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: schizoaffective disorder, disorders of bone density and structure, osteoarthritis, age related osteoporosis with current pathological fracture, right femur, and chronic obstructive pulmonary disease (COPD). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 required extensive physical assistance from at least two staff members for transfers and extensive assistance from one staff member for bed mobility and toilet use. Review of an Admission/Readmission Assessment for R801 dated 1/12/23 revealed R801 was readmitted into the facility with a fractured femur (thigh bone); was totally dependent on staff for bed mobility, transfers, and toilet use; and had bruising to the front of their right knee and stitches and bruising to the right thigh/groin. No pressure ulcers were identified on the readmission skin assessment. Review of a Nursing Progress Note dated 1/13/23 at 10:24 AM, written by Nurse 'A', who was identified as the facility's wound nurse, revealed, Resident readmitted w/ (with) Fracture of unspecified part of neck of right femur .Second Skin check completed observed discoloration/bruising to Right proximal (center) Thigh . Right knee bruising/scab noted. Bruising/discoloration to right forearm. Doctor/Guardian was updated on findings, will continue ongoing care. There was no documentation of any additional skin impairments. Review of a consultation report written by Wound Care Physician 'I' on 1/13/23 revealed an assessment of R801's surgical wound on the right thigh. There was no documentation of any additional skin impairments. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a Practitioner Progress Note dated 1/13/23 at 2:00 PM, written by Attending Physician 'E' revealed, .Developed pressure wounds on the right heel and right leg. Also seems to have developed pressure wound on the sacrum. Overall declined general condition .pressure wound rt (right) heel/calf .Sacral stage 2 (partial-thickness skin loss with exposed dermis) on Rt buttock/Lt (left) buttock red and excoriated . RT HEEL with ESCHAR (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) .Assessment and Plan .Right leg and heel decubiti wounds .local wound care .pressure offload from the sacrum with air mattress and also right heel with pressure relieving boot . It should be noted that this evaluation was done the same day as Nurse 'A's second skin check and at that time no pressure areas were identified. Review of a Weekly Skin Sweep dated 1/14/23 revealed the following skin impairments were identified: Right heel .open area .Sacrum .open area .Right lower leg (rear) .redden area . Review of a Practitioner Progress Note dated 1/15/23, written by Attending Physician 'E' revealed, .Sacral wound raw - ? deeper .SKIN - Secral <sic> skin becoming raw/worse .Right leg posteriorly (back) and heel show pressure damage .Assessment and plan .Right leg wound/deep tissue injury to rt healing right calf - pressure off load with air mattress and 'moon' boot (pressure offloading boots) .Sacral wound - may be appearing deeper/worse - air mattress/pressure offload - local care and wound care to follow . On 1/18/23 at 9:00 AM, R801's physicians orders were reviewed. There were no active orders for an air mattress, heel boots, or treatment to R801's stage 2 pressure ulcer on the sacrum and right heel with eschar. There was no order for treatment for R801's right calf. An order created on 1/17/23 (four days after R801's pressure ulcers were identified by Physician 'E') documented, Apply Triad Hydrophilic Wound Dressing Paste to Bilateral Buttocks every day for Wound prevention AND as needed for Wound Prevention. It should be noted that the order was for prevention of wounds and did not specifically address the open area on R801's sacrum. The order did not provide protection from fecal matter according to the facility's policy. On 1/18/23 at approximately 11:00 AM, the Director of Nursing (DON) was interviewed. When queried about the facility's protocols for addressing pressure ulcers for newly or readmitted residents, the DON reported the admitting nurse assessed residents' skin on admission or if Nurse 'A' was in the building they would complete the full head to toe skin assessment. If there were any identified skin impairments they would be noted in the skin assessment, a wound consult was ordered, and the resident was placed on the communication board. The DON reported that Nurse 'A was to be notified of any skin impairments. The DON further reported if residents developed any new skin impairments, the same process was followed. When queried about who determined the treatment and interventions for identified pressure ulcers, the DON reported treatments and interventions would be put into place immediately until Wound Care Physician 'I' could evaluate the resident and at that time any changed would be made. It was reported that Wound Care Physician 'I' only evaluated identified skin impairments and did not do a full head to toe skin assessment. The DON explained Nurse 'A' was responsible to oversee any needed orders for skin issues. The DON further explained for residents with pressure ulcers, they would be switched to an air mattress which if available in the facility would be switched out immediately or if not available, an order was placed with the mattress supplier. When queried about R801 and why no interventions or treatments were put into place for the pressure ulcers identified by Physician 'E' on 1/13/22, the DON reported she did not know the resident had pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/18/23 at 3:00 PM, an interview was conducted with the DON regarding the open areas on R801's right calf. The DON reported she was unaware of any open areas to R801's calf. (It should be noted that Physician 'E' documented a pressure area to R801's right calf on 1/13/23). On 1/18/23 at 5:10 PM, an interview was conducted with Nurse 'A' via the telephone. When queried about their role as the facility's wound nurse, Nurse 'A' reported they rounded with (Wound Care Physician 'I') on Fridays. When queried about the skin assessment conducted by them on 1/13/23 that did not identify any pressure ulcers despite Physician 'E' identifying pressure ulcers that same day, Nurse 'A' reported she did not conduct a full head to toe skin assessment because of human error. Nurse 'A' reported Wound Physician 'I' did not evaluate R801's pressure ulcers on 1/13/23 because they were not identified yet. When queried about any assessment that was completed after it was identified by Physician 'E' that R801 had pressure ulcers to the sacrum, right heel, and right calf, Nurse 'A' reported they did assess the resident but did not document the assessment due to human error. When queried about why orders for treatment and interventions, such as an air mattress and heel boots, were not implemented at the time the pressure ulcers were identified, Nurse 'A stated, I entered orders a couple days later. On 1/18/23 at 5:15 PM, further review of R801's Physician Orders was conducted. An order for AIR LOW LOSS MATTRESS revealed the order date was 1/17/23. Further review of the order revealed Nurse 'A' created the order on 1/18/23. An order for CLEANSE HEEL W/NS (with normal saline) BEATDINE <sic> (antiseptic solution) SOAKED GAUZE AND COVER W/ABD (abdominal pad - an absorbent dressing) and COVER W/KERLIX (gauze bandage) every day shift for WOUND CARE had a documented order date of 1/14/23 with a start date of 1/19/23. Further review of the order details revealed Nurse 'A' created the order on 1/18/23. On 1/18/23 at 5:30 PM, the above physician's orders were reviewed with the DON and Regional Clinical Director of Operations who confirmed the orders were not in place until that day, 1/18/23.

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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 pertains to Intake Number(s): MI00133578. Based on observation, interview, and record review, the facility failed to ensure one resident (R801) of three residents reviewed for accidents was transferred in a safe manner, resulting in increased pain and decreased mobility from a closed displaced fracture of the right femoral neck (thigh bone) which required surgical repair. Findings include: Review of a policy titled, Use of Gait Belt Policy, revised 12/2020, revealed, in part, the following: It is the policy of this facility to use gait belts with resident that cannot independently ambulate or transfer for the purpose of safety .It will always be the responsibility of each employee to ensure they have it available for use when at work .Failure to use gait belt properly may result in corrective action and/or termination . On 1/18/23 at 8:30 AM, R801 was observed sleeping in their bed. On 1/18/23 at 9:30 AM, R801 was lying in bed. An interview was attempted with R801 who appeared to be in a considerable amount of pain. R801 was tearful and repeatedly reported that they did not 'feel well' and that they 'hurt all over'. R801 was very difficult to understand due to their expressions of pain. R801 did report they 'broke her leg', but it was unclear how it happened as they continued to request to go to the bathroom, moan in pain, and report they did not feel well. On 1/18/23 at approximately 2:00 PM, R801 was observed up in their wheelchair attempting to self propel in the hallway of the unit. R801 was tearful and moaning and asking to go back to bed. At that time, CNA 'B' and Therapy Staff 'H' were observed transferring R801 into the bed from the wheelchair and used a mechanical lift. When moved, R801 grimaced and moaned in pain. Review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: schizoaffective disorder, disorders of bone density and structure, osteoarthritis, age related osteoporosis with current pathological fracture, right femur (not diagnosed until after the fracture on 12/24/22). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 required extensive physical assistance from at least two staff members for transfers and rarely experienced pain. The highest level of pain experienced by R801 during the assessment period was 2 with 10 being the highest level of pain. Review of R801's care plans revealed R801 required extensive assistance of 1 person assist (initiated on 6/30/21 and canceled on 1/10/23). The care plan was updated on 1/12/23 and it was documented that R801 required total assist with person - with mechanical lift). This indicated decline in R801's transfer status. Review of R801's progress notes revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Nursing Progress Note dated 12/24/22 at 9:00 PM documented, Late Entry .Assigned CNA (Certified Nursing Assistant) noted resident had c/o (complained of) pain and facial grimaces to right upper leg during transfer. Assigned CNA notified writer, writer observed right upper leg swollen and painful upon touch. Limited ROM (range of motion). A Nursing Progress Note dated 12/24/22 at 9:00 PM documented, Writer observed resident right upper leg swollen and painful upon touch. ROM is limited to right leg. No discoloration is noted to right leg. (Physician 'E') is notified via telehealth new order to send resident to (hospital) . A Practitioner Progress Note dated 12/24/22, written by Physician 'A', documented, .Patient was seen by video-conferencing with help of the nurse on duty .Complaining of pain in the right thigh - patient felt the pain while getting transferred .nurse on duty observed the swelling of the right thigh .There was apparently no fall . appears in pain and uncomfortable .swelling of the right thigh .Swelling/pain of the right thigh deformity suggesting right femoral fracture, likely pathological fracture secondary to osteoporosis as no traumatic event ? happened during routing transfer/care (It should be noted that the facility's investigation was not complete at the time of the physician's evaluation to determine if it could have occurred during care/transfer) .Patient to be transferred to the hospital for further evaluation and x-rays and management likely requiring .surgery . Further review of R801's care plans revealed there was no plan of care prior to their injury on 12/24/22 that addressed osteoporosis and risk of pathological fractures. Review of R801's hospital discharge summary revealed a diagnosis of Closed displaced fracture of right femoral neck (thigh bone) and it was documented R801 required intramedullary nailing (surgical repair) of the fracture. Review of R801's Pain Summary revealed R801's highest level of pain between 7/5/22 and 12/24/22 was '2' (out of a scale of one to 10 where 10 was the highest level of pain). On 12/24/22 at 6:28 PM, R801's pain level was documented as '7'. On 1/17/23, R801's pain level was documented as '8'. On 1/18/22 at 10:17 AM and 2:59 PM, R801's pain level was documented as '9'. Review of an investigation conducted by the facility revealed the following: (continued on next page)

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	235187	A. Building B. Wing	01/18/2023

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 0689 Level of Harm - Actual harm Residents Affected - Few	An Administrative Statement Investigative Analysis 5 Day Summary completed by the Administrator and Director of Nursing (DON) on 12/29/22 that documented, R801 .was a 1 person extensive assistance with transfers, bathing, and daily care .According to staff interviews, witness statements, and record review, (CNA 'F'), was assigned to the resident on 12/24/22 and states that she was transferring the resident back to bed from the wheelchair and that the resident did not complain of pain during the transfer, it was after the transfer that she started complaining of pain to her right leg. (CNA 'F') immediately notified (Nurse 'G') regarding the residents change of condition and complaints of pain to her right leg. (CNA 'F') was asked if anything happened during the transfer for example, did her leg hit an object or become twisted during the transfer and she stated no that 'I transferred her the same way I always do' .(Nurse 'G') completed a skin and pain assessment. Skin assessment identified that the right upper leg was swollen and painful upon touch. ROM was limited to the right leg. Pain assessment was completed, and (acetaminophen) was administered for pain .(Physician 'E') saw the resident via telehealth and gave ordered to transfer the resident to the hospital to rule out a fracture. His assessment and plan notes swelling to the right thigh with deformity suggesting right femoral fracture, likely pathological fracture secondary to osteoporosis as no traumatic event happened during routine transfer and care. Patient to be transferred to the hospital for further evaluation .No equipment was utilized to transfer the resident. Therefore, abuse, neglect or failure of equipment cannot be substantiated . Further review of the facility's investigation revealed no further questions were asked of CNA 'F' when they said they transferred R801 'the same way I always do'. On 1/18/23 at 3:05 PM, an interview was conducted with CNA 'F'. When queried about how staff knew a resident's transfer status, CNA 'F reported it was documented on the Kardex. When queried about R801, CNA 'F' reported they were assigned to the resident on 12/24/22. When asked if they assisted R801 with transferring on 12/24/22, CNA 'F' reported they did. CNA 'F' was asked to describe the technique they used when transferring R801. CNA 'F' stated, I pulled her wheelchair up to the bed like I normally do, locked the chair, grabbed the back of her pants, put my leg between her left and hoisted her up to the bed. CNA 'F' reported they did not use a gait belt to assist with R801's transfer. CNA 'F' further explained that R801 did not express any pain during that shift until after the transfer was conducted. On 1/18/23 at approximately 4:55 PM, an interview was conducted with the DON. When queried about how R801 was transferred by CNA 'F' on 12/24/22, the DON reported R801 was a one person assist and that was how CNA 'F' transferred them. When queried about whether CNA 'F' used the proper technique to transfer R801, the DON reported she did not inquire about that and only focused on whether R801 required one or two people for transfers. The DON reported no education was provided to CNA 'F' because it was only determined that she transferred with the right number of staff members, not the proper technique. When queried about whether residents should be transferred by the waste band of their pants and without a gait belt, the DON reported a gait belt should have been used.