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	05/12/2023

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 This citation pertains to Intake #: MI00135801 Based on interview and record review, the facility failed to initiate and maintain timely Cardiopulmonary Resuscitation (CPR) per standards of care, federal regulation, and the facility policy, resulting in an immediate jeopardy when one resident (R707), who was a full code (desired all life saving measures), was observed not breathing and did not have any vital signs. Licensed nursing staff's failure to verify code status and, respond timely and appropriately resulted in death of R707. This deficient practice placed all residents, who are designated as a Full Code and are found unresponsive at risk for not receiving timely CPR with a potential for serious harm and/or death. The IJ began on [DATE]. The IJ was identified on [DATE] at 1:30 PM, the Administrator was notified and a plan to remove the immediacy was requested. The immediacy was removed on [DATE] at 4:57 PM, based on the facility's implementation of an acceptable plan of removal verified on-site by the surveyor. Findings Include: A state agency report received from [local fire department] read, On [DATE], at 1759 hours [local fire department] units were dispatched to . Nursing Home .for a complaint of a cardiac arrest. While in route to the nursing home, nursing staff contacted the dispatch center to cancel the response due to the patient was in hospice with a DNR (do not resuscitate). [Local fire department] was canceled, and .Police Department was dispatched to take report on the deceased patient. While the police department was on scene, the nursing staff was not able to produce any DNR paperwork and when the hospice nurse arrived on scene, she stated that the patient was not a DNR. The fire department was dispatched again to respond to a CPR in progress. Patient was treated on scene with continued CPR and ACLS (advanced cardiac life support) treatments but was eventually pronounced on scene by Dr. (Name Omitted) at .Hospital with a Time of Death of 1840 hours. (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Due to nurse (name omitted) canceling EMS (Emergency Medical Services) prior to verifying if the patient had DNR paperwork on file, patient care was significantly delayed. Mission Point nursing home staff was also negligent by not starting patient care (CPR) and assuming the patient was a DNR. Calls to .Nursing Home Administration, (Name Omitted) .have not been returned as of [DATE] at 1555 hours. Record review revealed R707 was a long-term care resident of the facility. Most recently R707 was readmitted to the facility after hospitalization on [DATE]. R707's admitting diagnoses included cerebral infarction (stroke); seizures; bacterial pneumonia; and acute kidney failure. R707 had a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment. Review of R707's physician order dated [DATE], read Full Code. Further record review revealed that R707 had multiple hospitalization s during their stay at the facility. R707 had orders to be a Full code throughout their stay at the facility. Review of R707's facility form Titled Medical Treatment Decision Form dated [DATE], signed by the legal guardian read, CPR Full Resuscitation - I request that in the event my heart and breathing should stop, I am given resuscitating measures. The form also revealed that R707's legal guardian had marked YES to all the other treatment options such as hospitalization , artificial feeding, blood transfusion, intravenous fluids etc. listed on the form. Review of R707's Electronic Medical Record (EMR) revealed nursing progress notes dated [DATE] at 19:22 that read Upon rounds approx.(approximately) 17:20 writer observed sleeping in bed AEB (as evidenced by) chest rising and falling and no s/s (signs/symptoms) of distress, at 17:50 writer could not obtain any vital signs. CPR immediately initiated. 911 notified. Hospice notified. No supporting documents during the code pertaining documents of DNR status. EMS (emergency medical services) pronounce death. The progress note was completed by staff member A. A staff schedule provided by the facility for [DATE] was verified to confirm that the staff member A was assigned to care for R707 during that shift. A review of the 911 Response report from [local fire department] from the initial 911 call revealed the following timeline and details: An initial 911 call was placed at 17:59:10 (nine minutes after R707 was observed unresponsive with no vital signs). At 17:59:10 - [local fire department] 911 crew was dispatched to the facility for advanced life support. At 18:00:27 - [Local fire department] 911 crew en route to facility. At 18:01:09 - [Local fire department] received a call from the facility staff to cancel the dispatch. 911 dispatch was cancelled, and call was closed. Further review of the report read, that [local police department] was onsite at the facility after the initial 911 call was cancelled by the facility due to patient on hospice and a DNR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The report revealed that the facility was unable to produce a valid Do Not Resuscitate (DNR) document while the police department was on the scene. R707's hospice nurse arrived on the scene and reported that R707 was not a DNR. A second 911 call was placed at 18:29 by the law enforcement and the fire department was dispatched again to the facility. Review of the second 911 call response report from [local fire department] revealed the following timeline and details: At 18:29:50 - A second 911 call was placed after hospice nurse verified and reported that R707 was a Full Code(approximately 30 minutes after the resident was observed unresponsive with no vital signs). At 18:29:50 - [Local fire department] 911 crew was dispatched to the facility. At 18:30:47 - [Local fire department] 911 crew en route to facility. At 18:33:10 - [Local fire department] 911 crew was on the scene. At 18:37:42 - [Local fire department] 911 crew started working with R707. The [local fire department] response report also read in part, (police department) office (name omitted) has been on the scene with nurse (name omitted) since approx. 1800 hrs.states nurse on scene originally called and cancelled the EMS at approx. 1759 hrs. due to pt (patient) being on hospice with DNR. Officer states that facility originally could not find paperwork for pt. It was not until hospice nurse arrived on scene and paperwork was found and it was deemed that pt. was full code. At that time notified (police department) dispatch for EMS. Pt has been down for approx.(approximately) 1 hour. (Local fire department) took over CPR .[Local hospital] contacted for priority 4 traffic and request to terminate resuscitation. Dr (name omitted) was on the phone and advised of the situation with downtime being approx. an hour and delayed response due to error on nursing home staff .pronounced time of death at 1840 hrs. R71 cleared the scene and (local police department) left on scene. An interview was completed with the staff member A on [DATE] at approximately 10 AM. Staff member A was assigned to care for R707 on [DATE] during this event. Staff member A was queried on the sequence of events with R707. Staff member A reported that they remembered the event and provided the following details. They were doing rounds and noticed R707 was breathing during their initial observation. During the next observation they noticed that R707 was not breathing. Staff member reported that have checked the code status and R707 was a full code and they started CPR and called 911. Staff member was queried on how they had verified the code status. Staff member A reported that they had stayed with R707 and had asked the staff member B to verify the code status for the resident. Staff member B verified that R707 was a full code. Staff member A also reported that they had initiated the 911 call with their cell phone from R707's room. Staff member A reported that staff member B notified hospice. Staff member A confirmed that the hospice nurse arrived at the facility and reported that the police department and EMS arrived at the facility. Staff member A reported that they continued CPR until EMS arrived and EMS took over after. They did not recall anything that happened after. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff member A was queried specifically on the initial delay staff response, verification of code status, and cancellation of 911 call based on the EMS report. Staff member A reported that there were a lot of confusion. Staff member A reported that staff member B informed them of a DNR order from hospice notes and notes on the computer. Staff member A added that CPR was initiated after some time and were not able to recall how much time had lapsed before CPR was initiated. Staff member A reported that the 911 call was cancelled and was called again due to the confusion with R707's code status order verification. An initial interview was completed with Staff member B on [DATE], at approximately 10:30 AM. Staff member B was queried on the [DATE] event for R707. Staff member B reported that they remembered initiating a code and CPR and reported that R707 was receiving hospice services but they were a Full code. When queried on the time frame specifics on when they had found out R707's code status from hospice, Staff member B reported that they did not recall all the specifics. At approximately 11:45 AM, a follow up interview was completed with Staff member B. During the interview, Staff member B reported that there was confusion with checking the orders for R707. When queried on why there was confusion and how they had resolved during the code, Staff member B reported that they had checked the code status and assumed that R707 was a DNR. Staff member B reported that most of the times when residents were DNR when they received hospice services and that they notified staff member A that R707's code status was a DNR based on R707's hospice services. Staff member A verified that R707 was a full code after speaking with the hospice nurse. The statements, sequence, and specifics of the events were inconsistent. Staff member B reported that they took responsibility for the confusion, and they had received education from the facility administration. Further review of R707's EMR revealed a late entry tele-health physician progress note for [DATE] completed on [DATE] read in part, assessment and plan: apnea/pulseless emergency situation - instructed to do CPR if patient is full code/and to call emergency services An interview with attending physician, Dr. D was completed on [DATE], at approximately, 12:35 PM. Physician D was queried on the event for R707. Physician D reported that there was some confusion about the DNR status and added that R707 was receiving hospice services, but they were a full code. Physician D reported that the discussion was that the facility should proceed with CPR, if R707 did not have the appropriate DNR documentation. An interview was completed with Hospice Executive Director, Staff member E. Staff member E confirmed that the on-call hospice nurse was on site on [DATE]. Staff member E reported they would review and provide a summary of the call times and events. Staff member E also reported that calls to the hospice provider were received, triaged, and directed to the on-call nurses by their after hours on-call service team. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At approximately 1:30 PM, an interview was completed with the Director of Nursing (DON). The Administrator was present in the room during the interview. The DON was queried on the process of identifying code status, how the information was readily available for the nurses and the facility process on initiating a code. The DON reported the staff obtained the residents' code status from the EMR dashboard. If a resident was full code and observed nonresponsive, staff will check the code status, initiate CPR, call code blue and call 911. The DON also reported that staff will continue CPR and follow the process until EMS arrives. The DON showed this Surveyor on the EMR where code status appeared on a resident dashboard. The DON further reported that if staff did not see any code status on the resident dashboard, then the resident was considered full code, and staff initiated the CPR and followed the facility policy. The DON reported that R707 was receiving services from a hospice provider, but they were a full code. The DON was queried on the specifics on delay in CPR initiation and EMS call cancellation. The DON reported that there was a note from the hospice nurse that indicated R707 was a DNR when R707 was admitted to hospice. Staff member B without appropriate documentation, placed an order in the chart prior to this event. The DON reported that Staff member A who was assigned to care for R707, initiated CPR when the resident was unresponsive. Staff member B notified Staff member A that R707 was a DNR during CPR and the code was stopped. Staff members A and B were counseled and educated after the event. The DON was queried on the cause of the system failure. The DON reported that cause of system failure was due to placing an order on resident's EMR without appropriate documentation and the nurse who initiated the CPR did not review and follow the code status that was in R707's EMR. A review of the hospice summary note received via email on [DATE] at 2:37 PM, from Staff member E revealed, R707 was admitted for hospice services on [DATE]. R707 was a full code and the guardian would not sign a DNR order. An after hours triage nurse note dated [DATE] at 7:16 PM, read in part, Caller is (name omitted) from (facility) Re: R707 is full code and transitioning. Writer told her that we also have her as full code. Asked if family came in to sign DNR, would they honor it? If not, they had to send her out to the hospital . On [DATE], at approximately 1:45 PM, the Administrator and DON reported that they have identified the issue the same day after it had happened and followed up. The Administrator and DON reported that they had completed a past noncompliance documentation for the identified issue, provided staff education, and completed audits of all code status for all residents. The DON reported that they were at the facility after the event and had started the staff education. The facility provided a past noncompliance binder with a description of the incident, root cause analysis, staff education and systemic changes made to correct the identified areas that needed improvement. A review of the facility policy titled Cardiopulmonary Resuscitation - Adult with a most recent revision date of , d+[DATE] read in part, Appropriate cardiac and respiratory function will be maintained until a definitive treatment can be given. CPR will be initiated on all residents with an advanced directive stating 'CPR full resuscitation' except in circumstances where you are responding to an emergency (drowning, choking, or electrocution). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	It is the policy of this facility to respect each resident's individual, informed decision regarding advanced directives and code status. Cardiopulmonary resuscitation (CPR) will be initiated for residents who have requested CPR not formulated an advanced directive and for residents who do not have valid DNR order. To provide basic life support (BLS) to residents with the absence of respiration and pulse, as designated by the resident or legal guardian except in circumstances listed above . The Administrator provided the following accepted Immediate Jeopardy Removal Plan: The facility took the following actions to address the citation and prevent any additional residents from an adverse outcome. This immediate jeopardy removal plan is submitted as the facility's immediate actionable response that was executed to remove the likelihood that any similar event will occur. Description of Incident: On [DATE], the assigned nurse did not follow the advance directive as designated per facility protocol. The nurse was confused by what was documented in [EMR] versus the hospice book and did not know how to validate the resident code status. Resident # 707 Status at time of event: Hospice but FULL CODE . Diagnosis: Seizures, Cerebral Infarction, Hemiplegia and Hemiparesis, Encephalopathy, Dysphagia, Gastrostomy, Protein-Calorie Malnutrition, Expressive Language Disorder, Obesity, Muscle Wasting and Atrophy, Lack of Coordination, Anemia, Lymphocytopenia, Nutritional Deficiency, Unspecified Fracture of Left Acetabulum, Sequela, Muscle Weakness, Dementia, Dysarthria, Osteoarthritis, Alkalosis, Arthropathy, Major Depressive Disorder, AKF (acute kidney failure), Adult Failure to Thrive, Paranoid Schizophrenia, and HTN (hypertension). Date of event: [DATE] Element # 1 The affected resident no longer resides at the facility. All current residents have the potential to be affected by this practice. On [DATE] the Director of Nursing/ designee will complete an audit of all current resident Advance Directives to ensure that the physician orders match the designation and supporting documentation is complete per facility protocol. No other issues identified. The Medical Director was notified on [DATE] by the Administrator of this event. Element # 2 The two direct nurses were nurse 1 and nurse 2 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] all Advance Directives were reviewed to ensure that the physician's order matches the designation and all supporting documentation is complete per facility protocol. No other issues identified. On [DATE] the DON reviewed the Residents Rights Regarding Treatment and Advance Directives and CPR policies and deemed both appropriate. On [DATE] Improved communication between Social Worker and nursing related to Advance Directives is discussed in the morning meeting. All staff working on [DATE] were interviewed and statements obtained for the investigation. The DON interviewed the involved staff on [DATE]. Element # 3 In-servicing for all facility nurses was started immediately on [DATE] by the Director of Nursing/ designee regarding the facilities standard of practice related to Advance Directives with emphasis on how to validate code status and CPR. Staff nurses will not be able to work the floor until they are in-serviced. The In-service addressed the following: 1. Standard of practice related to Advance Directives with emphasis on how to validate a code status and to be and what supporting documentation is needed. 2. Received education on CPR. All new hires will receive education and training on Advance Directives during orientation. Element # 4 On [DATE] the Director of Nursing/ designee will conduct audits of all new/ re-admissions daily, Monday through Friday x 4 weeks and then weekly x 2 weeks then monthly x2 to ensure the physicians order matches the designation on the Advance Directive and supporting documentation is complete per policy. Mock codes to be conducted annually. The findings will be submitted to QAPI (quality assurance performance improvement) monthly to determine if substantial compliance is present or further monitoring is required. Any concerns identified will be addressed immediately. The Administrator is responsible for sustained compliance. Ad hoc QAPI held on [DATE] The facility alleges the immediacy of these discrepancies have been removed on [DATE] based on the Past Non-Compliance documentation submitted.