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	08/26/2021

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation contains two Deficient Practice Statements (DPS) DPS #1 Based on observation, interview and record review, the facility failed to ensure two residents (R32 and R33) and six residents who attended a confidential Resident Council meeting were treated in a dignified manner. Findings include: On 8/25/21 at approximately 11:05 AM, a group interview was conducted with six cognitively intact residents who wished to remain anonymous. During the meeting the resident's expressed a concern that staff were entering into their rooms without knocking, would not provide their names and/or what care they were going to provide, and often would just turn off their call lights off and say they would return and would either not return or return several hours later. A review of the past Resident Council Meeting Minutes (5/21 through 8/21) documented, in part, the following: Short staffed .want to know who aides are . staff coming in . call lights not answered . R32 At 6:38 AM, LPN S was observed to have entered into R32's room without knocking on the resident's door. LPN S placed their items on the bedside table and turned on the resident's wall light above their bed and proceeded to provide G-tube care, medication and bolus feeding. LPN S did not inform the resident of their name or position. Review of the medical record revealed R32 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: quadriplegia and gastrostomy. A MDS assessment dated [DATE] documented in part resident is rarely/never understood and required staff assistance for all ADLs. R33 (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/24/21 at 5:25 AM, while conducting a Medication Observation with Licensed Practical Nurse (LPN) S, it was observed that LPN S had entered into multiple resident rooms without knocking on the resident doors or introducing themselves. At 5:52 AM, LPN S entered into R33's room, turned on the room light and proceeded to R33's bed to provide G-tube care and administered bolus feeding. R33's awakened due to LPN S attempting to obtain the resident's gastrostomy tube. LPN S did not inform the resident of their name or position. Review of the medical record revealed R33 was admitted into the facility on [DATE] with a readmitted [DATE] and diagnoses that included: hemiplegia and hemiparesis following cerebral infarction, gastrostomy status and dementia. A MDS assessment dated [DATE] documented a BIMS of 15 indicating intact cognition and requiring staff assistance for all ADLs. On 8/25/21 at 2:02 PM, the Director of Nursing (DON) was interviewed and asked about the above concerns and stated in part, No, this is their (resident's) home and we are to respect that. The staff is supposed to knock before entering the rooms and tell the residents who they are. On 8/26/21 at approximately 7:49 AM an interview was conducted with Activity Director (AD) V. When asked about the resident's expressing concerns that staff are not knocking before entering their rooms and/or providing their names and care to be provided, AD 'V reported that she was not sure as to why that was continuing as it had been addressed to staff. On 8/26/21 at approximately 12:47 PM, a phone interview was conducted with the Administrator. When asked about residents expressing concerns about staff not knocking or providing their names prior to entry, the Administrator indicated that she was aware of those concerns and reported that staff should always knock and introduce themselves when entering a room. She indicated she was aware of the concerns. A facility policy titled Promoting/Maintaining Resident Dignity last reviewed on 12/20 documented in part, . It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality . Respect the resident's living space . Assist residents to participate in activities of choice . DPS #2 Based on interview and record review, the facility failed to ensure non-smoking residents were given the same opportunity to go outside as residents who smoke as expressed by five of six residents who attended a confidential Resident Council meeting. Findings include: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/25/21 at approximately 11:05 AM, a Resident Council meeting was held with six cognitively intact residents who wished to remain anonymous. When asked about life in the facility, the residents reported feeling like they were not given the same opportunity to go outside in the facility courtyard as residents who smoked. The residents explained that for those residents that smoked, they had scheduled times and would be escorted outside with staff. One resident explained that if they asked if they could go outside with the smokers the staff will tell me No because they can't handle extra residents. Another resident expressed that they felt like they felt like they were in a correctional facility and never allowed outside. The residents further stated that if they asked to go outside during non-smoking hours, they would be told there was not enough staff to take them out. The residents stated that access outside was not permitted without staff and there was a code to enter into the enclosed courtyard. On 8/26/21 at approximately 07:49 AM, an interview was conducted with Activity Director (AD) V AD V was asked about how resident were able to exit the building into the enclosed courtyard, AD V explained that generally Activity Aides would escort residents out during smoking hours and indicated that they often would not take out the non-smokers as there was a lack in staff supervision. When asked why non-smokers could not be taken out at other times during the day, AD V reported that often Staff would be inside doing indoor activities with the other residents and would not have time to take residents outside. On 8/26/21 at 12:47 PM, a phone interview was conducted with the Administrator. When asked why non-smoking residents were not able to go outside in the courtyard in the same manner smoking resident were, the Administrator reported that she was fairly new to the facility and was not aware the residents had expressed concerns. The Administrator did note that staffing was low, and they had hired staff that had not started yet. The Administrator did state that all residents, not just smokers, had a right to go outside. A facility policy titled Promoting/Maintaining Resident Dignity last reviewed on 12/20 documented in part, . It is the practice of this facility to .care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality . Respect the resident's living space . Assist residents to participate in activities of choice . 41415

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to Intake # MI00121870 Based on observation, interview, and record review, the facility failed to timely notify the physician of a resident's change in condition to ensure timely hospital treatment after a fall for a resident with a diagnosis of thrombocytopenia (a condition characterized by abnormal low levels of platelets generally requiring emergency care following major injury) for one (R31) of one resident reviewed for quality of care/falls, resulting in pain, severe bruising, an extended stay in the hospital and delay in diagnosis of a C2 (cervical spine) fracture. Findings include: A complaint was filed to the State Agency by a (name redacted) hospital staff that alleged concerns regarding a failure to seek immediate treatment after a fall due to the extent and severity of the injuries. The Complainant noted the residents face and neck area were severely bruised and swollen upon admission and the resident had a fractured left forament transversarium at the CT vertebrae. Review of (name redacted) hospital records documented, in part: In ED (emergency department), was found to have a significant hematoma with facial ecchymosis (bleeding under skin caused by bruising), C2 fracture . pancytopenic with platelet of 45 (a condition in which there is a lower-than normal number of red and white blood cells and platelets in the blood) .History of Present Illness .(name redacted) presents to the hospital apparently 5 days after multiple falls .She has extensive ecchymosis over her face, neck, and shoulders and is . thrombocytopenic (low platelet count) .Fracture of the left foramen transversarium at C2 .Per the EMS (emergency medical services) run sheet documentation she was sent here for a second opinion after the falls, although the reason for the delay is not appropriate. The patient herself is demented with markable impaired memory, she becomes quite tearful when asked a question she cannot answer .The resident reports posterior neck pain .Wound Care .Purple, diffused, irregular shaped ecchymosis to the forehead, peri orbital, eyes areas that extend under chin and cervical, back probable residual bleeding .Purple ecchymosis to L anterior forearm approximately 13 x 5 cm (centimeters) . On 8/24/21 at approximately 12:39 AM, R31 was observed with bruising covering her entire face and neck. Bruising was also noted on the right arm. A second observation was made on 8/25/21 at approximately 8:59 AM, again the resident was observed to have bruising of dark purple/black color over her entire face, neck, right and left arms. The resident reported having pain from lying in bed for so long but was not able to provide any information as to the fall and/or hospitalization . A review of the resident's clinical record documented that the resident was initially admitted to the facility on [DATE] with diagnoses that included: Type II diabetes, schizoaffective disorder, dementia with behavior and anxiety. A review of R31's Minimum Data Set (MDS) indicated the resident was significantly cognitively impaired. Continued review of the resident's record documented, in part, the following: (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Nursing Progress Note (8/5/21-3:08 PM): Writer was informed by staff the resident was on floor .observed resident on floor in supine position face down .Hematoma/Laceration to right side of skull . (Authored by Nurse 'X) Nursing Progress Note (8/5/21 - 10:34 PM): .Pain assessment: 5 patient cries out during any movement to her entire body. patient medicated times 1 with some relief . Nursing: Post Fall Documentation (8/6/21- 11:05 PM): Pain Assessment . Res did not give a numerical number but did say she was in pain .Res had bruising to the entire right side of her face, her neck and arm . Nursing: Post Fall Documentation (8/7/21- 9:00 PM): Pain Assessment 4/10 .Discoloration/bruising to the right side of face, neck, chin and left forearm. Laceration to top head . Nursing Progress Note: (8/9/21 - 4:20 PM): doctor request for patient to be sent to (name redacted) hospital . patient face and neck remains bluish in color. patient c/o (complains of) generalized body pain and medicated without relief . An Incident/accident report (date 8/5/21) was reviewed and documented, in part, the following: Resident (name redacted) R31 .Incident location .Resident's room .Nursing Description: Writer was informed by staff that resident was on floor between bed and nightstand. Observed resident on floor in supine position face down .Hematoma/laceration to right side of skull .STAT X-Ray .Injury Type .Bruise 1) top of scalp . Hematoma 1) Top of Scalp . R31's Care plan documented, in part: Focus: I have thrombocytopenia (a condition characterized by abnormal low levels of platelets) .Interventions .Observe for abnormal bleeding, bruising .weakness .: (11/24/21) A Radiology Results Report dated 8/5/21 documented in part, Procedure .Skull less than 4 views .Reason for Study .Localized swelling, Mass and Lump, Head .Findings: no acute fracture .Conclusions: Normal skull series. Skull radiographs are insensitive for subtle abnormalities. If clinical concern continues to exist, further workup with CT imaging is recommended . An attempt to contact Nurse X was made on 8/26/21 at approximately 8:20 AM. No contact was made, and the Facility reported the nurse was out on leave. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 8/26/21 at 9:50 AM an interview and record review were conducted with MD (Doctor of Medicine) W regarding R31. MD W reported that he was aware of R31's fall and had viewed her hospital records including photos and was aware of her severe bruising and fracture. He stated that residents who sustain a head trauma, like R31, should be sent out immediately to the hospital for further assessment and noted that he was not made aware of the situation on 8/5/21, but on 8/9/21 ordered the resident to be sent to the hospital. MD W indicated that Physician Extender Y may provide further information with respect to delayed hospital care. With respect to R31's diagnosis of thrombocytopenia he indicated that he was aware the resident had a low Platelet count and stated he had been in contact with the Hematologist yesterday. When asked when CBC (complete blood counts) should be obtained for residents with thrombocytopenia, he reported they should be completed monthly. When asked why the last CBC was completed in 11/2020, MD W indicated that it should have been done monthly. In addition, he stated that if a resident has a Platelet level under 15, they should be sent immediately to the hospital and residents who have bleeding should also be addressed immediately. On 8/26/21 at 11:20 AM, an interview was conducted with the Director of Nursing (DON) regarding a delay in hospitalization following R31's fall. The DON reported that he was aware of the fall and returned to the facility on Monday, August 9, 2021, and noted that R31 was severely bruised everywhere and needed to be sent to the Hospital for further evaluation. When asked if given the residents diagnoses, bruising and reported pain, should the resident have been sent out earlier, the DON reported that they should. On 8/26/21 at approximately 3:01 PM a voice message was left with Physician Extender Y. No return call was made prior to the end of the Survey. The facility policy titled, Change of Condition and Physician Notification documented, in part: .Physical Symptoms .If any one of these items occur contact the physician .Pain .New onset that is greater than 4 on 10-point scale .Pain worsening in severity or duration .Vital signs .Complete blood count .Platelets less than 50,000 .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to immediately report an allegation of physical abuse for one (R127) of six sampled residents reviewed for abuse, resulting in an allegation of abuse that was not reported to the State Agency and delayed notification to the Nursing Home Administrator/Abuse Coordinator. Findings include: On 8/24/21 at 8:12 AM, during an interview with an alert resident who wished to remain anonymous, they reported concerns about about a resident who had a fall and alleged abuse that this resident was being held down by Certified Nursing Assistant (CNA 'H'). The resident further reported that CNA 'H' had been fired because of this alleged abuse. When asked when this had occurred, the resident reported it was not this past weekend, but the one before. On 8/25/21 at 9:40 AM, an interview was conducted with the Director of Nursing (DON) and Senior Administrator (Staff 'F') who was covering for the current Administrator (who was also the facility's Abuse Coordinator). At that time, when asked about whether they were aware of an abuse allegation which involved an employee and a resident, the DON confirmed there was a current abuse investigation which involved R127, CNA 'H' and two other employees. The DON reported CNA 'H' had been suspended pending the facility's abuse investigation and as of this time remained suspended. The DON and Staff 'F' were requested to provide any documentation of their investigation into this abuse allegation. Review of the clinical record revealed R127 was admitted on [DATE] and discharged on [DATE] to the hospital with diagnoses that included: heart failure, age-related physical debility, unspecified injury of unspecified kidney, and other intervertebral disc degeneration lumbar region. The Minimum Data Set (MDS) assessment dated [DATE] was still in progress and not completed/submitted at this time. On 8/25/21 at 11:20 AM, review of the documentation provided by the facility included R127's face sheet, a typed summary and three typed interview forms. The interviews forms indicated they were conducted on 8/14/21 but the DON's signature was dated as completed on 8/16/21. Review of the abuse investigation summary provided (which was not dated, or signed) read, ON <sic> 8/14/21 the DON was notified about 2:30 pm that resident was picked up off the floor by three aides and that two of the aides did not think it looked appropriate. The staff member was immediately suspended pending an investigation . On 8/25/21 at 11:51 AM, an interview was conducted with the DON and Staff 'F'. When asked when this summary had been completed, the DON reported they had written the summary today. When asked when they were first notified of the abuse allegation, the DON reported they had received a call from CNA 'I' after CNA 'I' had tried to contact the Administrator but did not get a call back. The DON reported CNA 'I' called them and reported concerns about the way CNA 'H' was handling the resident following a fall. When asked what time they were notified, the DON reported they were called about 2:30 pm and the DON told the nurse on the floor to send CNA 'H' home and didn't want them in the building. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON further reported they called the other CNA (CNA 'G') and they reported the manner in which CNA 'H' held down R127 didn't look right. When asked whether that allegation had been reported to the State Agency, the DON reported it had not because they determined it wasn't abuse. When asked how that was determined since their investigation had not been completed, and CNA 'H' remained suspended, the DON reported they should have reported this abuse allegation immediately to the State Agency, then completed their investigation to determine the outcome at that time. When asked for the specific reason why CNA 'H' had been suspended and remained suspended, the DON reported the reason was for an abuse concern. The DON and Staff 'F' acknowledged the concern with lack of reporting. On 8/25/21 at 3:10 PM, a phone interview was conducted with CNA 'H'. When asked to recall the events from 8/14/21, CNA 'H' reported they had assisted CNA 'I' and CNA 'G' with R127 who was laying on the floor. When asked what time this had occurred, CNA 'H' reported, .Took four of us to put (R127) in bed. Next thing at 2:30 (PM) I'm getting walked out. It happened maybe between 9:00 AM and 10:00 AM. It was after the breakfast trays were out. The next thing you know been accused of abusing (R127). CNA 'H' identified Licensed Practical Nurse (LPN 'J' and LPN 'K') were present at that time. On 8/25/21 at 3:30 PM, an interview was conducted with LPN 'K'. When asked to recall the events from 8/14/21, LPN 'K' stated I didn't know about anything until when (name of DON) called me to walk him (CNA 'H') out. When asked what CNA 'H' was told about the reason for the suspension and walk out, LPN 'K' stated, For possible abuse. On 8/25/21 at 11:20 AM, a phone interview was conducted with CNA 'I'. When asked to recall the events from 8/14/21, CNA 'I' reported, I was doing my rounds and found (R127) on the floor. I called two other co-workers to help me get him off the floor (CNA 'H' and CNA 'G'). We (CNA 'I' and CNA 'G') didn't care for the way CNA 'H' handled the resident. Was like a police hold from behind and we told him to stop and he didn't at first we kept telling him to stop. When asked what time of day this happened, CNA 'I' stated, I wanna say like 10:00 AM or 11:00 AM. There were no lunch trays so it was before that. When asked if they had reported their concerns to anyone at that time, or if they had waited until closer to the end of their shift, CNA 'I' reported, At that time. I tried to contact the Administrator but she didn't respond so I called the DON. On 8/26/21 at 12:50 PM, a phone interview was conducted with the Administrator. When asked about the events from 8/14/21 and what they could recall, the Administrator reported, I was notified by the DON after staff talked to me .Asked staff to make a statement. Staff was (CNA 'I'). It was on a Saturday I can't recall the time. Already aware of concerns with my investigation. My apologies I didn't finish. When asked if that allegation should have been reported to the State Agency, the Administrator reported it should've and there should also be an investigation completed in five days. The Administrator was informed of the concern that this alleged incident had occurred at some point after breakfast and before lunch as reported during interviews with the staff involved, but the DON and the Administrator had not been notified until approximately 2:30 PM. The Administrator reported staff were to report immediately and was unable to provide any further explanation. Review of the facility's policy titled Abuse, Neglect and Exploitation dated 12/2020, documented: .Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies .within specific timeframe .Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to complete a timely and thorough investigation of alleged physical abuse for one (R127) of six residents reviewed for abuse. Findings include: On 8/24/21 at 8:12 AM, during an interview with an alert resident who wished to remain anonymous, they reported concerns about about a resident who had a fall and alleged abuse that this resident was being held down by Certified Nursing Assistant (CNA 'H'). The resident further reported that CNA 'H' had been fired because of this alleged abuse. When asked when this had occurred, the resident reported it was not this past weekend, but the one before. On 8/25/21 at 9:40 AM, an interview was conducted with the Director of Nursing (DON) and Senior Administrator (Staff 'F') who was covering for the current Administrator (who was also the facility's Abuse Coordinator). At that time, when asked about whether they were aware of an abuse allegation which involved an employee and a resident, the DON confirmed there was a current abuse investigation which involved R127, CNA 'H' and two other employees. The DON reported CNA 'H' had been suspended pending the facility's abuse investigation and as of this time remained suspended. The DON and Staff 'F' were requested to provide any documentation of their investigation into this abuse allegation. Review of the clinical record revealed R127 was admitted on [DATE] and discharged on [DATE] to the hospital with diagnoses that included: heart failure, age-related physical debility, unspecified injury of unspecified kidney, and other intervertebral disc degeneration lumbar region. The Minimum Data Set (MDS) assessment dated [DATE] was still in progress and not completed/submitted at this time. Additionally, there were no progress notes or any other details regarding R127's fall on 8/14/21. On 8/25/21 at 11:20 AM, review of the documentation provided by the facility included R127's face sheet, a typed summary and three typed interview forms. The interview forms documented the date of the interviews were 8/14/21 and the person that conducted the interview was the DON, but not signed until 8/16/21. The three interviews included: R127, CNA 'G', and CNA 'I'. There were no interviews conducted from any of the nurses, CNA 'H', or other residents. Review of the summary provided (which was not dated, or signed) read, ON <sic> 8/14/21 the DON was notified about 2:30 pm that resident was picked up off the floor by three aides and that two of the aides did not think it looked appropriate. The staff member was immediately suspended pending an investigation . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/25/21 at 11:51 AM, an interview was conducted with the DON and Staff 'F'. When asked when this summary had been completed, the DON reported they had written the summary today (11 days following the alleged abuse). When asked about their process for investigating abuse allegations, the DON reported the facility should complete an investigation and determine if abuse was substantiated at that time. The DON and Staff 'F' were informed of concerns with their lack investigation into the abuse allegation and both acknowledged similar concerns. When asked why CNA 'H' remained suspended, the DON reported they still had not completed their investigation and Since (CNA 'H') was contingent and requested to pick up work was not as much of a rush. When asked if they had obtained interviews from any other staff such as the nurses, or any other residents to see if they had similar concerns, the DON reported they did not and was unable to offer any further explanation. On 8/25/21 at 11:26 AM, a phone interview was conducted with CNA 'G'. When asked to recall the incident from 8/14/21, CNA 'G' recalled similar events as identified in the summary. When asked if anyone from Administration had followed up with them about this alleged incident, CNA 'G' reported the DON had just called them about 30 minutes ago trying to recall date of the incident and get details from 8/14/21. CNA 'G' reported they had completed a written statement on 8/14/21 and had given that to the nurse (this was not included in the documentation provided by the facility). On 8/25/21 at 1:11 PM, the DON reported they had spoken to the Administrator by phone and was able to find written statements from CNA 'G' and CNA 'I' from 8/14/21. On 8/25/21 at 3:10 PM, a phone interview was conducted with CNA 'H'. When asked to recall the events from 8/14/21, CNA 'H' reported they had assisted CNA 'I' and CNA 'G' with R127 who was laying on the floor. When asked what time this had occurred, CNA 'H' reported, .Took four of us to put (R127) in bed. Next thing at 2:30 (PM) I'm getting walked out. It happened maybe between 9:00 AM and 10:00 AM. It was after the breakfast trays were out. The next thing you know been accused of abusing (R127). When asked if anyone had contacted them to obtain a statement from the alleged abuse, CNA 'H' reported, Nobody has called me since August 14th. Either tell me I'm fired, suspended or something .I'm in a position where I haven't heard nothing since I got walked out. On 8/26/21 at 12:50 PM, a phone interview was conducted with the Administrator. When asked about the events from 8/14/21 and what they could recall, the Administrator reported, I was notified by the DON after staff talked to me .Asked staff to make a statement. Staff was (CNA 'I'). It was on a Saturday I can't recall the time. Already aware of concerns with my investigation. My apologies I didn't finish. Review of the facility's policy titled Abuse, Neglect and Exploitation dated 12/2020, documented: .An immediate investigation is warranted when suspicion of abuse .or reports of abuse .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 on the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause .Providing complete and thorough documentation of the investigation .

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Mission Point Nsg Phy Rehab Ctr of Madison Heights	31155 Dequindre Madison Heights, MI 48071

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan to address the use of bed rails for one resident (R1) of 22 residents whose care plans were reviewed. Findings include: On 8/25/21 at 11:10 AM, R1 was observed laying in a bariatric bed with bilateral quarter metal (silver) bed rails which were in the raised position. When asked about their use of the bed rails, R1 stated, They come as part of the bariatric bed. When asked how long they had the bariatric bed, R1 reported, I'm not sure, was out of it when first came in. According to the facility's policy titled, Bed Rails dated 12/2020 documented, .Initiate a Care Plan . Review of the clinical record revealed R1 was admitted into the facility on [DATE] with diagnoses that included: contusion of unspecified hip, contusion of right knee, encephalopathy, and morbid obesity due to excess calories. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R1 had severe cognitive impairment, required extensive assistance of two or more people physical assistance for bed mobility and transfers. The section of the MDS for restraints which included bed rails, indicated they were not in use. Review of the care plans revealed there was no care plan initiated to identify the resident's use of bed rails. On 8/25/21 at 9:15 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's use of bed rails on resident beds, the DON reported, We don't use side rails. We use enablers. I'm not aware of any, I don't think we have anyone that uses them. The DON was requested to provide any documentation regarding resident's use bed rails including any care plans. On 8/26/21 at 9:25 AM, the DON reported they had initiated care plans for residents using side rails today.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 41415 Based on observation, interview and record review, the facility failed to ensure medications was administered according to professional standards of practice for one R77 of six residents reviewed for medication observation. Findings include: On 8/25/21 at 8:19 AM, a medication observation was conducted with Licensed Practical Nurse (LPN) L . While preparing medications for a resident, LPN L opened the top drawer of the medication cart revealing a plastic medication cup containing four pills. LPN L quickly closed the drawer and was asked to reopen the drawer. The medication cup was labeled with a resident's room in black marker. Two big white pills, one small white pill and one yellow pill was identified. When asked, LPN L stated in part, I get so busy sometimes and she (R77) gets her pills crushed, so it helps me to pre-pour hers. At the time of the observation, LPN L was preparing medications for another resident, however LPN L had already prepared medications for R77 and stored it in their cart. LPN L acknowledged that they shouldn't have prepared R77's medications without administering them before preparing and administering medications for other residents. Observation of the prepared medication for R77 contained the following: Aspirin 81 mg (milligram) chewable tablet, Metformin HCL 1000 mg tablet, Xanax 0.25 mg tablet and Senna Lax tablet. On 8/25/21 the Director Of Nursing (DON) B was interviewed and asked if it was normal protocol for the nurses to prepare medications and store them in their medication cart while preparing and administering medications for other residents. The DON B replied, absolutely not, it's unacceptable practice. At this time the facility policy for medication administration was requested, however not provided by the end of survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record review the facility failed to follow up with the neurologist as recommended by the hospital for one R68 of three residents reviewed for hospitalization s. Findings include: On 8/24/21 at 8:48 AM, R68 was observed sitting up in their bed. R68 was interviewed and answered all questions appropriately. Review of R68's medical chart revealed the resident was transferred to the hospital on 5/8/21 and 7/16/21. Review of a hospital History and Physical dated 5/9/21 documented in part, Chief Complaint- Breakthrough seizure . past medical history significant for seizure disorder . came to the hospital from extended care facility with a breakthrough seizure at facility patient did not recall event . was seen by neurology started on IV (Intravenous) Keppra IV fluid hydration she was admitted for further evaluation and treatment Review of a hospital Patient Discharge Summary dated 5/10/21 documented in part, Recommended Follow Up Information . (Doctor name redacted) Neurology . Follow Up Within 3-7 days Review of a Physician Progress Note dated 5/18/21 at 2:43 PM, documented in part (R68) is currently in observation unit due to being sent to the hospital . Impression . convulsions . PLAN . follow up with neurology when feasible R68 was admitted into the facility on [DATE] with a readmitted [DATE] and diagnoses that included: epilepsy, convulsions, and cerebral palsy. Review of the clinical record revealed no follow consultation documented with Neurology. Review of a Nursing Progress Note dated 7/16/21 at 6:00 PM, documented in part Resident had a grand mal seizure that lasted 7 minutes during dinner time. MD (Medical Doctor) notified, and the resident was send <sic> to the hospital via 911. Review of a SBAR (Situation Background Assessment Recommendation) Summary for Providers dated 7/16/21 at 6:01 PM, documented in part . resident had a seizure while she was in her bed for 7 minutes. During the seizure she urinated on her and she was constantly screaming . HR (heart rate) was 145 . Review of a hospital Patient Discharge Summary dated 7/19/21 documented in part, . DIAGNOSIS: Breakthrough seizure . Review of a Physician Progress Note dated 8/5/21 at 7:02 AM, documented in part . convulsions . follow up with neurology when feasible . Review of the clinical record revealed no follow up with Neurology documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/25/21 at 3:56 PM, the Director of Nursing (DON) B was asked to provide all Neurology consultation reports from May 2021 to current. On 8/26/21 at 3:52 PM, DON B stated the facility was unable to find a Neurology follow up consultation report. The DON stated they attempted to contact the Neurologist to see if the patient followed up in their office, however the Neurologist office was closed.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to ensure adequate assessment and restorative services and treatment to maintain range of motion (ROM) and mobility for one (R14) of two residents reviewed for ROM services, resulting in the lack of planned restorative services and R14's functional decline in mobility. Review of the clinical record revealed R14 was admitted into the facility on [DATE] with diagnoses that included: spinal stenosis (spinal column narrows and compresses the spinal cord), stiffness of right and left hip and osteoarthritis. According to the Minimum Data Set (MDS) assessment dated [DATE], R14 scored 15 on the Brief Interview for Mental Status (BIMS) exam, indicating R14 was cognitively intact. The MDS assessment also indicated R14 required the extensive to total assist of staff for all activities of daily living (ADL's). On 8/25/21 at 2:30 PM, R14 was observed lying in bed. R14 was asked if they were getting Physical Therapy (PT). R14 explained they had a while ago, but they needed therapy again because they couldn't walk and they wanted to be able to go to the bathroom by themselves. When asked if anyone at the facility did ROM exercises with them, R14 explained they tried to move their ankles and feet themselves sometimes, but no one at the facility did that. R14 further explained when they stood up, their feet felt like mushrooms and they could not walk. On 8/25/21 at approximately 3:00 PM, the Therapy Director (PT M) was interviewed and asked if R14 was receiving therapy. PT M explained R14 did receive therapy but had been discharged from therapy and was receiving Restorative Services. Review of R14's PT Discharge Summary for Dates of Service 5/21/21 - 7/4/21 read in part, .Mobility: .Walk 150 feet = Partial/moderate assistance . Mobility Function Score (ranges from 0 - 12; 12 being the highest function) 5 . Functional Maintenance: .Range of Motion Program Established / Trained: AROM (assisted range of motion) to BLE (bilateral lower extremities) in abailable [sic] ROM during ADL care . signed by PT M on 7/4/21. Review of the PT Evaluation & Plan of Care for R14 dated 8/26/21 read in part, .Mobility: .Walk 10 feet = Not attempted due to medical conditions or safety concerns . Mobility Function Score (ranges from 0 -12; 12 being the highest function = 2 . Clinical Impressions: . Patient was able to ambulate ~ (approximately) 150 ft wit [sic] 2WW (2 wheeled walker) with CGA (contact guard assist) as of 7/4/21 with PT. Patient stated that she hasn't walked for a mouth and wanted to walk again. Patient has good potential to improve her ambulation to PLOF (prior level of functioning) with skilled PT . On 8/26/21 at 1:06 PM, Certified Nursing Assistant (CNA) O, who was R14's assigned CNA was interviewed and asked if R14 was supposed to get Restorative ROM care. CNA O explained she did not know if R14 got Restorative care or not, but it would be in their Kardex (a care guide) if they did. Review of R14's Kardex revealed no mention of range of motion exercises. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 8/26/21 at 1:11 PM, CNA P, who was the facility's Restorative CNA, was interviewed and asked about Restorative services at the facility. CNA P explained for the past six to seven months, she had been pulled off Restorative and worked the floor as a CNA. CNA P further explained in a pay period, of the nine days she worked, she would get maybe two days to do Restorative, but on those days, she was busy weighing residents and really only had time to try to work with the resident with splints. When asked how residents were getting ROM exercises, CNA P explained the CNA's should be doing them. On 8/26/21 at 3:22 PM, the Director of Nursing (DON) was interviewed and asked why R14 was not receiving Restorative Services when therapy had recommended ROM exercises on 7/4/21. The DON explained that the therapy department did not use the facility's electronic charting system and he had not ever seen R14's PT Discharge Summary so the ROM exercises had not been put into R14's Kardex. On 8/26/21 at 4:15 PM, PT M was interviewed and asked about R14's PT evaluation. PT M explained R14 was place back on the therapy schedule for walking and had good potential to regain mobility. Review of a facility policy titled, Restorative Nursing Programs revised 12/2020 read in part, . Nursing personnel are trained on basic, or maintenance, restorative nursing care that does not require the use of a qualified therapist or licensed nurse oversight . All residents will receive maintenance restorative nursing services . by certified nursing assistants . Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for such services (Level II services). these services may include: a. Passive or active range of motion . A resident's Level II Restorative Nursing plan will include: a. The type of activities to be performed. b. Frequency of activities. c. Duration of activities .

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to ensure weekly weights were obtained two newly admitted /readmitted (R11 and R180) out of three reviewed for weights. Findings include: A review of the facility policy titled, Weight Management (Revision date 2017) documented, in part: 1. Weigh all residents upon admission and readmission; weigh weekly for an additional three (3) weeks .All residents are weighed; staff can compare current weight to previous weight. Residents with weight variance are re-weighed within 48 hours . R180 On 8/24/21 at approximately 9:23 AM, a full breakfast tray was placed on not eaten was observed in front of the resident. Unit Manager Nurse C reported that the resident had not been eating much. On 8/25/21 at approximately 8:49 AM during a med pass, 30 ml (milliliter)of sugar-free prostat was poured into a cup of water and mixed. It was observed R180 took two sips, and the remaining cup was left at the bedside table and the nurse exited out of the room. A review of R180's clinical record documented the resident was admitted to the facility on [DATE] with diagnoses that included: type II diabetes, acute respiratory failure, dementia without behavioral disturbance and anxiety disorder. A review of her Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 8/15 (moderately impaired cognition). The MDS indicated the resident was on a therapeutic diet and needed one person assistance from feeding. Continued review of the record noted the only weight taken from 8/4/21 to 8/25/21 were as follows: 8/4/21: 153.0 Lbs. 8/17/21: 123.0 Lbs. * Indicating a 19.60 weight loss within 30 days. It should be noted there were no further weights noted in the resident's clinical record. Progress notes authored by Registered Dietian E documented, in part, the following: 8/5/21: (name redacted) R180 nutritional status was evaluated .My weight history is admission weight pending .My appetite/intake has been fair . 8/17/21: Weight Change Note: .WEIGHT WARNING .RD review for sig weight change. Resident is triggering for sig weight loss at 30 days. Suspect initial weigh included w/c (wheelchair) or was otherwise inaccurate . Plan to add Medpass 2.0 12 mL 1x per day . (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 8/25/21 at approximately 3:27 PM, an interview was conducted with RD E. When asked the facility protocol for obtaining weights, RD E reported that residents should be weighed upon admission and every week for at least four weeks. When queried as to R180's significant weight loss (19.6%), RD E stated that while an initial weight of 153 lbs. was logged into the resident's record, it most likely was taken from a hospital record and the resident was not weighed. When asked why a weight was not completed the second week after admission, the RD stated that it should have been. on WT. On 8/26/21 at 11:16 AM, an interview was conducted with the Director of Nursing (DON) regarding obtaining weights to ensure an accurate weight management. The DON reported that a resident should be weighed on the first day they are admitted if possible and then weekly thereafter to determine accuracy and possible decline. 41415 R11 On 8/24/21 at 8:41 AM, an observation of R11 was made sitting up in their bed. An interview was conducted and R11 answered all questions appropriately. 08/25/21 at 11:18 AM, R11 was observed sitting up in bed eating breakfast out of a Styrofoam container. When asked the resident stated his brother sent breakfast to him. Gravy with meat in it over hashbrowns was observed. R11 was admitted into the facility on [DATE] with diagnoses that included: end stage renal disease, congestive heart failure, dependence on renal dialysis and long-term use of insulin. Review of R11's weights revealed the following: 2/18/2021 167.0 lbs. (pounds) 3/3/2021 200.0 lbs. This indicated a possible weight increase of 19.76 %. The facility failed to weigh the resident weekly from the admitted and failed to document a re-weight to verify the accuracy of the admission weight. Review of the clinical record and dietary assessments failed to acknowledge and follow up on the weight discrepancy and the missed weekly weight. On 8/25/21 at 3:26 PM, Registered Dietician (RD) E was interviewed and asked about the discrepancy in the weights and why the weekly weights weren't obtained per protocol and replied they were not employed with the facility at that time but would look into it. On 8/25/21 at 3:56 PM, Director Of Nursing (DON) B was interviewed and asked how often weight should be obtained for a new admission and asked about the lack of follow up on the weight discrepancy and stated in part, . Once a week, but dialysis takes it too . DON B acknowledged the facility failed to obtain the weight weekly and stated they would look into it and follow up. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 8/25/21 at 4:17 PM, RD E returned with dialysis communication forms from February and pointed out that one of the forms dated 2/20/21 documented a weight of (converted to 212.5) which still identified a weight discrepancy. RD E was asked to provide any documentation that the facility was aware of the weight discrepancies at that time and followed up on it. No further information or documentation was provided by the end of survey.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to identify and assess for the use of bed rails, attempt to use appropriate alternatives prior to use, ensure correct installation and maintenance, and obtain consent and a physician's order which identified the specific condition or symptom for bed rail use for one (R1) of one resident reviewed for bed rails. Findings include: On 8/25/21 at 11:10 AM, R1 was observed laying in a bariatric bed with bilateral quarter metal (silver) bed rails which were in the raised position. When asked about their use of the bed rails, R1 stated, They come as part of the bariatric bed. When asked how long they had the bariatric bed, R1 reported, I'm not sure, was out of it when first came in. According to the facility's policy titled, Bed Rails dated 12/2020 documented, .Full and half bed rails will be safely used only as needed to treat a resident's medical symptoms .The IDT (Interdisciplinary Team) to complete the following items prior to initiating side rail usage .Complete the resident bedrail consent form . Complete the bedrails clinical guidance assessment .Obtain a Physician order that contains statements and determinations regarding medical symptoms and is specific to the circumstances under which bed rails are to be used and time limit for use .Initiate a Care Plan .Complete the (company name) Side Rail Measurement Monitoring .at the time of instillation and every day for 4 days (to total 5 days of measurement) .Complete the (company name) Side Rail Measurement Monitoring .every quarter unless resident has any of the following: new/different mattress, new/different side rails, new/different bed frame and/or resident experiences weight loss .Prior to the discontinuation of side rails document reasons for the discontinuation in the medical record; to include resident choice and interdisciplinary team recommendations. Review of the clinical record revealed R1 was admitted into the facility on [DATE] with diagnoses that included: contusion of unspecified hip, contusion of right knee, encephalopathy, and morbid obesity due to excess calories. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R1 had severe cognitive impairment, required extensive assistance of two or more people physical assistance for bed mobility and transfers. The section of the MDS for restraints which included bed rails, indicated they were not in use. There was no care plan for the use of bed rails. Further review of the clinical record revealed there was no consent form, bed rail assessment, physician order with medical symptoms and specific circumstances under which bed rails were to be used or time limit. There was no documentation of when R1 had received the bariatric bed with bed rails, or any bed rail measurement monitoring at the time of and following installation, or quarterly per facility policy. On 8/25/21 at 9:15 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's use of bed rails on resident beds, the DON reported, We don't use side rails. We use enablers. I'm not aware of any, I don't think we have anyone that uses them. The DON was requested to provide any documentation regarding resident's use bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/21 at 8:14 AM, review of the additional documentation provided by the facility included an therapy evaluation dated 8/19/21 which had the following highlighted in yellow, mod (modified) I (independent) using bed rails and increased time/effort . There was no documentation provided that the facility had followed their policy to ensure all aspects were followed for R1 to have bed rails. On 8/26/21 at 9:25 AM, the DON was asked about the lack of supporting documentation despite R1's use of the bed rails and they reported as of yesterday, they were not aware of the use of any bed rails in the facility and the requirements needed but that maintenance had started today to do the measurements. Review of the manufacturer's recommendations and specifications for installing an maintaining bed rails for the bed used by R1 included, .When bed rails are used, perform on-going assessment of the patient's physical and mental status: closely monitor high-risk patients. Consider the following: Lower one or more sections of the bed rail, such as the foot rail .Use a proper size mattress or mattress with raised edges to prevent patients from being trapped between the mattress and rail .Reduce the gaps between the mattress and side rails .A process that requires ongoing patient evaluation and monitoring will result in optimizing bed safety .

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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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure drug irregularities identified by the pharmacist were acted on by the physician and the physician's response to the pharmacist's recommendations were documented in the medical record for two (R24 and R36) of five residents reviewed for medication regimen reviews. Findings include: Resident #24: Review of the clinical record revealed R24 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included: Parkinson's disease, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, moderate protein-calorie malnutrition, dementia without behavioral disturbance, insomnia, deficiency of Vitamin K, other seizures, adjustment disorder with mixed anxiety and depressed mood, sepsis, mood disorder and anxiety disorder. According to the significant change MDS assessment dated [DATE], R24 had intact cognition (scored 15/15 on bims), usually makes self understood and able to understand others without difficulty, received antidepressant medication for seven days and did not receive any psychological therapy in the last seven days of this assessment period of over seven days. Review of R24's pharmacy consultations since April 2021 identified two irregularities on 4/21/21 and 6/21/21 which both read, See report for any noted irregularities and/or recommendations. There was no report for either dates available in the clinical record. On 8/25/21 at 3:10 PM, the Director of Nursing (DON) was requested to provide the reports for 4/21/21 and 6/21/21. On 8/25/21 at 3:25 PM, review of the documentation provided by the facility included: .Recommendation date: 04/14/2021 .REPEATED RECOMMENDATION from 3/3/2021: Please respond promptly to assure facility compliance with Federal regulations. REPEATED RECOMMENDATION FROM 2/2/2021: Please respond promptly to assure facility compliance with Federal regulations .Please monitor a 25-hydroxyvitamin D concentration on the next convenient lab day, adjusting the vitamin D dose accordingly . If this therapy is to continue at the current dose, it is recommended that a) the prescriber document an assessment of risk versus benefit of continuing this medication, and b) the facility interdisciplinary team ensures ongoing monitoring for medication effectiveness and adverse consequences (e.g., nausea, vomiting, bone pain). There was no response to the repeated recommendations, signature or date from the physician or the DON as indicated to do so on the form. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Recommendation date: 06/21/2021 .(R24) receives Paxil, Desyrel, carbidopa- levodopa .Please reevaluate this combination .Rationale for Recommendation: The use of three or more CNS (Central Nervous System) active agents should be avoided in the elderly due to an increased risk for falls and fractures . Review of R24's psychiatric and physician evaluations revealed there was no specific supporting documentation to support the combination of medication as recommended by the pharmacist. The last available psychiatric evaluation was on 5/13/21 and there was no evidence R24 had been seen since this recommendation on 6/21/21 as of this review. .Recommendation date: 06/21/2021 .(R24) receives Polyethylene glycol a medication which is recommended to be administered with 4 to 8 ounces of fluid .Recommendation: Please ensure that this product is administered with 4 to 8 ounces of the recommended fluid, per the manufacturer's labeling . There was no response to this recommendation, signature or date from the physician or the DON as indicated to do so on the form. .Recommendation date: 06/21/2021 .(R24) has been receiving vitamin D 5000 international units twice weekly- q mon and Thursday .Recommendation: Please monitor a 25-hydroxyvitamin D concentration on the next convenient lab day, adjusting the vitamin D dose accordingly. Periodic assessment of serum calcium may be appropriate, based on the clinical profile .If this therapy is to continue at the current dose, it is recommended that a) the prescriber document an assessment of risk versus benefit of continuing this medication, and b) the facility interdisciplinary team ensures ongoing monitoring for medication effectiveness and adverse consequences (e.g., nausea, vomiting, bone pain) . There was no response to the repeated recommendations, signature or date from the physician or the DON as indicated to do so on the form. Further review of R24's clinical record revealed this recommendation that initially began on 2/2/21 was not followed up until 6/24/21, at which point the lab result was obtained. .Recommendation date: 07/16/2021 .REPEATED RECOMMENDATION from 6/21/2021: Please respond promptly to assure facility compliance with Federal regulations. (R24) receives Polyethylene glycol a medication which is recommended to be administered with 4 to 8 ounces of fluid . There was no response to the repeated recommendations, signature or date from the physician or the DON as indicated to do so on the form. Further review of R24's clinical record revealed this recommendation that initially began on 6/21/21 was not followed up until 7/28/21, at which time the order was revised to include the recommendations. On 8/26/21 at 4:06 PM, an interview was conducted with the DON. When asked what the facility's process was for following up on identified irregularities from the pharmacist, the DON reported one unit manager directly called each physician, then puts in place and the DON then signs off and that should then be scanned in the residents clinical record. When asked if the facility had identified any concerns with the follow through with these identified irregularities, the DON reported they had similar concerns and due to limitations with available staff, there were delays in following through with the recommendations. 34275 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R36 Review of the clinical record revealed R36 was admitted to the facility on [DATE] with diagnoses that included: heart failure, diabetes type II, dementia, anxiety disorder and depression. A review of the MDS revealed the resident had a BIMS score of 14/15 (cognitively intact) and required one person supervision for most ADLs. Review of R36's pharmacy consultations since June 2021 identified irregularities on 6/18/21, 7/16/21 and 8/20/21 which all read, See report for any noted irregularities and/or recommendations. There was no report for the dates noted above in the clinical record. On 8/25/21 at 3:10 PM, the DON was requested to provide the pharmacy reports from 6/18/2021 through 8/25/21 On 8/25/21 at 3:25 PM, review of the documentation provided by the facility included: Consultation Report: Recommendation date: 7/16/21 .Comment: (R36) receives Abilify (an antipsychotic medication) .Please monitor for involuntary movements now and at least every 6 months or per facility protocol .Rationale for Recommendation: Early detection of involuntary movements can prevent potential irreversible TD (tardive dyskinesia-uncontrollable movements like involuntary blinking, tongue movements and jerking of hands and feet). A second Consultation Report: Recommendation date 8/20/21 .Comment REPEATED RECOMMENDATION from 7/16/21 .(R36) receives Abilify .Recommendation: Please monitor for involuntary movements now and at least every 6 months or per facility protocol .Rationale for Recommendation: Early detection of involuntary movements can prevent potential irreversible TD . On 8/26/21 at approximately 11:02 AM, an interview and record review were conducted with the DON. When asked if there was any response completed based on the pharmacy recommendation, the DON acknowledge that as R36 was receiving an antipsychotic an AIMS (Abnormal Involuntary Movement Scale) should have been completed when the resident started the medication so that a baseline is established.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39592 Based on observation, interview and record review, the facility failed to follow it's policy, ensure medications were appropriately labeled, discarded after expiration and properly stored in multiple medication carts and one of two medication rooms reviewed, resulting in (1) unlocked medication and treatment carts; (2) undated and expired Insulins; and (3) an undated multiple dose vial of tuberculin (TB) solution. Findings include: On 8/24/21 at 5:46 AM and 6:37 AM, the 1 [NAME] medication cart was observed unlocked, and the nurse assigned to the medication cart was observed on their other assigned unit, 1 Center. It should be noted that the 1 [NAME] cart was around the corner, and beyond closed double doors from 1 Center. On 8/25/21 at 2:10 PM, an observation of a medication room was conducted with Licensed Practical Nurse (LPN) J. A multiple dose vial of Aplisol (Tuberculin Purified Protein Derivative solution - used for routine testing for Tuberculosis) was observed approximately half empty and undated, it was confirmed with LPN J the vial was open and had been used. On 8/25/21 at 2:29 PM, an observation of a medication cart was conducted with LPN L. One Novolog FlexPen (Insulin) was undated, it was confirmed with LPN L the pen was open and had been used. When asked when Insulin pens should be dated, LPN L explained they should be dated when opened and used for the first time. On 8/25/21 at 3:07 PM, the Director of Nursing (DON) was interviewed and asked when a multiple dose vial of tuberculin solution was to be dated, and how long it was good for once opened. The DON explained the vial should be dated when opened and used for the first time, and it was good for 30 days. When informed of the vial of used, undated tuberculin solution found in the medication room, the DON explained the vial should be thrown out. Review of a facility provided Aplisol package insert revealed the manufacturer's recommendation that, .Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency . Review of a facility policy titled, Medication Storage in the Facility dated June 2019 read in part, .Only nurses, pharmacists, and pharmacy technicians are permitted to access medications. Medication room, carts, and medication supplies are locked with not attended by persons with authorized access . Once any drug or biological package is opened, manufacturer/supplier guidelines regarding expiration dating will be followed . All expired medications will be removed from the active supply . 30675 On 8/24/21 at 5:20 AM a medication cart in the center hallway was observed unlocked and unsupervised. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/24/21 at 5:42 AM, 7:10 AM, and 8:01 AM, the treatment cart stored in the center hallway was observed to be unlocked and unattended by nursing staff. The cart was able to be opened and contained treatments including prescription creams and wound supplies. On 8/25/21 at 11:02 AM, the medication cart for the 2 east hallway was observed unlocked and unattended by nursing staff. LPN 'L' was observed to exit a room a few doors down and returned to the medication cart to open a drawer on the bottom without having to use a key to unlock the cart. When asked if the cart should be locked when unattended or out of sight, LPN 'L' reported they were in another room and that it should be locked when cart was left. On 8/25/21 at 2:16 PM, an interview was conducted with the DON regarding the facility's practices for medication storage and he reported, Should be locked when unattended. Only time should be unlocked is when present and utilizing it (cart). Only cart that is unlocked is emergency one right when walk in front.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 32568 Based on observation, interview, and record review, the facility failed to implement effective plans of action to correct identified quality deficiencies related to weight management, professional standards of nursing practice, and use of bed rails, resulting in the continuation of deficient practices including R802 receiving the incorrect tube feeding regimen, R804, R805, and R807 not being monitored for effects of having bed rails and their beds not being properly measured for risk of entrapment, and R803 sustaining severe weight loss. This had the potential to affect all residents who resided in the facility. Findings include: On 10/19/21 through 10/21/21, a revisit survey was conducted to determine compliance with deficiencies identified during the facility's recertification survey completed on 8/26/21. According to a CMS (Center for Medicare and Medicaid) 2567 form dated 8/26/21, the facility was found to be noncompliant with regulatory requirements related to nutrition (weight management), professional standards of nursing practice, and bed rails (use of, monitoring, and inspection/measurement to prevent entrapment). Review of the facility's Plan of Correction (POC) documented on the CMS 2567, with an alleged compliance date of 9/28/21 revealed the facility would do the following to correct the deficient practice related to the failure to administer medications according to professional standards of practice: .Licensed Nursing Staff were educated on medication administration .Nurses will be given an ad hoc in-service and directed to complete additional training with the staff development nurse. If compliance continue to not be met, disciplinary action will follow .The DON (Director of Nursing) or designee will complete two weekly audits on medication administration x 4 weeks, then bi-weekly x 4 weeks. Any deficient practice identified will be immediately corrected. Results will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee to review reports, make recommendations, and guide further action . Review of the facility's POC documented the following would be done to correct the deficient practice related to nutrition: .All Residents residing in facility have the potential to be affected by deficient practice of maintaining nutrition/hydration maintenance. A while house audit was completed to ensure new and readmission weights have been obtained .Unit managers and DM (Dietary Manager) were re-educated to ensure admission and readmission weights are obtained and documented timely during new admission review process. Nursing Staff were educated to take an admission weight upon arrival and then weekly x 3 weeks. Admission and weekly weights will be conducted per facility policy and will be reviewed weekly Monday - Friday during morning clinical meeting to ensure compliance. RD (Registered Dietitian) was educated on following up on weights and weekly weights, follow up on significant weight changes .Weights will be discussed in morning meeting and Unit manager will ensure they are done by end of day .The DON or designee will monitor all admission and weekly weights daily x 2 weeks to ensure a weight is obtained, (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	then 3 times weekly x 2 week, then weekly x 30 days. Any deficient practice identified will be immediately corrected. The DON or designee will also monitor [Electronic Medical Record software name redacted] daily x 2 weeks then 3 times weekly x 2 week, then weekly x 30 days to ensure that the weights are in the system and available for the RD to review. Results will be reported to the QAPI Committee to review reports, make recommendations, and guide further action . Review of the facility's POC documented the following would be done to correct the deficient practices related to bed rails: .monitoring placed on the Medication Administration Record (MAR) .All staff have been educated on the requirements of side rails including .monitoring .The DIRECTOR OF NURSING or designee will audit every room daily for new side rails and validate that all residents .monitoring on the MAR. Monday thru Friday x 2 weeks then twice weekly x 2 weeks, then once weekly x 1 week thereafter. The audits will be reviewed in QAPI to determine if further auditing is needed . On 10/21/21, it was identified that R802's tube feeding was not being administered according to physician's orders and clarification was not obtained when there were orders for both bolus and continuous tube feeding concurrently. It was further identified that multiple nurses documented R802's continuous tube feeding as administered when it was not. On 10/21/21, it was identified that R803's sustained a severe weight loss of 15 pounds that was not addressed which resulted in additional weight loss. On 10/21/21, it was identified that R804, R805, and R807 were not monitored according to the facility's POC for adverse effects from bed rail use. It was further identified that R804, R805, and R807's beds and bed rails were not properly inspected and measured to ensure there was no risk for entrapment or injury. Review of facility audits implemented and initiated due to the prior identified deficiency with professional standards of practice revealed R802 was not identified as part of the facility's audits. Review of facility audits implemented and initiated due to the prior deficiency with nutrition revealed a Weight Summary Report that identified R803 with a greater than 10 percent weight loss in less than 180 days on 9/30/21. Review of the facility's Weight Audit Tool completed on 10/1/21, 10/2/21, 10/4/21, 10/5/21, 10/6/21, 10/7/21, 10/8/21, 10/11/21, and 10/12/21 captured only new admissions or readmissions and did not address other residents with weight loss. R803 was not included on the Weight Audit Tool and after investigation it was discovered no interventions were put into place after the severe weight loss was identified on 9/30/21. It was also identified that R803 was not evaluated by a physician after the weight loss was identified. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility audits implemented and initiated due to the prior identified deficiencies with bed rails did not identify the lack of monitoring for R804, R805, or R807 and did not identify the inaccurate inspection and measurements of R804, R805, and R807's beds. Review of the facility's Side Rail Rounds and Measurement Audit Tool forms completed by the Assistant Director of Nursing (ADON) revealed R804, R805, and R807 were audited on 10/1/21, 10/4/21, 10/5/21, 10/6/21, 10/7/21, 10/8/21, 10/11/21, 10/12/21, and 10/13/21 for the following: Instillation measurements taken which were all marked Y to indicate yes. Daily measurements taken? which were all marked Y. Are 5 days completed? .If not explain in corrective action box which were all marked Y. None was documented in the Corrective action if needed box. There was no audit conducted to ensure monitoring was completed for residents with bed rails. On 10/19/21 at 2:06 PM, the AM, the DON was interviewed regarding the facility's POC. When queried about what was being audited to ensure nurses were administering all treatment and medications according to professional standards of practice, the DON reported the orders should have been looked at more closely. The DON reported R802's incorrect tube feeding orders should have been identified and nurses should not have signed off on treatment that was not provided. The DON reported issues with professional standards of practice had not been identified prior to the date of the survey. On 10/21/21 at 10:32 AM, the facility's Administrator was interviewed regarding their POC and how quality deficiencies were identified and addressed through the facility's QAPI program. When queried about whether any concerns were identified prior to the survey regarding professional standards of practice, nutrition, or bed rail use, the Administrator reported no concerns were brought to the QAPI committee. The Administrator reported herself and the DON were responsible for ensuring compliance with the deficiencies identified during the recertification survey conducted on 8/26/21. It was further explained that when concerns are brought to morning meeting or to QAPI, the interdisciplinary team became involved which included the Administrator, DON, Unit Managers, Social Work, Physicians, and Medical Director to develop an action plan. In relation to the POC, the Administrator reported compliance was confirmed by reviewing the audits and rounding to observe the interventions were implemented. When queried about how the audits were conducted as part of the plan of correction and did not identify quality deficiencies and/or did not accurately document compliance, the Administrator reported it was something she had to look into as they began working in the facility in June 2021. Review of a facility policy titled, Quality Assurance and Performance Improvement (revised on 1/2019) revealed the following: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life .The QA Committee shall be interdisciplinary and shall: .Develop and implement appropriate plans of action to correct identified quality deficiencies .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41415 This citation contains two deficient practice statements (DPS). DPS #1 Based on observation, interview, and record review the facility failed to maintain good infection control standards and practices and ensure an effective Infection prevention and control program for 81 residents of 81 residents residing in the facility. Findings include: On 8/25/21 at 8:19 AM, a medication observation was conducted observing Licensed Practical Nurse (LPN) L. LPN L prepared and administered medications to R180. LPN L then prepped R180's left hand, second digit with an alcohol pad then used the lacing device and lancet to obtain a blood sample to test the resident's blood sugar level. The nurse held a gauze on the second digit for a few seconds and removed it. LPN L disposed of their gloves and the used gauze. R180's second digit continued to bleed. Blood was observed falling on the resident other fingers and onto the bedside table. LPN L quickly exited the room to return to their cart to obtain additional gauze. LPN L returned and immediately applied pressure to the second digit with the new gauze. LPN L was observed with blood all over both hands and the tape roll that they grabbed. LPN L continued to apply pressure for a few more minutes than applied a band aid. LPN J was not wearing gloves. LPN J then exited the room, wiped their hands with a disinfectant wipe and utilized the hand sanitizer. LPN J was observed to have touched the medication cart drawers, laptop, medication cups, water cups, medication packets and then proceeded to prepare and administered medications to the next resident. LPN J failed to wash their hands with soap in water after coming in contact with a resident's blood. A facility policy titled Cleaning Spills or Splashes of Blood or Body Fluids (revised January 2021) documented in part, . Spills or splashes of blood or other body fluids must be cleaned and the spill or splash area decontaminated as soon as practical . Whoever spills or splashes blood or body fluid . shall notify environmental services . Whoever is exposed to blood or body fluids shall report the occurrence to the Infection Preventionist and wash his/her hands as soon as practical after exposure . On 8/25/21 at 2:07 PM, the Director of Nursing (DON) B was interviewed and asked about the facility blood spill protocols regarding the observation with LPN J and asked if that was the facility normal protocol, DON B stated in part No, that requires automatic hand washing, and she should have reported that to us because that requires us to do additional things. DON B stated they would follow up. Review of the facility's Monthly Infection Control Log for the months of June and July 2021, revealed an incomplete analysis of data, trends and clusters, corrective actions and preventative measures taken by the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of both logs for June and July 2021 revealed the failure of the facility to ensure infection surveillance, analyzation of the data, reporting (if necessary) and the implementation of any education, training or interventions needed. Failure to review and analyze the data also reveals the concern of the facility to quickly identify infections, clusters, and outbreaks timely to intervene. A facility policy titled Infection Surveillance lasted reviewed 12/20, documented in part . A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections . Monthly time periods will be used for capturing and reporting data . All resident infections will be tracked. Outbreaks will be investigated . On 8/26/21 at 4:12 PM, the DON who also serves as the facility's Infection Control Nurse (ICN) was interviewed and asked about the missing data for the months of June and July. The DON stated the facility has a new system in place and newly hired staff to help. The DON stated they have been putting in a lot of hours to try and capture things as they are happening. A facility policy titled Infection Preventionist last reviewed 12/20 documented in part, . Responsibilities of the Infection Preventionist include but are not limited to . Develop and implement an ongoing infection prevention and control program to prevent, recognize and control the onset and spread of infections . Establish facility-wide systems for the prevention, identification, reporting, investigations and control of infections and communicable diseases . 22960 Deficient Practice #2 Based on interview and record review, the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the 81 residents in the facility. Findings include: On 8/24/21 at 1:00 PM, review of the facility's Water Management Plan (WMP) binder, revealed an undated document entitled Water Safety Plan Workbook Instructions, with the following guidance: 1. Establish the Facility Water Safety Team, Complete Worksheet 1. 2. Perform an ASHRAE 188 Compliance Audit, Complete Worksheet 2. 3. Describe each facility water system and draw a flow diagram. Complete Worksheet 3 . 4. Evaluate hazards, establish control limits, and monitor water systems. Complete appropriate worksheets and implement monitoring . 5. Verify Water Safety Plan. Water Safety Team shall meet regularly to review water safety program .Annually update ASHRAE 188 Compliance Audit (Worksheet 2), Annually update and re-verify flow diagrams and hazard analysis (Worksheets 3 through 18), Record all Water Safety Team meetings to document meeting and actions . Further review of the facility's WMP binder, revealed a template with worksheets for developing a WMP. The template was labeled with the facility's previous name but was blank otherwise. (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	08/26/2021

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview to discuss the facility's Water Management Plan (WMP), at 1:30 PM on 8/24/21, with Maintenance Supervisor T, it was found that no active WMP was being carried out in the facility. When asked if there was currently a team in place to oversee the WMP, Maintenance Supervisor T stated, Basically not. When asked if there was a facility risk assessment that identified where legionella and other OPPP could grow and spread in the facility, Maintenance Supervisor T stated they flush the toilets weekly in the unit that is currently off-line but stated there is not a map showing where high risk areas are within the facility. When asked if the facility has specified testing protocols and acceptable ranges for control measures, Maintenance Supervisor T stated We check the water temperatures in the resident bathrooms.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 41415 Based on interview and record review the facility failed to establish and implement an effective antibiotic stewardship program that included protocols for appropriate antibiotic use for two (R's 31 and 51) of 18 sampled residents reviewed for antibiotic use. Findings include: Review of the facility's Monthly Infection Control Log (Line List) for May, June & July 2021 revealed no documentation of any of the residents meeting the criteria for antibiotic usage. The logs contained no documented signs or symptoms or evaluation of appropriateness of the prescribed antibiotics. On 8/26/21 at 4:12 PM, the Director of Nursing (DON) who also serves as the facility's Infection Control Nurse (ICN) was interviewed and asked about the criteria utilized by the facility and they confirmed that it was the McGreer criteria. When asked about the missing data on the facility's log the DON stated in part that the facility recently implemented a new program that doesn't allow the documentation to show the resident's meeting criteria for the antibiotics. Review of the facility's Month End Operation / Antibiotics reports for the month of May, June and July of 2021 revealed R's 31 & 51 were currently receiving antibiotics and not documented on the facility's Infection Control Log. Review of R31's physician orders revealed the following: Keflex Capsule 250 MG (milligram), Give 1 capsule by mouth one time a day for UTI (Urinary Tract Infection) prevention suppressive therapy. Start Date 1/23/2018 and End Date of 8/11/2021. Review of a hospital Patient Discharge Summary dated 8/16/21 documented in part, . Diagnosis: UTI . despite the administration of Keflex (for three and half years) for UTI prevention suppressive therapy the resident was hospitalized and diagnosed with a UTI. On 8/26/21 at 10:09 AM, Physician W who was identified as R31's primary physician at the facility was interviewed. Physician W was asked about their beliefs on treating residents with antibiotics prophylactically with antibiotics and stated in part, . I am not a fan of that, I don't believe in that . When specifically asked about R31 and the years of Keflex administration to prevent a UTI which the resident was recently admitted in the hospital for, Physician W stated that he had inherited that resident from a prior physician at the facility and was told that urology made that recommendation. On 8/25/21 at 2:29 PM, the DON was asked to provide a copy of the urology consultation report that documented the Keflex to use as prevention and suppressive therapy and no additional documentation was provided by the end of survey. Review of 51's physician orders revealed the following: Demeclocycline HCl Tablet, give 300 mg by mouth two times a day related to HYPO-OSMOLALITY AND HYPONATREMIA. Start date of 4/3/2020 and End date Indefinite. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R51 had been receiving this antibiotic for 1 year and 4 months at the time of this survey. On 8/26/21 at 2:11 PM, the DON was asked how R's 31 and 51 was receiving antibiotics for the past year but neither are documented on the facility's log. The DON was asked why both residents were receiving long term antibiotics, the DON obtained both resident names and stated they will follow up. No further explanation or documentation was received by the end of survey.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to ensure regular inspections for mattresses and bed rails (measurements for entrapment zones) were completed for one (R1) of one resident reviewed for bed rail entrapment zone measurements. Findings include: On 8/25/21 at 11:10 AM, R1 was observed laying in a bariatric bed with bilateral quarter metal (silver) bed rails which were in the raised position. When asked about their use of the bed rails, R1 stated, They come as part of the bariatric bed. When asked how long they had the bariatric bed, R1 reported, I'm not sure, was out of it when first came in. According to the facility's policy titled, Bed Rails dated 12/2020 documented, .Complete the (company name) Side Rail Measurement Monitoring .at the time of instillation and every day for 4 days (to total 5 days of measurement) .Complete the (company name) Side Rail Measurement Monitoring .every quarter unless resident has any of the following: new/different mattress, new/different side rails, new/different bed frame and/or resident experiences weight loss . Review of the clinical record revealed R1 was admitted into the facility on [DATE] with diagnoses that included: contusion of unspecified hip, contusion of right knee, encephalopathy, and morbid obesity due to excess calories. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R1 had severe cognitive impairment, required extensive assistance of two or more people physical assistance for bed mobility and transfers. The section of the MDS for restraints which included bed rails, indicated they were not in use. Further review of the clinical record revealed there was no evidence the facility had provided regular inspections of the bed rails and mattress at the time of, and following installation or quarterly, per facility policy and manufacturer's recommendation. On 8/26/21 at 9:25 AM, the DON was asked about the lack of supporting documentation despite R1's use of the bed rails and they reported as of yesterday, they were not aware of the use of any bed rails in the facility and the requirements needed but that maintenance had started today to do the measurements and they also put in care plans. Review of the manufacturer's recommendations and specifications for installing and maintaining bed rails for the bed used by R1 included, .When bed rails are used, perform on-going assessment of the patient's physical and mental status: closely monitor high-risk patients. Consider the following: Lower one or more sections of the bed rail, such as the foot rail .Use a proper size mattress or mattress with raised edges to prevent patients from being trapped between the mattress and rail .Reduce the gaps between the mattress and side rails .A process that requires ongoing patient evaluation and monitoring will result in optimizing bed safety .