STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235349	A. Building B. Wing	11/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Ishpeming	435 Stoneville Rd Ishpeming, MI 49849

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to provide timely assistance following a fall, which resulted in neglect of one Resident (#11) of three residents reviewed for falls and abuse. This deficient practice resulted in an extended time period on the floor, feelings of hopelessness, frustration, fear and emotional distress when calls for assistance were not answered. Findings include: An abbreviated survey was conducted 11/1/21 through 11/8/21 to investigate a confidential complaint that alleged Resident #11 sustained a fall and remained on the floor for an extended period of time. Review of Resident #11's Minimum Data Set (MDS) assessment, dated 10/6/21, revealed Resident #11 was admitted to the facility on [DATE], with diagnoses that included coronary artery disease (CAD), atrial fibrillation, depression, chronic obstructive pulmonary disease (COPD), obesity, muscle weakness and repeated falls. Resident #11 had clear speech, understood others and was able to be understood, scored 12 of 15 on the Brief Interview for Mental Status (BIMS), reflective of moderate cognitive impairment, and required extensive two-person assistance with bed mobility and transfers. Review of a Fall Incident Report for Resident #11, dated 10/2/21 at 6:25 a.m., revealed the following: Per wing nurse [Licensed Practical Nurse (LPN) CC] Resident (#11) was found on floor next to bed on the right side .Resident stated, 'My right side is week (sic) and I slid out of bed' . Resident assisted back to bed via hoyer lift x 3 staff members. Resident to be checked frequently for positioning in bed to reduce falls . Per dayshift nurse at 1100 (11:00 a.m.) resident starting to complain of right hip pain. ROM (range of motion) not within normal limits at time of assessment. Nurse stated the hip appears rotated. Resident to be sent to ER (emergency room) for evaluation . Other Info: Resident admitted to the facility for weakness and frequent falls at home, in facility for rehab to strengthen . No witnesses found . The Nursing Home Administrator (NHA) was notified at 11:00 a.m., and the Director of Nursing (DON) was notified at 11:15 a.m. Review of a Grievance and Satisfaction Form, dated 10/4/21, received from, and completed by Staff B, revealed the following, in part: Family wishes to be notified as to 'why [Resident #11] was on the floor for 3 hours. They would like to know why so long, what are we going to do to prevent this, and why do we think it happened .[NHA] and [Staff B] spoke with [Family Member (FM BB)] and [FM BB] expressed concerns and they have been addressed. She is satisfied. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note, dated 10/4/21 at 15:58 (3:58 p.m.), revealed the following COMMUNICATION with Family . [FM BB] did have concerns when resident fell and was re-assured that he was taken care of promptly and assessed . During a telephone interview on 11/2/21 at 12:50 p.m., when asked about care provided to Resident #11, FM BB said [Resident #11] fell out of bed on 10/2/21 and was lying on the floor and banging on the (heating) register . nobody came for about two and a half hours . He kept saying to get me home - get me out of here. I finally did . During a telephone interview on 11/2/21 at 1:00 p.m., when asked about care received at the nursing home facility, Resident #11 stated, It was a nightmare .I aggravated my whole body by laying on the floor and trying to get up . I am sure I layed there a good hour and a half. When you don't have a watch and you don't have a clock, it is hard to say (how long I was on the floor). I screamed and hollered and banged on the register, but I couldn't get no attention whatsoever. It is very aggravating to lay there and you can't do nothing. I can't walk so I couldn't get up from there. The only thing was to lay on my side and kick the (heating) register. During a telephone interview on 11/3/21 at 3:30 a.m., LPN CC confirmed she had worked the night of 10/2/21 when Resident #11 fell out of bed onto the floor. LPN CC said she had gone into Resident #11's room between 5:30 a.m. and 6:00 a.m. to give Resident #11 medications, and had not visualized him prior to that time. LPN CC stated, I could not see him when I entered the room. I could see his arm. He was on the right side of the bed (between the bed and the window) .He shocked me finding him on the floor . He said, 'I have fallen and I have been waiting a long time' . He was on the opposite side of the call light (inaccessible). I felt bad for him . LPN CC said no witness statements were completed by staff, and added that there was only one aide working for 30 residents. During a telephone interview on 11/3/21 at 5:21 a.m., Staff K said she had worked the night that Resident #11 fell . Staff K stated, I came in that morning at 2:30 a.m. I did not see him before he fell . I don't know if he was on the floor before I came in, or after. Staff K acknowledged she had not visualized Resident #11 when starting work, or anytime up until he was found by LPN CC between 5:30 a.m. and 6:00 a.m. Staff K confirmed she had not been asked to complete a witness statement regarding the incident. Review of a 10/2/2021 15:04 (3:04 p.m.) Nursing Progress Note revealed the following, in part: Resident (#11) did c/o (complaint of) rt (right) hip and leg pain following a fall on 11-7 shift. Right foot did appear to have an outward rotation . assessed resident. Spoke to [FM BB] and explained to her about the increased pain r/t (related to) fall. Decision made to have resident transferred via ems (emergency medical services) for evaluation at [acute care hospital] to r/o (rule out) injury. Left with ems at 11:30 (a.m.) . At 1430 (2:30 p.m.) resident returned via ems, report from ED physician stated no fracture or injury . Review of the facility Abuse, Neglect and Exploitation policy, revised 12/20, revealed the following, in part: Definitions: . 'Neglect' means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Possible indicators of abuse include, but are not limited to: . 8. Failure to provide care needs . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/2/21 at 11:43 a.m., when asked about reporting the allegation of neglect to the State Agency for Resident #11, the DON said no report was filed with the State Agency related to potential neglect of Resident #11, and there was no documentation of interviews completed to investigate the allegation. Review of text messages between the DON and staff who worked the night of 10/2/21, provided on 11/3/21, revealed the following related text from LPN CC: We are definitely short staffed and these are the results. 100/400 (halls) has a lot of unstable residents on it. We can't keep track of everyone especially with one aide. They (aides) mostly work on the 100 wing . During an interview on 11/3/21 at 10:43 a.m., the NHA and DON both acknowledged they understood the neglect concern for Resident #11 with no evidence provided to show any staff member observed Resident #11 between 2:30 a.m. and 5:30 a.m. to 6:00 a.m. on 10/2/21.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Protect each resident from the wrongful use of the resident's belongings or money. 35102 Intake #MI00123745 Based on observation, interview, and record review, the facility failed to: 1) prevent misappropriation of narcotic pain medication for one Resident (#10) of three residents reviewed for narcotic reconciliation; 2) prevent misappropriation of medical equipment and lab testing supplies and 3) follow the facility's drug free policy. These deficient practices resulted in the potential for inadequate pain management, the potential for resident misappropriation, and potential medication errors. Findings include: An abbreviated survey was conducted to investigate an anonymous allegation, filed on 10/27/21, of Resident #10 missing 2.5 ml (milliliter) of morphine sulfate immediate release (MSIR) liquid on 10/26/21. Review of Physician Visit, 10/13/21, read in part, (Resident #10) with progressive MS (multiple sclerosis) over time and now some dementia . has a history of . chronic pain due to osteoarthritis and MS . nursing staff notices that she complains a lot of pain on a regular basis . Review of the Controlled Substance Shift Inventory, beginning date of 10/21/21, documented on 10/26/21 at 0630 (6:30 a.m.) that Licensed Practical Nurse (LPN) P and LPN L counted narcotics at 6:30 a.m. and all narcotics were accounted for (reconciled). Review of LPN L's timesheet, dated 10/26/21, documented start time of 6:45 a.m. The next entry on the same Controlled Substance Shift Inventory form had an entry date of 10/26 at 1600 (4 p.m.) which was crossed out and did not contain any signatures. The next line entry was made on 10/26/21 at 1600 (4:00 p.m.) by Registered Nurse (RN) C and LPN Q. LPN L did not sign the Controlled Substance Shift Inventory prior to her leaving work on 10/26/21 at 9:45 a.m. Review of Physician Order dated 9/30/21, showed Resident #10 was prescribed Morphine Sulfate (concentrate) Solution 20 mg/ml (milligrams per milliliter) to give 0.25 ml orally every two hours as needed for pain. Review of Resident #10's Proof of-Use Record, undated, which contained hand-written entry (Resident #10's name) 0.25 ml Q 2 H PRN (every two hours as needed). No identification of the narcotic name, dose concentration, or total amount prepared in the bottle was written on the record. A hand-written note read, 7.0 cc (cubic centimeter) med (medication) over (carried over from previous page) with the first entry on 10/23/21 bringing the amount remaining in the bottle to 6.75 ml. The last entry on 10/26/21 at 0930 (09:30 a.m.) showed the amount remaining in the bottle was zero which was signed (witnessed) by RN C and LPN L. Review of Resident #10's October 2021 Medication Administration Record (MAR) showed Morphine Sulfate (20 mg/ml) 0.25 ml was administered on the night shift (10/25 to 10/26/21) beginning at 22:30 (10:30 p.m.), at 00:34 (12:34 a.m.), and lastly at 03:00 a.m. No additional times were recorded to show either LPN L or RN C had administered 0.25 ml of the Morphine Sulfate. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/1/21 at 2:56 p.m., RN C confirmed she had reconciled narcotics on LPN L's medication cart on 10/26/21 at around 9:30 a.m. RN C was asked about Resident #10's Morphine Sulfate discrepancy. RN C said the bottle was bone dry and acknowledged she had recorded zero in the amount remaining entry on the Proof-of-Use sheet on 10/26/21 at 09:30 even though she had not administered a dose to Resident #10 at that time. During an interview on 11/2/21 at 10:56 a.m., the Director of Nursing (DON) and Nursing Home Administrator (NHA) both confirmed concerns regarding LPN L's behaviors and physical well-being on 10/26/21. When asked about Resident #10's Morphine Sulfate discrepancy from 10/26/21, the DON said RN C came to her office later the same day and reported she needed to open another bottle of Resident #10's Morphine Sulfate since she didn't have enough for the 0.25 ml dose. When asked about the process of reporting narcotic discrepancies, the DON said staff were expected to complete a Concern/Complaint Form. The DON confirmed that neither RN C nor anyone else had completed a Concern/Complaint Form regarding Resident #10's missing Morphine Sulfate on 10/26/21. The DON confirmed no nurses were asked to complete witness statements and Resident #10's MAR was not reviewed which showed Morphine Sulfate 0.25 ml was not administered to Resident #10 between the time LPN L had possession of the medication cart and when RN C took over the cart around 9:30 a.m. During an interview on 11/3/21 at 1:44 p.m., LPN L confirmed the NHA, on 10/26/21 at around 8:30 a.m., had instructed her to go home since he had received complaints from staff that she was out of sorts. LPN L said she had reconciled her narcotic medications with RN C on 10/26/21 at around 9:30 a.m. LPN L said RN C found Resident #10's MSIR bottle to be empty and said she would later notify the DON. LPN L confirmed the DON never requested for LPN L to fill out a Concern/Complaint Form nor to write a witness statement. LPN L said, This is the first time I'm hearing about this. LPN L said she did not remember administering Morphine Sulfate to Resident #10 on 10/26/21. LPN L confirmed she was not asked to perform a urine drug test prior to being sent home on 10/26/21. Telephone interviews were attempted with LPN P on 11/2/21 at 3:39 p.m. and on 11/3/21 at 12:02 p.m. Voice mail messages were left to return the calls. No return calls were received from LPN P. During an interview on 11/2/21 at 3:42 p.m., Human Resources (Staff) G confirmed LPN L never completed a pre-employment urine drug screen. Review of facility's policy, Drug Free Workplace, revised 12/1/2014, read in part, All registered or licensed practical nurses will be asked to submit to a drug screen as part of the pre-employment process .Employees may be tested for drugs and/or alcohol when the company has reason to suspect that alcohol or drugs may be present or that this policy may have been violated. Employees who observe or suspect drug or alcohol use in violation of this policy are required to report their observation to a supervisor. In turn, supervisors are required to immediately follow up on all reports. Supervisors should utilize the Reasonable Suspicion Observation Checklist . 35103 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/1/21 at 3:39 p.m., Social Services Director (Staff) B was asked if she worked on 10/26/21, when LPN L was asked to leave the building. Staff B said she came in early that day, at approximately 7:50 a.m., and two facility staff, including Staff W were peeping around the corner down the 300 Hall and Staff B asked them what they were doing. The CNAs said LPN L was high (under the influence of drugs or alcohol), and they said it had not been reported to facility administration. Staff B sent a group text to nursing administration's personal cell phones to advise them of the situation. When asked about LPN L's behavior/appearance, Staff B said LPN L's speech was garbled, her eyes were bloodshot, and she was swaying. During an interview on 11/2/21 at 2:00 p.m., Staff W confirmed she had seen LPN L on the morning of 10/26/21. Staff W stated, [LPN L] was red in the face, her eyes were glossy, and she was sluggish. She looked like she was on drugs . she was leaning on her cart, and I seen her walk into the back bathroom, on the 200/300 hall, and she didn't come out for about 30 minutes. Review of the Drug Free Workplace policy, revised 12/1/2014, revealed the following, in part: The following list is a tool to determine if an employee is exhibiting symptoms consistent with a violation of this policy: Odor of alcohol or burning leaves; Slurred speech; Flushed, swollen face; Pupils dilated or constricted, or unusual eye movement' Lack of coordination, swings in mood or attitude; Tremors or sweats; Unusual weariness, exhaustion; Drowsiness/Sleepiness; Unexplained change in physical appearance or dress . Upon report of a suspected violation, the Chief Human Resources Officer and the Administrator will be notified, and a rapid drug or alcohol screen will be performed at the facility by a Manager or Supervisor . During an interview on 11/2/21 at 10:57 a.m., the NHA and the DON were read the list of symptoms consistent with drug and/or alcohol impairment noted above. The NHA acknowledge LPN L was not drug tested , even though symptoms were consistent with the above listed symptoms of possible impairment (flushed face, drowsiness, lack of coordination, and slurred speech), prior to LPN L being sent home from work. Medical Supplies and Equipment (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interviews on 11/1/21 and 11/2/21 at 2:26 p.m. and 11:32 a.m., respectively, the NHA and DON acknowledged there was a concern identified with a staff member attempting to steal medical supplies, a specialized wheelchair cushion, and heel protector boots. The NHA said LPN N reported a concern that LPN O had attempted to steal medical supplies and equipment in October of 2021. The DON confirmed she did not have any documentation that LPN O was trying to steal anything but acknowledged LPN O had written her name on boxes filled with medical supplies and equipment, both top and sides, and had them stacked right next to the back exit door in the service entrance where staff enter and exit the facility when working. During interviews with Staff W, LPN CC, and LPN N, on 11/2/21 at 2:00 p.m., and 11/3/21 at 3:46 a.m., and 4:06 a.m., respectively, all staff said they identified, or would have identified multiple stacked, closed boxes with a staff member's name written in multiple locations on the box as property of that staff person. Staff W stated, I thought LPN O called in, but showed up for the shift so we had three nurses . LPN O is a night shift nurse, she does not stock the supplies . She took them (medical supplies and equipment) out of Central Supply . Central Supply is not kept locked. LPN CC stated, You don't have boxes with your name on it. There were bandages, treatment care ointment and creams, gauze, and unusual thing - like why would she need them for herself - some of them are very expensive bandages . The boxed supplies were not things that you usually stock the cart with . [LPN O] is not a stocker. If we are looking for medical supplies, there are only like five things that we grab on the treatment cart. There is not much on the cart that she had in her boxes that needed to be replaced . LPN N stated, I thought OK [LPN O] is saving boxes for moving (personal move) . The two smaller boxes were packed full of wound care supplies - Medi honey, patches, wraps, creams, you name it - it was in there, sterile water, ABD (abdominal) pads - a mishmash of everything (she) could throw into the box. I couldn't believe what I was seeing . LPN O came through the back door and asked what we were doing . LPN O said I don't know how any of that stuff got in those boxes. LPN N walked away and did not know what happened to the medical equipment and supplies. None of the staff interviewed, reported seeing LPN O return the items to Central Supply. The boxes were later found empty, but the above staff did not see if the medical supplies were returned to central supply or taken out the back door to LPN O's personal vehicle. During an interview on 11/3/21 at 2:14 p.m., Central Supply Clerk (Staff) GG reported having no knowledge of items packed in boxes with a staff member's name near the back door. When asked about Central Supply, Staff GG said she did not keep an inventory of medical equipment or supplies kept in Central Supply. Staff GG stated, I lock up when I leave and when I come back the door is wide open, and lights are on. Staff GG said she would have no idea if items were or had been misappropriated, as nothing is signed out, and no inventory system was in place. When asked what she would think if three boxes were stacked next to the back entrance with a staff member's name on them. Staff GG stated, I would honestly think they were taking them home. Staff GG reported she had never been trained for the Central Supply position, and no administrative staff had come to her to ask if anything appeared to be missing. Staff GG reported there were no cameras anywhere in the building. Staff GG stated, Nobody cares around here. Those (Central Supply) doors are constantly open around here - every day. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/8/21 at 2:15 p.m., the DON confirmed LPN N had come to her with allegations of potential misappropriation of medical supplies, and LPN N had cell phone photographs of the boxes which had LPN O's name on them and contained medical supplies. The DON stated, [The NHA] and I decided together that [LPN O] had no use for those items, and we have never had an issue in the past. Her story seemed more honest . It was a Friday at about 4:00 p.m. and we were there with LPN N for one and a half hours. The DON said they just wanted to be done (and go home for the day). Review of the cell phone photos provided on 11/3/21 by LPN N, revealed the following observations of medical supplies and equipment in the boxes: protective boots, wheelchair cushion, Hypafix dressing supplies, ABD pads, protective creams, multiple boxes of comfort form dressings most with 10 dressing to a box, bottles of what appears to be sterile water, 2x2 gauze packages, Kerlix, with the great majority of items unidentified as they were underneath other products. The number of products in the boxes appeared inconsistent with restocking of treatment carts. The boxes were folded closed, with LPN O's name on side and top of each box. During a telephone interview on 11/8/21 at 5:00 p.m., LPN O confirmed she had placed assorted medical supplies into multiple boxes and wrote her own name on the boxes and stacked them by the back door. COVID-19 Testing Supplies During an interview on 11/3/21 at 4:06 a.m., LPN N reported facility staff were called to a meeting where facility administration said staff were walking out the door with things (potential misappropriation). Staff N stated, We had a zillion COVID test kits .people were removing the test drops (reacting agent) and taking test kits home. We had 22 boxes of COVID-19 test kits and only three bottles of solution. LPN N said a manager, believed to be the DON, came into the building, and went through all 22 boxes of COVID-19 test kits and only found three bottles of test solution. During an interview on 11/3/21 at 11:30 a.m., the NHA and DON confirmed knowledge about the missing COVID-19 test solution. The DON said the testing kits were previously stored unsecured and accessible to facility staff. The DON said she recently went through all the boxes of testing kits and found solution was missing from most of the boxes. The DON acknowledge her concern that COVID-19 test kits and test solution were being taken out of the building and brought home by facility staff and confirmed that only three or four bottles of test solution were found out of the 22 boxes (with 50 test kits each) for COVID-19 testing. The NHA and DON confirmed the COVID-19 rapid test kits were used by both facility residents and staff for COVID-19 testing. Review of the Abuse, Neglect, and Exploitation policy, revised 12/20, revealed the following: Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 35102 Intakes #MI123295 and #123745 Based on observation, interview, and record review, the facility failed to implement their abuse policy for two Residents (#10 and #11) for four residents reviewed for abuse by: 1) failure to report allegations of abuse (misappropriation and neglect) to the State Agency; and 2) failure to fully investigate allegations of abuse; and 3) failure to ensure completion of required annual abuse training. These deficient practices resulted in the potential for continued abuse and had the potential to affect all 50 residents who resided in the facility. Findings include: An abbreviated survey was conducted to investigate an anonymous allegation, filed on 10/27/21, of Resident #10 missing 2.5 ml (milliliter) of morphine sulfate immediate release (MSIR) liquid on 10/26/21. During an interview on 11/2/21 at 10:56 a.m., the Director of Nursing (DON), in the presence of the Nursing Home Administrator (NHA), was asked about Resident #10's Morphine Sulfate discrepancy from 10/26/21. The DON said Infection preventionist/Registered Nurse (RN) C came to her office later the same day and reported Resident #10 had a Morphine Sulfate discrepancy. The DON confirmed no nurses were asked to complete witness statements and the State Agency was not notified of Resident #10's narcotic discrepancy from the 10/26/21 incident. Review of Human Resources (Staff) G provided electronic based staff education records (on 11/2/21 at 3:48 p.m. and on 11/8/21 at 11:55 a.m.) showed the following incomplete required annual abuse training for the following staff: DON, RN C, Licensed Practical Nurse (LPN) L, LPN O, Certified Nurse Aide (CNA) II, Staff W, CNA LL, CNA JJ, and Staff J. 35103 An abbreviated survey was conducted 11/1/21 through 11/8/21 to investigate a confidential complaint that alleged Resident #11 sustained a fall and remained on the floor for an extended period of time. During a telephone interview on 11/2/21 at 1:00 p.m., Resident #11 stated it was difficult to know how long he was left on the floor (on 10/2/21), and he had screamed and hollered and banged on the register without getting assistance. During an interview on 11/2/21 at 11:43 a.m., when asked about reporting the allegation of neglect to the State Agency for Resident #11, the DON said no report was filed with the State Agency related to potential neglect of Resident #11, and there was no documentation of interviews completed to investigate the allegation. During interviews on 11/1/21 and 11/2/21 at 2:26 p.m. and 11:32 a.m., respectively, the NHA and DON acknowledged there was a concern identified with a staff member attempting to steal medical supplies, a specialized wheelchair cushion, and heel protector boots. The NHA said LPN N reported a concern that LPN O had attempted to steal medical supplies and equipment in October of 2021. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Ishpeming	435 Stoneville Rd Ishpeming, MI 49849

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/8/21 at 2:15 p.m., the DON confirmed LPN N had come to her with allegations of potential misappropriation of medical supplies, including cell phone photographs of the boxes which had LPN O's name on them and contained medical supplies. The DON stated, [The NHA] and I decided together that [LPN O] had no use for those items, and we have never had an issue in the past. Her story seemed more honest . It was a Friday at about 4:00 p.m. and we were there with LPN N for one and a half hours. The DON said they just wanted to be done (and go home for the day). No witness statements, other investigative documentation were available for review. This allegation was not reported to the State Agency and a complete investigation was not performed. During an interview on 11/3/21 at 11:30 a.m., the NHA and DON confirmed knowledge about the missing COVID-19 test solution. The DON said the testing kits were previously stored unsecured and accessible to facility staff. The DON acknowledge her concern that COVID-19 test kits and test solution were being taken out of the building and brought home by facility staff for personal use. The NHA and DON confirmed the COVID-19 Point-of-Care (POC) test kits were used for required COVID-19 testing of residents and staff. Review of Abuse, Neglect, and Exploitation policy, revised 12/20, revealed the following, in part: The facility will devlop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; b. Establish policies and procedures to investigate any such allegations, and c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misapporpriation of resident property, reporting procedures, and dementia management and resident abuse prevention .2. The facility will designate an Abuse Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occurr . Report of all alleged violations to the Administrator, state agency .within specified timeframes: a. Immediately, but not later than 2 hours after he allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35103 Based on interview, and record review, the facility failed to report allegations of abuse to the State Agency for two Residents (#10 & #11), out of four residents reviewed for abuse, failed to report potential misappropriation of medical supplies and COVID-19 Point-of-Care (POC) testing supplies. This deficient practice resulted in the potential for continued abuse for facility residents, and had the potential to affect all 50 resident in the facility. Findings include: Resident #11 An abbreviated survey was conducted 11/1/21 through 11/8/21 to investigate a confidential complaint that alleged Resident #11 sustained a fall and remained on the floor for an extended period of time. During a telephone interview on 11/2/21 at 1:00 p.m., Resident #11 stated it was difficult to know how long he was left on the floor (on 10/2/21), and he had screamed and hollered and banged on the register without getting assistance. During an interview on 11/2/21 at 11:43 a.m., when asked about reporting the allegation of neglect to the State Agency for Resident #11, the Director of Nursing (DON) said no report was filed with the State Agency related to potential neglect of Resident #11. Medical Supplies and COVID-19 Testing Supplies During interviews on 11/1/21 and 11/2/21 at 2:26 p.m. and 11:32 a.m., respectively, the Nursing Home Administrator (NHA) and DON acknowledged there was a concern identified with a staff member attempting to steal medical supplies, a specialized wheelchair cushion, and heel protector boots. The NHA said LPN N reported the concern to the NHA and DON in October of 2021. During an interview on 11/8/21 at 2:15 p.m., the DON confirmed LPN N had come to her with allegations of potential misappropriation of medical supplies, and LPN N had cell phone photographs of the boxes which had LPN O's name on them and contained medical supplies. The DON stated, [The NHA] and I decided together that [LPN O] had no use for those items . The DON confirmed no allegations of potential misappropriation of medical supplies to be purchased for use by facility residents was reported to the State Agency. During an interview on 11/3/21 at 11:30 a.m., the NHA and DON confirmed knowledge of the missing COVID-19 test solution. The DON said the testing kits were previously stored unsecured and accessible to facility staff. The DON said she recently went through all the 22 boxes of COVID-19 test kits (50 kits per box) and found the required test solution was missing from all but three or four of the boxes. The DON acknowledge her concern that COVID-19 test kits and test solution were being taken out of the building and brought home by facility staff for personal use. The NHA and DON confirmed the COVID-19 Point-of-Care (POC) test kits were used for COVID-19 testing of facility residents and staff. No allegations of misappropriation of the COVID-19 testing supplies was submitted to the State Agency or Local Authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	35102 Resident #10 An abbreviated survey was conducted to investigate an anonymous allegation, filed on 10/27/21, which reported Resident #10 was missing 2.5 ml (milliliter) of morphine sulfate immediate release (MSIR) liquid on 10/26/21. During an interview on 11/2/21 at 10:56 a.m., the DON, in the presence of the NHA, was asked about Resident #10's Morphine Sulfate discrepancy from 10/26/21. The DON said Infection preventionist/Registered Nurse (RN) C came to her office later the same day and reported Resident #10 had a Morphine Sulfate discrepancy. The DON confirmed the State Agency was not notified of Resident #10's narcotic discrepancy from the 10/26/21 incident. Review of Abuse, Neglect, and Exploitation policy, revised 12/20, revealed the following, in part: .The facility will designate an Abuse Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law . Report of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after he allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. 35103 Intake #MI00123745 Based on interview, and record review, the facility failed to fully investigate allegations of abuse to the State Agency for two Residents (#10 & #11), out of four residents reviewed for abuse, and potential misappropriation of medical supplies and COVID-19 Point-of-Care (POC) testing supplies. This deficient practice resulted in the potential for continued abuse for facility residents, and had the potential to affect all 50 resident in the facility. Findings include: Resident #11 An abbreviated survey was conducted 11/1/21 through 11/8/21 to investigate a confidential complaint that alleged Resident #11 sustained a fall and remained on the floor for an extended period of time. During a telephone interview on 11/2/21 at 1:00 p.m., Resident #11 stated it was difficult to know how long he was left on the floor (on 10/2/21), and he had screamed and hollered and banged on the register without getting assistance. During an interview on 11/2/21 at 11:43 a.m., when asked about investigation the allegation of neglect for for Resident #11, the Director of Nursing (DON) confirmed no written documentation was completed for the allegation that Resident #11 was left on the floor for an extended time period. Witness statements were not obtained, and no investigative documentation was avilable for review related to potential neglect of Resident #11. Medical Supplies and COVID-19 Testing Supplies During interviews on 11/1/21 and 11/2/21 at 2:26 p.m. and 11:32 a.m., respectively, the Nursing Home Administrator (NHA) and DON acknowledged there was a concern identified with a staff member attempting to steal medical supplies, a specialized wheelchair cushion, and heel protector boots. The NHA said Licensed Practical Nurse (LPN) N reported the concern to the NHA and DON in October of 2021. During an interview on 11/8/21 at 2:15 p.m., the DON confirmed LPN N had come to her with allegations of potential misappropriation of medical supplies, and LPN N had cell phone photographs of the boxes which had LPN O's name on them and contained medical supplies. The DON stated, [The NHA] and I decided together that [LPN O] had no use for those items . The DON confirmed witness statements were not obtained, Central Supply staff was not interviewed, and no written documentation was available to show the complete investigation of the allegation of potential misappropriation of medical supplies purchased for use by facility residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/3/21 at 11:30 a.m., the NHA and DON confirmed knowledge of the missing COVID-19 test solution. The DON said the testing kits were previously stored unsecured and accessible to facility staff. The DON said she recently went through all the 22 boxes of COVID-19 test kits (50 kits per box) and found the required test solution was missing from all but three or four of the boxes. The DON acknowledge her concern that COVID-19 test kits and test solution were being taken out of the building and brought home by facility staff for personal use. The NHA and DON confirmed the COVID-19 Point-of-Care (POC) test kits were used for COVID-19 testing of facility residents and staff. No allegations of misappropriation of the COVID-19 testing supplies was submitted to the State Agency or Local Authorities. Review of Abuse, Neglect, and Exploitation policy, revised 12/20, revealed the following, in part: .A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Investigations may include but not limited to: 1. Identifying staff responsible for the investigation. 2. Exercising caution in handling evidence that could be used in a criminal investigation . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and other who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause, and 6. Providing complete and thorough documentation of the investigation. 35102 Resident #10 An abbreviated survey was conducted to investigate an anonymous allegation, filed on 10/27/21, of Resident #10 missing 2.5 ml (milliliter) of morphine sulfate immediate release (MSIR) liquid on 10/26/21. During an interview on 11/2/21 at 10:56 a.m., the DON, in the presence of the NHA, was asked about Resident #10's Morphine Sulfate discrepancy from 10/26/21. The DON said Infection Preventionist/Registrered Nurse (RN) C came to her office later in the day on 10/26/21, and reported Resident #10 had a Morphine Sulfate discrepancy. When asked for the investigation file regarding Resident #10's narcotic discrepancy the DON acknowledged no investigation had been completed, no witness statements were obtained, and no narcotic reconciliation was performed. The DON said she had not reviewed Resident #10's October 2021 Medication Administration Record (MAR) which show Resident #10 never received Morphine Sulfate from the time LPN L took possession of the Medication cart on 10/26/21 at 6:45 a.m., until relieved by RN C that same day at 9:45 a.m Review of Abuse, Neglect, and Exploitation policy, revised 12/20, revealed the following, in part: .A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Investigations may include but not limited to: 1. Identifying staff responsible for the investigation. 2. Exercising caution in handling evidence that could be used in a criminal investigation . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and other who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause, and 6. Providing complete and thorough documentation of the investigation.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 35103 Based on interview and record review, the facility failed to ensure nursing staff, including Certified Nurse Aides (CNAs), had the appropriate competencies and skill sets to provide direct nursing care to maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice resulted in the potential for facility nursing staff to lack the specific skill sets to meet resident care needs which had the potential to affect all 50 residents. Findings include: During an interview on 11/8/21 beginning at 11:55 a.m., Human Resources Director (Staff) G, following review of personnel files, confirmed the absence of any annual competency for all CNAs and nursing staff. Staff G said the Director of Nursing (DON) was responsible for completion of, or delegation, to complete CNA and licensed nurse annual competencies. During an interview on 11/8/21 at 2:51 p.m., when asked about completion of required annual licensed nurse competencies, the DON stated, I have not done any nurses (nurse competencies). The DON confirmed 18 licensed nurses were employed by the facility and an annual competency had not been completed for any of the licensed nurses in the previous year. The DON provided evidence of seven CNA competencies completed, out of a facility CNA total staff number of 18. The DON acknowleged staff competencies should have been completed annually. Review of the Facility Assessment, dated 10/26/21, revealed the following, in part: Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides . Address areas of weakness as determined in nurse aides' performance reviews .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35102 Based on interview and record review, the facility failed to provide a system of medication record keeping that enabled accurate reconciliation and accounting for a controlled narcotic medication for one Resident (#10) of three residents reviewed for narcotic administration. This deficient practice resulted in the potential for Resident #10 not receiving medications per physician orders and/or possible drug diversion. Findings include: An abbreviated survey was conducted to investigate an anonymous allegation of Resident #10 missing 2.5 ml (milliliter) of morphine sulfate immediate release (MSIR) liquid on 10/26/21. Review of Physician Visit, 10/13/21, read in part, (Resident #10) with progressive MS (multiple sclerosis) over time and now some dementia . has a history of . chronic pain due to osteoarthritis and MS . nursing staff notices that she complains a lot of pain on a regular basis . Review of the Controlled Substance Shift Inventory, beginning date of 10/21/21, showed on 10/26/21 at 0630 (6:30 a.m.) that Licensed Practical Nurse (LPN) P and LPN L counted narcotics at 6:30 a.m. and all narcotics were accounted for (reconciled). The next entry on the same Controlled Substance Shift Inventory form had an entry date of 10/26 at 1600 (4 p.m.) which was crossed out and did not contain any signatures. The next line entry was made on 10/26/21 at 1600 (4:00 p.m.) by Registered Nurse (RN) C and LPN Q. Review of Physician Order, 9/30/21, showed Resident #10 was prescribed Morphine Sulfate (concentrate) Solution 20 mg/ml (microgram per milliliter) to give 0.25 ml orally every two hours as needed for pain. Review of Resident #10's Proof of-Use Record which contained hand-written entry, undated, (Resident #10's name) 0.25 ml Q 2 H PRN (every two hours as needed). No identification of the narcotic's name, dose concentration, and total amount prepared in the bottle was written on the record. A hand-written note read, 7. 0 cc (cubic centimeter) med (medication) over (sic carried) with the first entry on 10/23/21 bringing the amount remaining in the bottle to 6.75 ml. The last entry on 10/26/21 at 0930 (09:30 a.m.) showed the amount remaining in the bottle was zero which was signed (witnessed) by RN C and LPN L. Review of Resident #10's October 2021 Medication Administration Record (MAR) showed Morphine Sulfate (20 mg/ml) 0.25 ml was administered on the night shift beginning at 22:30 (10:30 p.m.), at 00:34 (12:34 a.m.), and lastly at 03:00 a.m. No additional times were recorded to show either LPN L nor RN C had administered 0.25 ml of the Morphine Sulfate. During an interview on 11/1/21 at 2:56 p.m., RN C confirmed she had reconciled narcotics on LPN L's medication cart on 10/26/21 at around 9:30 a.m. RN C was asked about Resident #10's Morphine Sulfate discrepancy. RN C said the bottle was bone dry and acknowledged she had recorded zero in the amount remaining entry on the Proof-of-Use sheet on 10/26/21 at 9:30 a.m. even though she had not administered a dose to Resident #10 at that time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/2/21 at 10:56 a.m., the Director of Nursing (DON), in the presence of the Nursing Home Administrator (NHA) confirmed awareness of Resident #10's MSIR discrepancy from 10/26/21. The DON said RN C came to her office later in the same day and reported she needed to open another bottle of Resident #10's Morphine Sulfate since she didn't have enough for the 0.25 ml dose. When asked about the process of reporting narcotic discrepancies, the DON said staff were expected to complete a Concern/Complaint Form. The DON confirmed that RN C nor anyone else had completed a Concern/Complaint Form regarding Resident #10's missing MSIR on 10/26/21. The DON confirmed no nurses were asked to complete witness statements and Resident #10's MAR was not reviewed which showed Morphine Sulfate 0.25 ml was not administered to Resident #10 between the time LPN L had possession of the medication cart and when RN C took over the cart around 9:30 a.m. During a telephone interview on 11/2/21 at 4:06 p.m., Pharmacist Consultant U, in the presence of the DON, confirmed the DON notified her on 11/1/21 of Resident #10's missing MSIR (not on 10/26/21- the date of the incident). During the same interview, the DON said she was not aware that she was required to notify the pharmacist with any narcotic discrepancies. During an interview on 11/3/21 at 1:44 p.m., LPN L confirmed the NHA, on 10/26/21 at around 8:30 a.m., had instructed her to go home since he had received complaints from staff that she was out of sorts. LPN L said she had reconciled her narcotic medications with RN C on 10/26/21 at around 9:30 a.m. LPN L said RN C found Resident #10's MSIR bottle to be empty and said she would later notify the DON. LPN L confirmed the DON never requested LPN L to fill out a Concern/Complaint Form nor to write a witness statement. LPN L said, This is the first time I'm hearing about this (the missing Morphine Sulfate medication). LPN L said she did not remember administering MSIR to Resident #10 on the morning of 10/26/21. Telephone interviews were attempted with LPN P (documented as having also counted narcotics on 10/21/21) on 11/2/21 at 3:39 p.m. and on 11/3/21 at 12:02 p.m. Voice mail messages were left to request return calls. No return calls were received from LPN P. Review of facility's policy CONTROLLED SUBSTANCE STORAGE, dated June 2019, read in part, E. At shift change or when keys are transferred, a physical inventory of all controlled substances .is conducted by two licensed nurses and is documented . F. Any discrepancy in controlled substance counts is reported to the Director of Nursing immediately. The Director of Nursing or designee investigates and makes reasonable effort to reconcile all reported discrepancies. The Director of Nursing documents irreconcilable discrepancies, and the Consultant Pharmacist is notified .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35103 Based on observation, interview, and record review, the facility failed to provide palatable food at the appropriate temperatures for resident consumption and enjoyment. This deficient practice resulted in dissatisfaction with food provided that had the potential to affect all 50 facility residents. Findings include: An abbreviated survey was conducted 11/1/21 through 11/8/21 to investigate a complaint that had multiple allegations including that facility food was not palatable (pleasant to taste). During an interview on 11/2/21 at 8:56 a.m., Resident #13 was asked about satisfaction with facility food. Resident #13 stated, I don't choose to eat the food most of the time because I don't like it. There is no spice in that food whatsoever. Some garlic would be wonderful, but they don't do that here. Resident #13 said he ate the oatmeal, but often it was cold. During an interview on 11/2/21 at 9:00 a.m., Resident #12 was asked how the food was in the facility. Resident #12 stated, It is not the best. Everything is so bland. They don't use seasonings . During a telephone interview on 11/2/21 at 1:00 p.m. Resident #11 was asked about the food while residing in the facility. Resident #11 stated, The food didn't taste good, and it was flavored to someone else's taste other than mine . During a telephone interview on 11/3/21 at 5:21 a.m., Staff K was asked about resident food satisfaction. Staff K stated, They (residents) usually get cold toast, with no butter, and eggs. It is terrible . rarely any meat with the breakfast. The residents complain all the time about the food, and I am embarrassed to even give it to them. With us being short of staff their food is also cold. Nobody comes to pass the breakfast trays. The only time that happens is when State (State Agency) shows up in the parking lot. When asked which residents complain about the food, Staff K stated, All of them! During an observation and interview on 11/3/21 at 12:10 p.m., Staff W was observed passing meal trays on the 400 hall. Staff W pulled a lunch tray from the meal cart that held soup, mashed potatoes, a biscuit, a brownie, and water. Staff W said she did not know what kind of soup was in the bowl, and stated, Some meals don't even make sense. Staff W said there was no meal tray card that even identified what food was on the tray so staff could tell residents what they were given to eat. Review of the Fall Winter [Corporation] North 2021-2022 Meal Schedule revealed the following 11/3/21 Lunch Menu: Pork Chop with Mushroom Gravy, Roasted Potato Medly, Dilled Carrots, and Turtle Squares. The food served on 11/3/21 at lunch was inconsistent with the lunch menu. Review of the Resident Council Food Council Minutes revealed the following food/meal concernst: October 5, 2021 - Temperature of food not hot enough, no weekly menus being distributed, and food is too bland. September 15, 2021 - Temperature of food not hot enough, food is too bland. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Ishpeming	435 Stoneville Rd Ishpeming, MI 49849

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	August 4, 2021 - Temperature of food too cold. July 7, 2021 - Temperature of food luke warm or cold. June 9, 2021 - Temperature of food if eating in room is cool, soup is often cool, During interview on 11/3/21 at 1:30 p.m. and 2:20 p.m., Registered Dietitian (RD) T acknowledged the lunch described above was not comparable to the meal provided in the prepared meal plan. RD T also provided Food Usage and Temperature Logs that included blank entries. RD T stated, We have blank Food Use and Temp Logs. Not one thing is written down. I will be doing education with staff. When asked the concern with appropriate food temperatures and meal replacements, RD T stated, I get it . We are doing weekly food palatability (surveys) now.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35103 Based on observation, interview and record review, the facility administration failed to effectively and efficiently maintain the facility environment and services, which included communication systems, hot water supply, and use of an inventory system to prevent medical supply diversion. This deficient practice resulted in the potential for compromised resident physical, mental, and psychosocial well-being and had the potential to affect all 50 facility residents. Findings include: An abbreviated survey was completed on 11/8/21 that investigated an anonymous complaint with multiple allegations related to environmental and physical care of facility residents. Communication Systems During interviews on 11/1/21 at 4:30 p.m., and 11/2/21 at 11:50 a.m., the Nursing Home Administrator (NHA) confirmed the facility telephones were out of service in the facility from 9/1/21 through 9/3/21. The NHA stated, It was a non-payment issue when asked about the reason for the extended communication outage. The NHA said the facility Business Office Manager RR had tried to call their communication provider, and at first it was thought to be a technical issue. When the service provider arrived at the facility he said there was no problem with the technology, but there was a concern with billing. The NHA said he then reached out to the corporate office, who advised it was not a billing issue but a technical issue. The NHA stated, I finally got a hold of the [Communication Company], because my name is on the account and they confirmed it was a billing issue. The bill had not been paid for about three months. The NHA confirmed the fax line, television, WiFi, and telephone were off. Residents with cell phones were unable to make or receive calls or texts because the WiFi was out. The NHA confirmed physician orders were texted to the Director of Nursing's (DON's) personal cell phone. The NHA said family members were not notified of the service interruption in the facility's communication systems. The NHA said Admissions Coordinator (Staff) QQ did have a facility cell phone, but that had also been previously turned off due to lack of payment on the bill. When asked if he understood the concern with the extended loss of communication in the building, the NHA stated, I think we both know billing has been an issue here. The NHA said the [Communication Company] bill was sent monthly to the corporate office, not the nursing home facility, so the facility was unaware of the accumulated outstanding balance. Review of emails between the Business Office Manager RR, the NHA, and Corporate Accounts Payable Manager SS confirmed the above details regarding the communication outage due to non-payment of a continued outstanding balance. The final email sent on 9/3/21 at 1:43 p.m., from Corporate Account Payable Manager SS read: Payments are (now) being made. Review of an undated Communication Plan, from the Emergency Operations Program and Plan Manual, pg. 75, revealed the following, in part: Our communication plan supports rapid and accurate communication both internally and externally . It is also important to communicate with relevant external partners to: . 2. share information regarding the facility's status, activities and needs . Our external communication equipment includes: PRIMARY COMMUNICATION: Land lines, Cell phones with texting, Internet/Email. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hot Water Boiler During observations on 11/2/21 at 3:29 p.m., 3:40 p.m., 3:42 p.m., and 3:43 p.m. the 400 hall, 100 hall, 200 hall, and 300 hall shower rooms, respectively, were observed with Maintenance Director (Staff) R. Water temperatures were measured in the two functional shower rooms. Both the 100 hall and 200 hall shower rooms were reported as not in use by facility staff. The 100 hall shower room contained cleaning carts and buckets, as well as dirty garbage and dirty linen containers. The tub in the 100 hall shower room was filled with what appeared to be dirty mop-head debris from water being discarded from the cleaning carts positioned next to the tub. The 200 hall smelled like methane gas (sewer gas) and was not in use. During an interview on 11/3/21 at 11:35 a.m., the NHA and DON were asked about the lack of hot water for showers. The NHA confirmed it had been months as the hot water issue was first identified in the early summer of 2021. The NHA acknowledged he was aware the hot water boiler needed to be replaced, and stated, We are well aware of the water temperature and the resident concerns. During an interview on 11/8/21 at 9:10 a.m., the NHA confirmed the bill for the water boiler was paid after this Surveyor's 10/13/21 survey and identified deficient practice related to unrepaired environmental concerns due to non-payment of outstanding balances. Review of the Rights of Resident in (State Name) Nursing Facilities, dated 11/28/16, revealed the following, in part: As a basic premise, all residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility . You have a right to a safe, clean, comfortable and homelike environment, including but no limited to receiving treatment and supports for daily living safely. Medical Supplies and Equipment During interviews on 11/1/21 and 11/2/21 at 2:26 p.m. and 11:32 a.m., respectively, the NHA and DON acknowledged there was a concern identified with a staff member attempting to steal medical supplies, a roho cushion and protective boots. The NHA said LPN N reported the concern with LPN O attempting to steal medical supplies and equipment. During an interview on 11/3/21 at 2:14 p.m., Central Supply Clerk (Staff) GG reported having no knowledge of items packed in boxes with a staff members name near the back door. When asked about Central Supply, Staff GG said she did not keep an inventory of medical equipment or supplies kept in Central Supply. Staff GG stated, I lock up when I leave and when I come back the door is wide open and lights are on. Staff GG said she would have no idea if items were or had been misappropriated, as nothing is signed out, and no inventory system was in place. Staff GG reported she had never been trained into the Central Supply position, and confirmed the NHA had never discussed potential misappropriation of medical equipment and supplies. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/3/21 at 11:30 a.m., the NHA and DON confirmed knowledge of missing COVID-19 test solution. The DON confirmed the COVID-19 test kits for point-of-care (POC) testing (each box contained 50 test kits) were not previously secured, and remained accessible to facility staff. The DON said she had gone through all the 22 boxes of COVID-19 test kits and found only three or four bottles of test solution. The DON acknowledge her concern that COVID-19 test kits and test solution were being taken out of the building and brought home by facility staff for personal use. The NHA and DON confirmed the COVID-19 test kits were used for required COVID-19 testing of facility for all residents and staff. Review of the Abuse, Neglect, and Exploitation policy, revised 12/20, revealed the following: Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35102 Based on observation, interview, and record review, the facility failed to implement a complete infection control program which affected all 50 residents. This deficient practice had ten noted deficiencies: 1. Failure to perform COVID-19 point of care testing (POC) per manufacturer's instructions. 2. Failure to appropriately manage an ongoing RSV outbreak (Respiratory Syncytial Virus). 3. Failure to perform resident line-listing surveillance and mapping. 4. Failure to exclude ill staff from direct patient care during high community spread of COVID-19. 5. Failure to follow Transmission-Based Precautions (TBP). 6. Failure to utilize proper Personal Protective Equipment (PPE). 7. Failure to follow appropriate housekeeping procedures for cleaning and disinfecting. 8. Failure to ensure appropriate hand hygiene. 9. Failure to suspend group activities and address smoking during the RSV outbreak. 10. Failure to notify transferring facility of RSV outbreak for Resident #1's and Resident #16's decline in condition. These deficient practices resulted in continuation of the RSV outbreak, the potential for cross-contamination of organisms and/or infections, and the likelihood of inaccurate COVID-19 POC test results, which had the potential to affect all 50 residents who resided in the facility. The Immediate Jeopardy began on 11/3/21 at 8:00 a.m. when Surveyors determined staff had not followed rapid COVID-19 POC testing per manufacturer's instructions when conducting bi-weekly testing on all residents and staff. The Nursing Home Administrator (NHA) and Director of Nursing (DON) were notified of the Immediate Jeopardy on 11/3/21 at 11:30 a.m. While the Immediate Jeopardy was removed on 11/3/21 at 3:00 p.m. with the initial implementation of the accepted abatement plan, non-compliance remained at the lower scope and severity of widespread potential for more than minimal harm that is not immediate jeopardy, pending on-site verification of the plan of correction. Findings include: During entrance to the facility, on 11/1/21 at 12:00 p.m., a sign was posted to the exterior door which read, Notice to Visitors: (facility) is closed at this time due to respiratory concerns . Rapid POC Testing (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 11/2/21 at 4:51 p.m., the DON said all staff were able to perform their own BinaxNOW COVID-19 Ag rapid POC testing. When asked about training from the Infection Preventionist, the DON said there wasn't any training but thought there should have been. The DON said staff were simply told to read the manufacturer's instructions. When asked to see staff competency and COVID-19 monitoring, the DON said there were none. When asked to see a policy and procedure for performing the rapid testing procedure, the DON said there wasn't one. The DON was asked to describe the steps to perform a COVID-19 test. The DON incorrectly indicated the nasal swab used for obtaining the specimen would be placed nasopharyngeal in only one nostril and rotated three times. The DON confirmed a timer was not made available to ensure the test was read at the required time. During an interview on 11/2/21 at 5:00 p.m., Human Resource (Staff) G confirmed she performed her own rapid COVID-19 test without ever being observed for competency. When asked to describe the rapid testing procedure, Staff G incorrectly said the swab would be inserted quite a way up the nostril and rotated three times before entering the other nostril. Staff G confirmed a timer was not made available. During a telephone interview on 11/3/21 beginning at 4:06 a.m., Staff N was asked about COVID-19 POC testing. Staff N said prior to the RSV outbreak (10/27/21) night staff were coming into the building and testing in the nurses' medication room behind the front nursing desk. When asked about the specific testing procedure, Staff N stated, I put it (swab) in the back of my throat, swab three times, and wait it out. Staff N said it usually went positive for about ten minutes. Staff N took a picture of the COVID-19 test card for personal documentation and said the test kits were previously placed in a box in the medication room (not in the soiled utility room) for the infection control nurse to review at a later time and date. No documentation of COVID-19 results was provided to Registered Nurse/Infection Preventionist (IP) C, other than a verbal statement of negativity. During a telephone interview on 11/3/21 at 5:21 a.m., Staff DD said night staff completed COVID-19 testing inside the building at the nurses' station. Staff DD stated, Half the time I don't think the tests even get done. Infection control here is [NAME] t. Half the time there is nobody checking (COVID-19 testing). I can do the test and then we just throw it away because . nobody reads them. They don't even know if we are doing the test. We don't have to take a picture of it, we don't put it on a log, we just throw it away. If somebody doesn't know how to do the testing right - it is pointless. When asked to describe the COVID-19 testing procedure, Staff DD stated, We swab our throat or nose. I use my nose .one nostril . I put the swab really far up in my nose. I swab it twice .I wait a couple of minutes . then I throw the test in the garbage . During interviews on 11/3/21 at 11:44 a.m. and 1:43 p.m., with Staff J and Staff W (interviewed together) and Staff L, respectively, confirmed staff members were not performing their own COVID-19 testing per manufacturer's instructions. Staff W took the COVID-19 test sample from her throat, and noted she threw the test away with no facility staff ever seeing the test results. Staff J went way up the nose and waited just til (sic) I see the line all the way across without the use of a timer. Staff J said instruction had been provided by IP C to wait a couple of minutes (for results) and throw out the (COVID-19) test in the garbage. Staff L said the swab was inserted as far up the nose as possible and rotated six times using only one nostril. Staff L looked at a clock and checked it later for the results. The used COVID-19 test kit was then left in the med room, IP C's door, or in IP C's office (on the desk). Staff L said sometimes the test kits were thrown away, or sometimes she would get tested at a different job and self-report t to IP C. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 11/ 8/21 at 11:25 a.m., Staff OO was observed performing a COVID-19 self-test. Staff OO did not perform hand hygiene prior to beginning the test and did not don gloves. Staff OO touched the front of her face mask with her bare hand and pulled it up and over her previously exposed nose. No hand hygiene was performed. Staff OO touched the multi-use COVID-19 test solution bottle, and again touched the front of her mask with her bare hand. When asked about using the swab to collect the specimen, Staff OO' stated, It is very uncomfortable . I am not used to doing our nostrils. Staff OO said she had only used one nostril - the right nostril. Staff OO again had her mask down beneath her nose following completion of the test. Staff OO sat less than six feet from Staff PP who had tested minutes earlier. Staff OO touched the arms of the chair she was sitting in and rose from the chair to leave the room. No hand hygiene had been observed. When asked about hand hygiene, Staff OO stated, No, I didn't do it (hand hygiene) . but I will now. Review of BinaxNOWCOVID-19 AG manufacturer's instructions, Rev2 12/2020, read in part: PRECAUTIONS . 7. Treat all specimens as potentially infectious. Follow universal precautions when handling specimens, this kit and its contents. 8. Proper sample collection, storage and transport are essential for correct results . 17. Wear appropriate personal protective equipment and gloves when running each test and handling patient specimens. 18. INVALID RESULTS can occur when an insufficient volume of extraction reagent is added to the test card . External Positive and Negative Controls: Good laboratory practice suggests the use of positive and negative controls to ensure that the test reagents are working and that the test is correctly performed . Anterior Nasal (nares) Swab To collect a nasal swab sample, carefully insert the entire absorbent tip of the swab (usually 1/2 to 3/4 of an inch . into the nostril. Firmly sample to nasal wall by rotating the swab in a circular path against the nasal wall 5 times or more for a total of 15 seconds, then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril . TEST PROCEDURE Read result in the window 15 minutes after closing the card. In order to ensure proper test performance, it is important to read the result promptly at 15 minutes, and not before . During an interview on 11/3/21 at 11:30 a.m., the DON confirmed the facility had not performed the required positive and negative controls with each BinaxNow COVID-19 Ag test kit. The DON confirmed that staff test results were not formally recorded on a log and maintained by the IP C. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	RSV The Centers for Disease Control and Prevention for Healthcare Providers (https://www.cdc.gov/rsv/clinical), read in part, (RSV) causes annual outbreaks of respiratory illnesses in all age groups . In Older Adults and Adults with Chronic Medical Conditions . Symptoms are usually consistent with an upper respiratory tract infection which can include rhinorrhea (runny nose), pharyngitis, cough, headache, fatigue, and fever. Disease usually lasts less than five days. Some adults, however, may have more severe symptoms consistent with a lower tract infection, such as pneumonia. Those at high risk for severe illness from RSV include *Older adults, especially over [AGE] years and older * Adults with chronic lung disease or heart disease *Adults with weakened immune systems. RSV can sometimes lead to exacerbation of serious conditions such as *Asthma * Chronic obstructive pulmonary disease (COPD) * Congestive heart failure. Transmission-Based Precautions During an initial tour on 11/1/21 beginning at 12:27 p.m., all halls' double-doors which separated the 100, 200, 300, and 400 halls remained wide-opened. The following resident rooms contained contact/droplet isolation signage and every resident room door remained wide-open: Resident #18 was observed sitting up in wheelchair eating lunch. Resident #1 and Resident #2 were both observed both lying in bed. Resident #3 was observed lying in bed. Resident #4 was observed using oxygen. Resident #5 was observed self-propelling in a wheelchair down the 100 Hall without the use of any PPE. Resident #6 was observed in bed. PPE supplies were not located outside the door. Resident #7 was observed and heard coughing in bed. Resident #8 had a large floor fan was observed on and blowing in the center of the room. Resident was lying in bed. During an observation on 11/2/21 beginning at 8:56 a.m., the following Resident rooms in Contact/Droplet TBP room doors were wide-open: 102, 104, 108, 109, 115 (where linens were placed directly on the handrail to the right side of the door), 116, 303, and room [ROOM NUMBER]. Only one resident resided on the 200 hall. During a second observation on 11/2/21 at 9:18 a.m., Licensed Practical Nurse (LPN) H had removed contact/droplet signage from various rooms on the 100 hall. When asked why, LPN H said she got a list of residents who's test results for RSV were positive, so she was taking down the signage of the rest. During this time, LPN H had removed room [ROOM NUMBER] (Resident #1 and Resident #2) contact/droplet isolation signage. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the 13 residents tested for RSV on 10/28/21, showed that Resident #1 was not tested and that Resident #2's RSV results were indeterminant (the test did not provide a clear negative or positive result). Review of Resident #1's Progress Notes on 10/28/21 at 13:14 (1:14 p.m.) read in part, Notified by wing nurse that res (resident) with change in condition . Diaphoretic and very minimal response . V/S (vital signs) 162/92 (blood pressure) 36 (respiratory rate) 89% RA (room air oxygen saturation) 120 (heart rate). Lung sounds diminished throughout . EMS (emergency medical service) called at 1320. During an observation on 11/2/21 at 9:23 a.m., Resident #18 (who was in TBP) door was wide open. Resident #18 sat in a wheelchair in the doorway. Resident #18 had a cough and was not wearing a mask. Another unidentified male resident, who was not wearing a mask, self-propelled directly in front of Resident #18 while he was in the doorway. During an observation on 11/8/21 at 9:40 a.m., all TBP room doors with Droplet Precaution signage were observed wide open. During an interview at this same time Staff AA was asked about the open doors on rooms [ROOM NUMBERS]. Staff AA said she was unaware that the doors were supposed to remain closed for those droplet precaution residents. Staff AA stated, [IP C] said if the care plan says they can have the door open it is fine. Staff AA said facility staff had not received any instruction to close the doors on the isolation rooms. During an interview on 11/8/21 at approximately 9:43 a.m., IP C was asked about the open doors on all RSV droplet precaution rooms. IP C said if it was care planned, residents could have their doors open if they wanted them open. When asked if open doors during a respiratory outbreak was acceptable, IP C stated, I don't know why the doors are open. During an interview on 11/8/21 at 10:27 a.m., the NHA, DON, and IP C were asked about failure to close doors for RSV isolation residents. All agreed that droplet TBP should be closed if at all possible. Review of facility's posted TBP Droplet Precautions signage, undated, read in part, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. TBP/Personal Protective Equipment/Hand Hygiene During an observation on 11/1/21 at approximately 12:41 p.m., LPN M and Staff W entered room [ROOM NUMBER] which contained contract/droplet isolation signage without performing hand hygiene, donning an N95 (high filtration mask), a gown, eye protection (face shield or goggles), nor gloves. Both LPN M and Staff W wore surgical masks which were observed being worn earlier and not changed prior to entering room [ROOM NUMBER]. After several minutes, Staff W exited room [ROOM NUMBER], wearing the same surgical mask, carrying a soiled meal tray which was placed back into the meal cart without the performance of hand hygiene afterwards. During two observations on 11/1/21 and on 11/2/21 (12:37 p.m. and 9:48 a.m., respectfully), IP C was observed with a surgical mask pulled down under her nose while seated in a desk facing the doorway in a small office located on the 300 hall. The door was wide open, and a second unidentified staff person was in the room seated at a separate desk. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Ishpeming	435 Stoneville Rd Ishpeming, MI 49849

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 11/1/21 at 2:25 p.m., Resident #8's room door was wide open with a male visitor in the droplet precaution room. Resident #8 was positive for RSV on 10/28/21 and could be heard coughing from the doorway. The visitor was observed without mask, face shield or goggles, or gloves while he consumed, what appeared to be, a sandwich in Resident #8's room. Signage was present on Resident #8's door showing all PPE was to be donned while in the room. Both the clean PPE and the garbage cans for removal of dirty PPE were located outside of the room, in the hallway. LPN M instructed the visitor he needed to wear a mask. LPN M also confirmed the dirty PPE container should be inside the room, for doffing (removal) of PPE prior to entering the hallway. During an interview on 11/1/21 at 3:03 p.m., when asked what PPE visitors should be wearing, IP C said visitors should be wearing the same PPE staff were required to wear in isolation rooms: gloves, face mask, face shield, and gown. IP C confirmed the garbage can for removal of dirty PPE observed outside of Resident #8's room should have been inside the room and noted dirty PPE should be removed inside the isolation room. When asked about all the RSV isolation room doors remaining open, IP C stated, I would not consider that standard of care precautions. Surveillance Line-Listing Infections/Mapping/Outbreak Management During an interview on 11/1/21 at 1:05 p.m., IP C confirmed the facility had identified an RSV outbreak which began with residents having upper respiratory symptoms on 10/27/21. IP C was asked to provide October 2021 and November 2021 resident line-listing surveillance and mapping. IP C provided October 2021 resident line-list surveillance which did not include any of the residents suspected and/or confirmed with RSV. IP C provided October 2021 infection mapping which only identified four residents with the following infection concerns: one wound infection, one herpes virus, one UTI (urinary tract infection), and one mouth abscess. When asked why none of the residents suspected of RSV who were in TBP were not included, IP C said she had not had time to complete the line-listings and mapping for October 2021 and November 2021. When asked to identify which residents were suspected of RSV, IP C provided a piece of scratch paper, dated 10/28/21, with 12 resident names that were hand-written that had several names crossed out. (Note-It was later determined after review of RSV test results that one resident (Resident # 19) was not identified on IP C's scratch paper dated 10/28/21 nor on the October 2021 line-listing. IP C was asked and unable to provide an outbreak timeline to show what actions and interventions were taken to manage the outbreak (i.e. notification to the Medical Director, notification to the local health department, implementation of isolation of symptomatic and/or suspected residents, contact tracing of staff illnesses, staff education of RSV and appropriate PPE use, staff monitoring, cessation of communal dining, cessation of in-person visitation, responsible party notifications, housekeeping department notification/education, etc.) When asked when should hand hygiene be performed with glove use, IP C answered before and after glove usage when entering/exiting an isolation room. When asked how RSV was transmitted, IP C said it was airborne. During an interview on 11/8/21 at 10:16 a.m., when asked if the RSV outbreak had been contained to the original 13 residents from 10/28/21, IP C and the DON confirmed additional residents had become symptomatic the first week of November 2021 who now included: roommates (Resident #17 and Resident #20), roommates (Resident #21 and Resident #22), and (Resident #16 who was a prior roommate to Resident #23 who was RSV positive) and Resident #24 who became acutely ill on 11/4/21 and transferred to the hospital. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of facility's policy Standard and Transmission-Based Precautions, dated 12/2020, read in part, Isolation will be initiated for residents who are known or suspected to be infected or colonized with infectious agents that require additional controls to prevent transmission effectively. Review of facility's policy, Infection Outbreak Response and Investigation, dated 12/2020, read in part, The facility promptly responds to outbreaks of infectious diseases .Implementation of infection control measures: a. Symptomatic residents will be considered potentially infected, assessed for immediate needs, and placed on empiric precautions while waiting for physician orders. b. Symptomatic employees will be screened by the Infection preventionist . and referred to appropriate medical provider. c.Transmission-based precautions will be implemented . d. Surveillance activities will increase to daily for the duration of the outbreak .b. The Infection Preventionist will be responsible for coordinating all investigations activities .d. A line list about each person affected by the outbreak will be maintained . GROUP ACTIVITY/SMOKING During an observation on 11/1/21 at 2:12 p.m., four residents without the use of face masks (which included Resident #5 who was in contact/droplet isolation for RSV) were seated side-by-side in the activity room with Activity Aide (Staff) V and Activity Director (Staff) X. When asked about the group activity observation, Staff X said, (Resident #5) should not be in here. She's on the sick list . During an interview on 11/2/21 at 11:55 a.m., the DON and NHA were asked about the Surveyor's group activity observation from 11/1/21 at 2:12 p.m. The DON said all group activities should have been canceled due to the identification of the facility-wide RSV outbreak. When asked who was responsible for the outbreak timeline and interventions, the DON said IP C. The DON confirmed that symptomatic residents for RSV beginning on 10/27/21 were not placed into isolation until 10/28/21. During an observation on 11/8/21 at approximately 1:30 p.m., a group of residents were seated together (not each separated by 6 feet) smoking outside of the facility's building. No residents were wearing face masks. During an interview on 11/8/21 at 2:00 p.m., the DON and IP C confirmed residents were still permitted to smoke during the RSV outbreak. The DON provided a list of residents who smoked which included Resident #7 who was positive for RSV and Resident #2 who was indeterminate of RSV. When asked what interventions were in place to address these residents, IP C said she had not considered the residents who smoked. During an interview on 11/8/21 at 3:00 p.m., Staff V confirmed that residents went out to smoke as a group, without wearing masks, at 9:30 a.m., 1:30 p.m., and 6:30 p.m. When asked what infection control education and interventions were in place with regards to the RSV outbreak, Staff V said she had not received any education or direction. Ill STAFF PERFORMING DIRECT RESIDENT CARES During an interview on 11/1/21 at 2:20 p.m., the NHA and DON said LPN L was sent home on 10/26/21 around 9:30 a.m. because she sounded groggy, had a cough, and seemed unwell. When asked about her COVID-19 entrance screening, the NHA indicated she may have answered the screening questions untruthfully; therefore, was not prevented from entering the facility. (continued on next page)

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Mission Point Nsg & Phy Rehab Ctr of Ishpeming	435 Stoneville Rd Ishpeming, MI 49849

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 11/1/21 at 2:56 p.m., IP C was asked why she replaced LPN L on her medication cart on 10/26/21 at approximately 9:30 a.m. IP C said, Oh, she went home. I'm not sure why . When told about other staff reporting to the NHA of suspected illness, IP C then said, She did have a cold. Her voice was hoarse. IP C was asked to provide October/November 2021 Employee Illness Logs where LPN L had one entry on 10/9/21 for being tired and none for leaving work on 10/26/21 for a cold. Further review of October/November Employee Illness Logs showed Staff G had cold symptoms on 10/20 and LPN P on 11/1/21 had cough/sinus congestion (possible symptoms of RSV). No contract tracing had been performed by IP C for any of the three identified ill staff. During an interview on 11/2/21 at 10:41 a.m., Registered Nurse (RN) H said she was asked to be present by the NHA on 10/26/21 when LPN L was being directed to leave the facility. When asked how LPN L appeared, RN H said LPN L had a cough, was clearing her throat, appeared tired/exhausted, and indicated her eyes were runny. LPN H said LPN L was very sick the prior week. During an interview on 11/2/21 at 10:56 a.m., the DON was asked about LPN L being asked to leave work early on 10/26/21. The DON said she was not in the building at the time since she wasn't feeling well but indicated she came into work later that day sometime between 10 a.m.-11:00 a.m. The DON said either IP C or LPN H reported that LPN L was very sick and coughing. Review of October 2021 Employee Infection Control Log showed no entry was made for the DON's illness on 10/26/21. During the same interview on 11/2/21 at 10:41 a.m., the NHA said on 10/26/21 that LPN L was observed at her medication cart on the 300 hall hacking up a lung and described as definitely sick. When asked about the COVID-19 entrance screening for signs/symptoms of illness not preventing LPN L from entering the facility and caring for residents, the NHA responded, That's a concern for me. During an interview on 11/3/21 at 1:44 p.m., LPN L was observed with her surgical mask under her nose. When asked how she was feeling since her voice appeared hoarse and strained, LPN L responded, awful. LPN L explained that she was ill the previous week (sent home 10/26/21) due to having the following symptoms: fever, cough, shortness of breath, sore throat, and loose stools. When LPN L was asked why she came to work last week feeling ill and again today, LPN L said, I had already called in and we were short staff. 35103 LOCAL HEALTH DEPARTMENT OUTBREAK REPORTING During a telephone interview on 11/1/21 at 3:25 p.m., the local health department (LHD) Communicable Disease Nurse, Registered Nurse (RN) Y confirmed IP C had reported nine residents (not 13 residents) on 10/28/21 with upper respiratory infections. RN Y said IP C reported that all symptomatic residents were cohorted and resided on one hallway (not three different hallways where Surveyors identified resident rooms in TBP during initial tour on 11/1/21 beginning at 12:27 p.m. was facility-wide). RN Y said the LHD did not know other halls were involved. When asked about the facility leaving all room doors open for symptomatic residents, RN Y stated, I would not consider that standard of care for (TBP) precautions. HOUSEKEEPING (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 11/2/21 at 3:35 p.m., of the 200 hall shower room, Maintenance Director (Staff) R said the shower room smelled like sulfur. When this Surveyor noted it smelled like methane (sewer gas), Staff R agreed. During an interview on 11/3/21 at 5:31 a.m., Staff DD was asked about the cleanliness of the facility. Staff DD stated, Everything is dirty. We don't have enough housekeepers . Some of the bathrooms stink and they have mildew and mold around the water line (in the toilets). Staff DD said it appeared they were dumping dirty housekeeping water down the tub in the 100 hall shower room. During an observation on 11/3/21 at 11:40 a.m., the 100 hall shower room was observed with Staff W due to a very strong odor emitted outside of the closed door. Inside the room contained a soiled linen bin which contained dirty linens. Staff W said the shower head had been broken for a long time and indicated the water never really got hot enough. The white bathtub was grossly soiled and stained brown. A mop and dirty water pail were located directly next to the bathtub. Staff W explained housekeeping emptied their dirty mop bucket water into the bathtub. During an interview on 11/3/21 at 12:41 p.m., Housekeeping (Staff) F confirmed she did not know why the current residents were in TBP. When asked if the organism would be pertinent to know for appropriate cleaning and disinfection products selected to clean the isolation room, Staff F agreed. Staff F confirmed IP C had not communicated with housekeeping regarding the current outbreak of RSV within the facility. Observation of the facility hallway floors on 11/1/21, 11/2/21, and 11/3/21 at 12:37 p.m., 3:35 p.m., and 12:30 p.m., respectively, found brown smeared residue and droplets that resembled dried liquid diarrhea, along with shiny dried liquid stains on all four hallways. During an observation/interview on 11/2/21 and 11/3/21 at 3:25 p.m., and 12:35 p.m., respectively, RN KK and (Staff) F were asked to observe the smeared brown residue and round brown droplets on the 200 hall floor with this Surveyor. RN KK stated It looks like poop to me. And Staff F stated, Could be poop. Staff F said the new maintenance director should be cleaning the floors daily. Staff F said empty rooms were to be cleaned to prevent the accumulation of mold and mildew in the toilets. When asked to look into a 200 hall bathroom, Staff F stated, No Way! Oh my God! at the accumulation of mold and mildew in the toilet. Review of the Floor Care policy, dated 1/11/2021, revealed the following in part: One of the ways infection is spread in a facility is through air-born particles. Since these particles settle on the floors throughout a facility, sanitizing the floors is the key to a good Infection Control Program . DAILY FLOOR CARE: . Damp Mopping Hallways and Common Areas, Hallway - Hallways must be damp mopped half a hallway at a time . Change water and solution regularly to keep the germicide effective . Review of the Routine Cleaning and Disinfection policy, implemented 1/11/2021, revealed the following, in part: 11. Horizontal surfaces (hard surface flooring) . should be cleaned: a. On a regular basis, b. When soiling and spills occur . HAND HYGIENE (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 11/2/21 at 9:19 a.m., IP C removed a used (dirty) water mug from Resident #13's room and placed it on the clean water mug cart. IP C did not perform hand hygiene and picked up a clean water mug, from the same cart, and delivered the mug into room [ROOM NUMBER]. No hand hygiene was performed upon exit from room [ROOM NUMBER]. When asked about the hand hygiene, IP C acknowledged failure to perform hand hygiene and said hand hygiene would be done right now. Review of the Hand Hygiene policy, revised 12/20, revealed the following, in part: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . Review of the Centers for Disease Control and Prevention, Hand Hygiene in Healthcare Settings, last reviewed 1/30/2020, revealed the following, in part: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: . After touching a patient or the patient's immediate environment, After contact with blood, body fluids, or contaminated surfaces . HOSPITAL TRANSFERS Resident #1 Review of Resident #1's Admission Record, print date 11/3/21, reflected the following applicable diagnoses: ischemic cardiomyopathy, congestive heart failure, diabetes, and cognitive communication deficit. Resident #1 was a roommate of Resident #2 (who was indeterminate of RSV on 10/28/21 lab collection) and placed in TBP on 10/28/21. Review of Resident #1's hospital transfer form, dated 10/28/21, was completed by IP C and read in part, Currently on isolation precautions (no) was selected. Significant communicable disease (left blank). Resident #16 Review of Resident #16's Admission Record, print date 11/3/21, reflected the following applicable diagnoses: multiple sclerosis (disease in which immune system eats away at the protective covering of nerves), lung cancer, chronic obstructive pulmonary disease, and fibromyalgia (widespread muscle pain). Resident #16 was a roommate of Resident #23 (who was positive for RSV on 10/28/21) and placed in TBP on 10/28/21. Review of Resident #16's hospital transfer form, dated 11/4/21, read in part, Currently on isolation precautions (no) was selected. Significant communicable disease (left blank). During an interview on 11/8/21 at 2:00 p.m. the DON and IP C were asked about Resident #16's hospital transfer documentation which incorrectly indicated no isolation precautions. Neither the DON nor IP C could identify any documentation which would show the transferring hospital knew of the facility's RSV outbreak. Both the DON and IP C agreed notification of the RSV outbreak was relevant information for c [TRUNCATED]

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 35103 Based on observation, interview, and record review, the facility failed to a maintain safe, functional and comfortable environment by the loss of critical telephone, fax, internet, and Wi-Fi service and an prolonged delay in replacement of the hot water system for resident showers. This deficient practice resulted in an unsafe and uncomfortable environment, loss of routine communication systems, use of private cell phones for receipt of physician orders, lack of television for resident viewing, inability to make emergency calls from facility phones, and loss of internet and fax services for residents and staff. This deficiency affected all 50 facility residents. Findings include: An abbreviated survey was conducted 11/1/21 through 11/8/21 to investigate an anonymous complaint that had multiple allegations including that the facility had no working facility phone for an extended period of time and facility equipment was not being maintained. During an interview on 11/2/21 at 9:00 a.m., Resident #12 was asked if there had been an interruption in telephone service in the facility. Resident #12 stated, The phones didn't work, the TVs didn't work, and the internet didn't work. It was in September or October of 2021. We had no TV. They (facility staff) did not provide an explanation of what happened, and they said they were working on it. I had family that tried to call to make an appointment (for visitation) and the phone just kept on ringing and ringing - because it wasn't working. Resident #12 confirmed the services were out for several days. Review of an undated Communication Plan, from the Emergency Operations Program and Plan Manual, pg. 75, revealed the following, in part: Our communication plan supports rapid and accurate communication both internally and externally . Our internal communication equipment includes: . Cell phones with texting . It is also important to communicate with relevant external partners to: . 2. share information regarding the facility's status, activities and needs . Our external communication equipment includes: PRIMARY COMMUNICATION: Land lines, Cell phones with texting, Internet/Email . (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interviews on 11/1/21 at 4:30 p.m., and 11/2/21 at 11:50 a.m., the Nursing Home Administrator (NHA) confirmed the facility telephones were out of service in the facility from 9/1/21 through 9/3/21. The NHA stated, It was a non-payment issue when asked about the reason for the extended communication outage. The NHA said the facility Business Office Manager RR had tried to call their communication provider, and at first it was thought to be a technical issue. When the service provider arrived at the facility he said there was no problem with the technology, but there was a concern with billing. The NHA said he then reached out to the corporate office, who advised it was not a billing issue but a technical issue. The NHA stated, I finally got a hold of the [Communication Company], because my name is on the account and they confirmed it was a billing issue. The bill had not been paid for about three months. The NHA confirmed the fax line, television, WiFi, and telephone were off. Residents with cell phones were unable to make or receive calls or texts because the WiFi was out. The NHA confirmed physician orders were texted to the Director of Nursing's (DON's) personal cell phone. The NHA said family members were not notified of the service interruption in the facility's communication systems. The NHA said Admissions Coordinator (Staff) QQ did have a facility cell phone, but that had also been previously turned off due to lack of payment on the bill. When asked if he understood the concern with the extended loss of communication in the building, the NHA stated, I think we both know billing has been an issue here. The NHA said the [Communication Company] bill was sent monthly to the corporate office, not the nursing home facility, so the facility was unaware of the accummulated outstanding balance. Review of emails between the Business Office Manager RR, the NHA, and Corporate Accounts Payable Manager SS confirmed the above details regarding the communication outage due to non-payment of a continued outstanding balance. The final email sent on 9/3/21 at 1:43 p.m., from Corporate Account Payable Manager SS read: Payments are (now) being made. During an interview on 11/2/21 at 9:00 a.m., Resident #12 reported having to wait eight to nine days between showers. Resident #12 stated, When I had my shower yesterday . it was cool water. It was not hot . I couldn't wash my hair with no hot water. I asked them to get me out quick because the water was cold. The water didn't warm up the whole time I was in there. During observations on 11/2/21 at 3:29 p.m., 3:40 p.m., 3:42 p.m., and 3:43 p.m. the 400 hall, 100 hall, 200 hall, and 300 hall shower rooms, respectively, were observed with Maintenance Director (Staff) R. Water temperatures were measured in two of four operational shower rooms. Both the 100 hall and 200 hall shower rooms were reported as not in use by facility staff. The 400 hall shower room went from 84 degrees to 91 degrees after the water ran for five minutes. The 300 hall shower room reached 92.9 degrees, and remained cool to the touch as confirmed by Staff R. When asked if the water temperatures measured were acceptable for resident showers, Staff R stated, No. When asked what the appropriate temperature range would be for a comfortable shower, Staff R said he would find out. Staff R returned at 3:59 p.m. on 11/2/21, and said water temperatures should fall between 105 and 115 degrees (Fahrenheit) for a comfortable shower. During an interview on 11/3/21 at 5:21 a.m., Staff K was asked about resident showers. Staff K said the water took forever to get hot. Staff K stated, Even doing wash ups (in bed) you have to let it (water) run for 20-30 minutes to even get warm water in there. The residents complain about the temperature of the showers. There has been times I have not given showers - because there isn't hot water. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Rights of Resident in (State Name) Nursing Facilities, dated 11/28/16, revealed the following, in part: As a basic premise, all residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility . You have a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. During an interview on 11/3/21 at 11:35 a.m., the NHA and Director of DON were asked about facility water temperatures. The NHA said a new hot water boiler was going to be installed the next week. When asked how long it had been since the issue had been identified and remained unresolved. The NHA confirmed it had been months as it was first identified in the early summer of 2021. The NHA said the bill for the new hot water boiler had not been paid until the middle of October, when the facility was cited for lack of other building maintenance due to non-payment of outstanding balances. The DON stated, We are well aware of the water temperature and the resident concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235349	A. Building B. Wing	11/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Ishpeming	435 Stoneville Rd Ishpeming, MI 49849

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 35103 Based on interview, and record review, the facility failed to ensure completion of required annual abuse training and dementia care training for all staff. This deficient practice resulted in the potential for absent or delayed abuse reporting, failure to identify potential abuse, and the possibility of continued resident abuse within the facility. This deficient practice had the potential to affect all 50 facility residents. Findings include: Review of electronic-based staff education records provided by Human Resources (Staff) G on 11/2/21 at 3:48 p.m., and on 11/8/21 at 11:55 a.m., revealed the following facility staff had not completed their required annual abuse training: Director of Nursing (DON), Registered Nurse (RN) C, Licensed Practical Nurse (LPN) L, LPN O, Certified Nurse Aide (CNA) II, Staff W, Staff LL, Staff JJ, LPN Z, LPN MM, and Staff J. Review of additional staff education records, with Staff G on 11/8/21 beginning at 11:55 a.m., identified the following CNAs had not completed their required annual dementia training: Staff J, Staff W, Staff JJ, and Staff LL. Review of the Abuse, Neglect and Exploitation policy, revised 12/20, revealed the following, in part: Employee Training: A. New employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation. B. Existing staff will receive annual education through planned in-services and as needed. C. Training topics will include: 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation; 2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property; 3. Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators; 4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources; 5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect. Review of the Facility Assessment, dated 10/26/21, revealed the following, in part: Required in-service training for nurse aides. In-service training must: .Include dementia training and resident abuse prevention training . During an interview on 11/8/21 at 3:24 p.m., the DON was asked for additional evidence of specific abuse education, the curriculum covered, and assessment of staff competency regarding abuse. None was provided prior to survey exit.