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	01/18/2023

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 0557 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to maintain the right to retain and use personal possessions including furnishings and clothing, as space permits, resulting in psychosocial harm for one Resident (#7) out of 10 residents reviewed for respect and dignity. This deficient practice resulted in psychosocial harm, fear, increased anxiety, increased insomnia, feelings of insecurity, and exacerbation of Resident #7's Post Traumatic Stress Disorder (PTSD). Findings include: This citation pertains to Intake #MI00131613. During interviews on 1/7/23 and 1/10/23 at 5:21 p.m. and 4:49 p.m., respectively, Resident #7 discussed the same incident, [Certified Nursing Assistant (CNA) H] . decided to change things up in my room. She came into my room at night and rearranged my whole room .She threw out a lot of my stuff . My safety and security has all been shot to hell. With my bed like it is I can't even see my Jesus wall (with multiple pictures of Jesus) and that is very important to me . [Social Services D] was supposed to give me new tools to feel safe but that hasn't happened yet .I can't find any of my notes. I can't find any of my medical records, and I spend my days sorting through what I can get to (in the room, due to staff rearrangement of the furniture without permission). It felt like I had been psychologically changed, when I came back, and everything had been changed . I have never had my home invaded. I have to move forward. I don't feel safe anymore. I don't feel as secure as I did before .I wanted her fired for what she did to me, and I wanted her to tell me why . I felt like what she did was like psychological rape, and she should not be able to work around people that were vulnerable. I came back in August from being in the hospital and the room was all rearranged . They went dumpster diving (for some of my belongings), but what was on the bottom (of the dumpster) they left in the dumpster. The packing stuff she threw away I used to make open frames. It was not garbage. It was part of the supplies that was the gift I was making. I couldn't believe they let this happen, and that there wasn't an immediate response . No tools (for safety) still. She violated my rights. She violated my home. She totally shot to hell all the tools that had been making me feel safe. The do not disturb sign, and the doorknob cover. I could not even sleep when I got back - I couldn't even sleep. I was afraid if I left, I would not have a home to come back to .Her taking my things, and her deciding what I could keep and what she was going to throw out .My privacy, my home, my safety and security were all shot to hell. Resident #7's eyes filled with tears and her voice began to quiver, as she stated, I am going to cry about this. I am trying to get past this, but it is so hard . (continued on next page)

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

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

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F 0557 Level of Harm - Actual harm Residents Affected - Few	Observation of Resident #7's room found the bed and all other furniture in the room, to be in a different position that last observed by this Surveyor during multiple surveys previously conducted. The bed, previously against the left wall upon entering the room, was placed perpendicular, with the headboard only against the left wall, now in the middle of the room. Review of Resident #7's Minimum Data Set (MDS) assessment, dated 11/25/22, revealed Resident #7 was admitted to the facility on [DATE], with current active diagnoses that included, in part: anxiety disorder, depression, psychotic disorder, PTSD, need for assistance with personal care, and insomnia. Resident #7 scored 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition, and was able to speak clearly, understand others, and be understood in making needs known. Review of Resident #7's Care Plans, initiated 3/27/17, revealed the following, in part: Focus: Potential for alteration in mood/behavior/psychosocial well-being r/t (related to) dx (diagnosis) of major depression, anxiety, borderline personality, unspecified psychosis not due to a substance or known physiological condition, PTSD and depressed mood, anxious mood, feelings of helplessness, changes in eat/sleep patterns .isolation, excessive worry, unfounded accusations . paranoid ideation, accusations towards others, negative statements, fearfulness, withdrawn, hypervigilant, difficulty with trust - specifically men, yelling at staff . racing thoughts, trouble with sleep pattern . trouble with concentration. Interventions included: - [Resident #7] wishes to have a sign to notify visitors and staff members that she would like her door shut at all times. - I am agreeable to having a child safety doorknob cover installed over my outside doorknob to deter unwanted visitors. - I have requested a DO NOT DISTURB sign placed any time that I am receiving cares and showers - this is not for the convenience of me but is for my sense of safety and security and to prevent acute panic attacks and exacerbation of PTSD. THIS IS NOT OPTIONAL FOR ANY SHIFT, as per recommendation from [Psych Consult Organization], Focus: I may feel unsafe in the facility at times. Interventions, in part; Provide active, supportive listening when I am having difficulty feeling safe. - Reassure me that all staff is concerned with my safety and available to reassure me as needed. - To help me to feel safe I have a child safety doorknob cover installed over my outside doorknob to deter unwanted visitors and a 'do not disturb' sign on the outside of her door, and Focus: Potential for Alteration in Mood. Interventions, in part: I have a history of different forms of abuse. Allow me time to speak with staff in a safe and quiet environment. (continued on next page)

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F 0557 Level of Harm - Actual harm Residents Affected - Few	Review of progress notes revealed Resident #7 was transferred to a local emergency department for right-sided flank pain, with air transport to a regional hospital where Resident #7 had been previously seen on 8/18/22. Progress note documentation included: 8/19/22 16:20 Note Text: alleged abuse (misappropriation of residents property reported to the State of [State Name] at 4:20 p.m. Staff member removed from facility pending investigation .Dispatcher [number] notified at 4:40 p.m. and officer [Name] will call back tomorrow at 8:00 a.m., as it is a civil manner and resident is not currently in the building. 8/19/22 15:45 (3:45 p.m.) Resident is not currently in the building as she is LOA (leave of absence) at [City Name] hospital . Staff member removed from facility pending investigation. 8/20/22 21:41 (9:41 p.m.) Spoke with resident regards to incident that happened in regard to alleged abuse when resident was out of the facility. Resident stated, 'I am shocked at the appearance of my room'. Review of a hand-written Witness Statement, dated 8/20/22, and signed by Certified Nurse Aide (CNA) H revealed the following explanation of her rearrangement of Resident #7's room, and disposal of items CNA H considered garbage without the Residents permission, while Resident #7 was hospitalized and not in the facility: .I discussed with my floor nurse (Licensed Practical Nurse (LPN) NN) that this would be a good time to remove all garbage from the room and place the bed back to the far side of the room since [Resident #7] has a geriatric bed and the staff needs to use a [mechanical] lift on her and it is unsafe due to no room up against the bathroom door .so this morning . I took an hour to move her bed, 2 nite (sic) stands, 2 movable tables, 1 bookshelf, a large 6-foot movable storage shelving unit, 1 card table, wheelchair, garbage cans, multiple laundry baskets on the floor, empty cardboard boxes, and numerous other types of bags. I combined many of her bags into her laundry baskets and placed them in an organized manner on her 6-foot movable shelving unit instead of having them all over the floor. I did remove old papers dated back to 2017 of Daily Chronicles the facility provides, old food that was stored in baggies that did have mold on them, 4 rolls of toilet paper that had been used at some point that were placed in bags, used Kleenex boxes, and dirty/used tissues that were stored in baggies, used paper med cups, caps from her catheter bags (blue), used dirty plastic silverware, used straws, 6 used wash basins (pink), 1 large cardboard box, small containers of brown sugar that the facility supplies on meal trays. Absolutely NO personal items were removed, they are still in the room, just organized up off the floor for the time I had. Extra linens from the facility was (sic) taken to laundry. (continued on next page)

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F 0557 Level of Harm - Actual harm Residents Affected - Few	Two Witness Statements, by CNA G, via telephone on 8/19/22 at 4:15 p.m., and Licensed Practical Nurse (LPN) O on 8/19/22 (handwritten with no time noted), both confirmed CNA H had completely rearranged Resident #7's room, bagged up between two and four garbage bags of items CNA H determined to be discarded. CNA H, according to the Witness Statements told both CNA G and LPN O that Resident #7 was a hoarder, and it needed to be cleaned out and/or needed to happen. Both Witnesses were told by CNA H that she had taken papers from 2017 that Resident #7 had been saving. Neither CNA G nor LPN O was aware that no authorization for rearrangement of the room, or disposal of any items in the room was given by Resident #7. Review of the 1:1 Education regarding resident personal items, dated 8/23/22, for CNA H, provided by the Nursing Home Administrator (NHA), revealed the following: Residents have the right to maintain their personal items as they see fit outside of imminent safety concerns. Residents maintaining their personal items promotes independence, dignity, and respect. Staff do not have the right to remove items or rearrange a resident's room without obtaining permission. If you feel there are safety concerns with a residents' room, the appropriate action is notifying a member of the IDT (Interdisciplinary Team). The 1:1 Education was signed by CNA H and the NHA. Review of the Resident Rights policy, revised 8/21, revealed the following, in part: .4. Respect and Dignity. The resident has a right to be treated with respect and dignity, including: .b. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents . 5. Self-determination. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to . b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident . 8. Safe Environment. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to provide necessary care and services resulting in neglect of six Residents (#1, #2, #3, #4, #5, and #10) and all Residents on the 200/300 halls, out of 15 sampled residents reviewed for abuse (neglect). This deficient practice resulted in residents being left saturated in urine and feces, lack of consistently scheduled resident showers, inadequate nurse staffing, delayed medication administration, and failure to ensure residents were dressed, groomed, and able to get out of bed. Findings include: This citation pertains to Intakes #MI00132709, MI#00126137, #MI00131908, and #MI00132379. Resident #1 Review of the Complaint allegations, file by an advocacy organization, revealed the following, in part: . [Resident #1's Guardian BB] reported [Resident #1] is incontinent of urine and sometimes stool. He wears a pull-up (incontinence) brief . his brief was soiled and saturated to the point that he had urine in his shoes. His skin was caked with stool. She looked for incontinent (incontinence) wipes and was told by staff that they were completely out of wipes . Review of Resident #1's Minimum Data Set (MDS) assessment, dated 12/5/22, revealed Resident #1 was admitted to the facility on [DATE], with active diagnoses that included: diabetes mellitus, renal insufficiency, aphasia (loss of ability to understand or express speech), and downs syndrome. Resident #1's cognition was severely impaired, and the Resident required extensive one-person assistance with toilet use, personal hygiene, and bathing. Observation of Resident #1 on 1/4/23 at 12:10 p.m., found the Resident dressed and sitting in a wheelchair in a room with two beds, but assigned to only Resident #1. Dried food particles were seen on the floor, underneath a small table in the left corner of the room, as you entered the room. Resident #1 did not respond verbally to any conversation. During a telephone interview on 1/3/23 at 4:02 p.m., when asked about any concerns with care provided by the facility, Guardian BB stated, What are you going to do. They (facility) don't have enough staff to take care of all of these people. I don't want this facility shut down, because then it would just be worse for me, I don't know what I want to say. Guardian BB did agree to answer one question. When asked if she had found Resident #1 saturated with urine all the way down to his shoes, and soiled with dried feces, Guardian BB confirmed she had found and observed Resident #1 in that condition while the Resident resided in the facility. Resident #2 Resident #2 was observed on 1/4/23, at approximately 12:05 p.m., lying in bed, undressed, naked from the waist up. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Complainant CC's allegations, from the advocacy organization, included: . [Resident #2 was visited in his room (on 12/6/22 between 11 a.m., and noon (12:00 p.m.). He (Resident #2) was desperate to get out of bed. He was tearful and panicked. He said if staff did not come soon then he would miss bingo. He was undressed. [Resident #2] did not appear to have any grooming completed that morning (12/6/22) . A staff member was in the hallway and Complainant CC asked the staff member to help Resident #2. Thirty minutes later, Resident #2's call light was still on and had not been answered. Resident #2 missed bingo. Complainant CC said [Resident #2] reported being stuck in bed all day long the previous day, 12/5/22. Review of Resident #2's MDS assessment, dated 12/19/22, revealed Resident #2 had the following active diagnoses: atrial fibrillation, coronary artery disease (CAD), heart failure, peripheral vascular disease (PVD), arthritis, osteoporosis, depression, and dependence on a wheelchair. Resident #2 scored 14 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition, and was able to be understood and understand others. Resident #2 required extensive, two-person assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #2 used a wheelchair for mobility. During an interview and observation on 1/5/23 at 11:46 a.m., Resident #2's floor appeared dirty, soiled with multiple food particles, floor stains, dust, and what appeared to be dirt under the bedside table. When asked about care received in the facility, Resident #2 stated, .I might have to wait three or four hours for someone to come and wait on me (take care of me); like if I poop my pants. One time I was here (in bed) at breakfast and lunch, and nobody got me out of bed. I want to get out of bed. I don't want to be in bed . My bottom gets sore when I have a bm (bowel movement) and urine and I have to sit in it . You get a bath every two weeks or something like that . Sometimes they will comb my hair, but they will comb my hair if I have a bath (reportedly given every two weeks per Resident #2) . Hair was observed in complete disarray - sticking straight out from the back of his head. Resident #2's moustache was long and untrimmed, extending down over his mouth. Resident #2 was unshaven, with long stubble on his face, and appeared unkempt. Review of Resident #2's electronic medical record (EMR) documentation for showers given during the previous 30 days, retrieved on 1/11/23 revealed Resident #2 had two bed baths, on 12/26/22 and 1/9/23, one shower on 12/28/22, and two documented refusals on 12/19/22 and 1/2/23. Resident #2 was scheduled for Task: Shower/Bathing/Bed Bath on Monday Evening Shift. Review of Resident #2's ADL Care Plan revealed the following, in part: .BATHING: I Prefer a shower. Date Initiated: 10/23/2020 . Shower/Bathing/Bed Bath on Monday Evening Shift . Revision on: 11/08/2021. Resident #3 Review of Complainant CC's allegations, from the advocacy organization, included: . on 12/6/22 between 11am and noon, [Resident #3] was observed in the hallway . asking staff to change him because he was soaked in urine. Thirty minutes later, he was in the hallway with a towel in his lap asking a visitor to help him. He was still soaked in urine. [Resident #3's] pants were soaked from the groin to his knees. He was concerned he was going to get sick or catch a cold due to sitting in his urine. There was no staff available to assist him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's MDS assessment, dated 12/16/22, revealed the following active diagnoses: CAD, Heart failure, renal insufficiency, urinary tract infection (UTI) (last 30 days), diabetes mellitus, depression, psychotic disorder, diverticulosis of intestine, and acquired absence of other specified parts of digestive tract. Resident #3 scored 14 of 15 on the BIMS, reflective of intact cognition. Resident #3 required extensive two-person assistance with bed mobility, transfers, dressing, and toilet use. Resident #3 had clear speech and was able to understand others and be understood to make his needs known. During an observation and interview on 1/5/23 at 10:05 a.m., Resident #3 was observed sitting in a wheelchair with a towel on his lap. When asked about care received from staff, Resident #3 stated, The staffing is terrible. They don't have enough staff to do what they need to do. I had to wait two hours, a couple of weeks ago, because I had a bowel movement. After I eat sometimes, I have a bowel movement. I tell them that I have to go (to the bathroom), but there is no staff or no lift to get me to the toilet in time, so I end up going (defecating in incontinence brief). It was burning my testicles and the skin in that area. Oh, it was burning terrible! . It took two hours for someone to come and clean me up. It was so painful. Then someone came and took the (mechanical) lift for someone else. I couldn't believe they were taking it for someone else because I needed it badly. I was in so much pain. It was horrible . Review of Resident #3's Shower POC (point of care) Response History for the past 30 days, retrieved 1/12/23, revealed Resident #3 had one shower between 12/29/22 and 1/12/23, with two refusals documented, and one not applicable checked. The POC Shower Task revealed: Shower/Bathing/Bed Bath Scheduled - Monday and Thursday Afternoon Shift. Resident #4 Review of Complainant CC's allegations, from the advocacy organization, included: . [Resident #4] is often left sitting in their own urine overnight due to a lack of staff . It is a common occurrence and most recently occurred on the night of 12/5/22 . Resident #4 receives only one shower a week. Showers are scheduled for Wednesdays and Sundays, but she misses bathing . due to a lack of staff . During an interview on 1/10/21 at 2:01 p.m., when asked about care provided by the facility, Resident #4 stated, I have been left soaked (in urine) all the way down to my feet . I don't feel safe here - not anymore. We don't have the staffing . Review of Resident #4's POC Response History for the last 30 days, as of 1/11/23, revealed Resident #4 had showers on 12/10/22, 12/14/22, 1/8/23, and 1/10/23. The Shower documentation included: TASK: Shower/Bathing/Bed Bath Scheduled - Wednesday and Sunday Day shift. No refusals or other documentation was present on the POC shower task for Resident #4. During a telephone interview on 1/17/23 at 9:00 a.m., Complainant CC, in the presence of Compliance Officer III, confirmed the above written complaint allegations acquired through interview and observations on 12/6/22, as documented in the complaint Intake. Resident #5 During an observation on 1/5/23 at 9:16 a.m., Resident #5 was found lying in bed, wearing a hospital gown. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's MDS assessment, dated 10/6/22, revealed the following current diagnoses: heart failure, renal insufficiency, anxiety disorder, depression, chronic obstructive pulmonary disease (COPD), morbid obesity, pain in thoracic spine, and breast cancer. Resident #5 scored 15 of 15 on the BIMS, reflective of intact cognition. Resident #5 required extensive two-person assistance with bed mobility, transfers, and toilet use. During an interview on 1/5/23 at 9:17 a.m., when asked about the provision of care in the building, Resident #5 stated, Just about every day they have only one aide working the 200/300 halls. Sometimes there is a float, and she floats between the halls. I use the Hoyer (mechanical) lift, and if there is only one aide, then I can't get up (out of bed) because it takes two people to operate that lift. I got up for the Christmas party for the first time in a long time, and I was up for my appointment, last Wednesday (December 28th), and I won't be out of bed until my next appointment on the 13th (of January). Resident #5 stated, I don't get my medication timely . The daytime is when my pills are late. When the nurse walked off, they waited until the next nurse came in (to give me my pills). There are quite a few meds that I need to help me . Resident #5 said their shower day was Tuesday, but she didn't get a shower on Tuesday, 1/3/23. Resident #5 said the sheets were only changed on her bed on shower days, so when she didn't get a shower, she didn't get clean sheets. Resident #5 said she had gone for two weeks without having the dirty sheets changed. When asked about the frequency of staff checking and changing incontinence brief, the Resident #5 stated, I did not get changed last night, and I did not get changed until 7:30 a.m., so it can go 10-12 hours. There is someone at night that is supposed to check me, Certified Nurse Aide (CNA) P, but she is 'old and tired', and that is what she tells me . Resident #5 said she had heard the girls (CNAs) say, 'Oh my god she has been loaded with poop all night', about another resident. Resident #5 said they did not provide fresh water every shift. Resident #5 stated, I am drinking water from last night, and when I ask for water, they will take it to the kitchen and bring the same (dirty) mug back . When asked about participation in activities, Resident #5 stated, If I could get up (out of bed) I would go to bingo. I love to play bingo . I am not guaranteed that I will get back to bed (if I am able to get out of bed). Sometimes that has taken an hour and I am too tired after that. During an interview on 1/5/23 at 9:54 a.m., CNA MMM said the mugs were refilled twice a day if there was time. CNA MMM said residents could be drinking the same water all night and agreed the water could be warm before consumed. When asked about Resident #5 getting out of bed, CNA MMM stated, It has been a while since she got up in her wheelchair. The only day I have to get her up, is for a shower. When I have a partner (another CNA on the hall) we will get her up, but I don't have a partner very often. Review of Resident #5's POC Response History for the Shower Task . Scheduled Tuesday Day shift for the previous 30 days revealed showers were completed on 12/27/22 and 1/10/23, with a bed bath on 1/3/23. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident#5's Care Plans revealed the following, in part: 1. ADLs: Administer my medications as ordered by the MD (physician). 2. ADLs: Encourage and assist me to sit up in my chair daily . 3. Incontinence: Check me every 2 hours and as needed for episodes of incontinence . 4. Activities: I have indicated the following items are important to me, books, word puzzles, and bingo. These items are available to me through the facility . I would prefer the following groups: bingo. Resident #10 Review of Resident #10's MDS assessment, dated 11/26/22, revealed Resident #10 scored 15 of 15 on the BIMS, reflective of intact cognition, and required extensive two-person assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #10's active diagnoses included: CAD, heart failure, neurogenic bladder, diabetes mellitus, hemiplegia (paralysis on one side of the body), multiple sclerosis (MS), seizure disorder, anxiety disorder and need for assistance with personal care. During an interview on 1/5/23 at 10:30 a.m., Resident #10 was asked about care provided by the facility. Resident #10 stated, I was devastated, but I had not been changed (incontinence brief change) yesterday. I had not been changed (at night) and my brief was wet . Last week . I needed to be changed and I had been waiting quite a while. She (CNA) came back (into my room) and said, 'I have two more showers and then I will be back to change you'. I said 'I don't need a f*ck*ng shower, I need to be changed. She (CNA) said 'I don't need no f*ck*ng attitude', and threw my diaper across the room . During an interview on 1/5/23 at 12:59 p.m., when asked about completion of resident showers, LPN EE stated, If we have one aide on the floor, I am not going to say people are getting their showers - whether it is call-ins or miss-managed scheduling. When asked about residents not being checked and changed for incontinence timely, LPN EE stated, There are definitely individuals who remain wet for a little while . 200/300 Hall Residents Review of the Complaint Intake Information for Intake #MI00132379 revealed the following, in part: On 10/21/22, the nurse on duty [Licensed Practical Nurse (LPN) Q], was pulled from her management duties to work on the medication cart. At 6:30 p.m. she left (the facility without a replacement nurse), because the nurse who was scheduled to take over was not due to come in until 10:30 p.m. The two halls of people went without a nurse for 4 hours. People did not get their medications and insulin at 6 PM when it was scheduled . (continued on next page)

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	235349	A. Building B. Wing	01/18/2023

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/4/23 at 1:15 p.m., LPN Q confirmed she had left the faciity on [DATE] at approximately 6:30 p.m., without a replacement nurse to cover care for the residents on the 200/300 hall. When asked if the residents all received their necessary medications, LPN Q stated, I don't know. LPN Q said she gave the keys to the medication cart to LPN R, working that night on the 100/400 halls. LPN Q said the narcotic count had been completed with LPN R prior to LPN Q leaving the facility. She stated, I am almost sure I did. LPN Q stated, To be honest, at that time I told [Director of Nursing (DON)] I was done (quitting). I work Monday through Friday and when I have to leave, I just can't always be having to pick up shifts. On 1/4/23 at 2:30 p.m., the Controlled Substance Shift Inventory Log for the 200/300 halls for October 2022 was reviewed with the DON. Review of the 10/21/22 date in question, revealed at 1830 (6:30 p.m.) all columns were absent documentation, but filled in with question marks. In the Outgoing Nurse Signature and Oncoming Nurse Signature columns, No Nurse was written. When asked about the absent narcotic reconciliation documentation on 10/21/22, the DON said it was not acceptable and she would have to educate her staff. During an interview on 1/5/23 at 12:18 p.m., the Nursing Home Administrator (NHA) was asked about LPN Q's abandonment of the 200/300 hall residents when she left the facility without a replacement. The NHA stated, It was definitely unprofessional. The NHA also agreed it had the potential to leave vulnerable residents without necessary medications that could impact their health status. During a telephone interview on 1/5/23 at 1:46 p.m., LPN R said she had worked the 100/400 hall on 10/21/22 when LPN Q left the facility without a nurse replacement. LPN R said LPN Q had come over at approximately 6:10 p.m. and said the previous nurse should not have left because LPN Q was going to mandate her (to stay longer to cover the shift). LPN Q said she was leaving. She was not staying in the building one more second, and she was out of there. LPN R stated, I told her (LPN Q] I could not accept the keys from her without a (narcotic) count, or without getting report (on the residents' conditions on the 200/300 hall). If you insist on leaving you put the keys in the med room. I am not going to handle them. LPN R said LPN Q wanted her to take the medication cart for the 200/300 halls with no count (of narcotics), no (resident) report, and no calling of upper management. LPN R stated, I told her I was not comfortable doing that. LPN R said she told LPN Q she was putting her license on the line, and LPN Q said I am quitting. LPN R said she told LPN Q she still could not quit and walk out of the building. LPN Q left the facility and her assigned Residents at approximately 6:30 p.m. Review of a Medication Administration Audit Report, received 1/10/23 from MDS Coordinator/LPN E, for all current residents on the 200/300 halls revealed seven Residents (#2, #3, #5, #16, #17, #33 and #34) received their evening and/or hour of sleep medications late. The medications were not administered at the correct time by LPN Q, as she left the building at 6:30 p.m. The medications were documented as administered late by LPN U, between her arrival at approximately 10:30 p.m. through 12:58 a.m., after discovering the medications had not been administered. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Abuse, Neglect and Exploitation policy, revised 6/22, revealed the following, in part: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. 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 .

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F 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation pertains to Intakes: #MI00131708, #MI00131704 and #MI00126137. Based on observation, interview, and record review, the facility failed to prevent misappropriation of resident property for one Resident (#4) of two residents reviewed for misappropriation, resulting in misappropriation of $190. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 06/26/22, revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including seizure disorder, myoclonus (quick, jerking movements), myopathy (muscle disorder with weakness), chronic pain, depression, and anxiety disorder. Resident #4 required extensive, two-person assistance with bed mobility, transfers, dressing, and toileting, and extensive one-person assistance with feeding. Review of the Brief Interview for Mental Status (BIMS) assessment showed Resident #4 scored 15/15, which indicated Resident #4 had intact cognition. Review of the PHQ-9 score [a depression assessment scale] revealed a score of 6/27, which placed Resident #4 in the mild depression score range. Review of Resident #4's Accident and Incident Report, dated 07/21/22 at 16:10 (4:10 p.m.), completed by the Director of Nursing (DON), revealed, Resident [#4] reported incident to nurse [unnamed] and nurse reported it the [Nursing Home Administrator (NHA)] immediately, in regards to a staff member [Nursing Aide (NA) NN] borrowing money from [Resident #4]. [Resident #4] alleged that a staff member [NA NN] borrowed money from [Resident #4] via app on cell phone and has not paid her back . The report showed law enforcement was notified of the occurrence, and [NA NN] was removed from the facility pending investigation. Review of Resident #4's Accident and Incident Report, dated 07/21/22 at 16:25 (4:25 p.m.), completed by the DON, revealed, Staff member [unnamed] reported to the [NHA] that another staff member [CNA OO] had allegedly borrowed money from [Resident #4] in the past. [Resident #4] confirmed that staff member [CNA OO] had borrowed money in the past, and later requested more money but [Resident #4] did not give [CNA OO] the money the 2nd time . The report showed law enforcement was notified of the occurrence, and [CNA OO] was removed from the facility pending investigation. During an observation on 01/10/23 at 2:00 p.m., Resident #4 was observed in their hospital bed. Resident #4 was observed with pronounced tremors of her arms and hands. Resident #4 agreed to be interviewed. (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 0602 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/10/23 at 2:32 p.m., Resident #4 was asked about any missing property. Resident #4 confirmed she had money taken from her by two former staff members, NA NN, and CNA OO, with a total of $190.00. Resident #4 clarified, [CNA OO] told me someone stole her paycheck . and [asked] if I could loan her $100. I did, and I sent it to her on [social media cite]. And then a couple months later [CNA OOO] said, 'Could I have $58.00?', as she was going to lose the minutes on [CNA OO's] phone. I ignored it. I didn't because I [prior] loaned [NA NN] $90.00, and she said, 'Next week, when I get paid, I'll pay you.' I didn't get paid. [It happened] in July [2022]. So then when [CNA OO] asked, I was like, '[Expletive], no.' .The total amount was $100, then $90.00, $190.00 total .It was abuse. Resident #4 reported she was reimbursed the total amount ($190.00) by the Administrator. Resident #4 explained law enforcement spoke to her the day of the incident, and the two involved staff were terminated. Resident #4 reported the former Social Services Director, SS designee, Staff QQ, provided supportive visits in the past, and reported the current SS designee, Staff RR, had only been in to see her twice since Staff QQ left their position (in August, 2022). Resident #4 reported Staff RR stood at the end of her bed, greeted her, and would leave without providing emotional support or a visit, or promised to return the next week and did not return. Resident #4 reported she still wanted supportive visits, as Resident #4 felt depressed after this occurred, and more recently as her son had passed away in the past few months. Review of NA's NN's witness statement, dated 07/21/22, revealed, [Resident #4] offered [money]. I had an emergency at home. I've turned it [money] down a lot . Document signed by CNA MM. Review of CNA PP's witness statement, dated 07/21/22, revealed, [CNA PP] was in washing up [Resident #4] .; [Resident #4] had asked who was coming on [shift]. I told her it was [NA NN]. [Resident #4] said, 'Last time I saw [NA NN] I lent her money. I felt bad. [NA NN] hasn't paid me back; it was $90.00 .' Review of CNA G's witness statement, dated 07/22/22, revealed, [CNA G] heard from [Resident #4] that she sent [NA NN], [sic] had borrowed money from her, and [CNA G] heard from [Resident #4] that [CNA OO] had lost their paycheck, and [Resident #4] gave [CNA OO] money as well. Review of the document, untitled, dated 08/08/22, revealed Resident #4 received $190.00 from facility for reimbursement, signed by Resident #4. Resident #4 confirmed $190.00 was received. Review of Resident #4's Social Services (SS) visit note, dated 07/22/22, by the SS designee, Staff QQ, revealed, Contact with [Resident #4] in regards to psychosocial well being from misappropriation of funds/abuse allegation. [Resident #4] stated, ' .My feelings are hurt.' .' Review of Resident #4's SS visit note, dated 07/25/22, by Staff QQ revealed, .[Staff QQ] asked [Resident #4] how she was doing with [misappropriation] incident that happened. [Resident #4] did say it did affect her psychosocial well-being, especially with one of the aides [unnamed], because [Resident #4] felt they were friends, and [Resident #4] loved her . Review of Resident #4's SS visit note, dated 07/27/22, by Staff QQ, revealed, .[Resident #4] said it [the misappropriation incident] does affect her psychosocial well being because it hurt her feelings. [Resident #4] also said sometimes it makes her feel depressed . The note referenced the behavioral care provider would be seeing her the first week of August [2022] to provide additional psychosocial support. (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 0602 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #4's SS visit note, dated 07/28/22, by Staff QQ revealed, .SSD [Social Services Director - Staff QQ] discussed [Resident #4's] psychosocial well being today in regards to [misappropriation] abuse allegation. [Resident #4] said it does affect her psychosocial well being because it hurt her feelings and she has lost trust. [Resident #4] also said sometimes it makes her feel depressed . Review of Resident #4's MDS PHQ-9 assessments dated 09/24/22 and 12/25/22 revealed Resident #4 scored 9/27 (minimal depression) and 18/27 (moderate depression), respectively. It was noted Resident #4's depression assessment scores showed worsening depression on each assessment after the incident. Review of the Electronic Medical Record [EMR] revealed the behavioral care provider visit did not occur until 09/22/22, when Resident #4 was seen for depression. There was no mention of the misappropriation incident, or any support provided. The (current) SS designee, Staff RR, confirmed there was no other behavioral care provider visits after the incident found in the EMR or elsewhere per their review, including in August (2022), as referred. Further review of the EMR including Resident #4's Social Services progress notes showed no Social Services visit was completed with Resident #4 from 07/31/22 until 12/12/22, which SS designee RR confirmed. This visit on 12/12/22 was a referral for discharge planning and for counseling services. No emotional support was documented as provided during this visit, or between this time period. During an interview on 01/11/23 at 1:54 p.m., Social Services designee, Staff RR, was asked about Resident #4's depression score of 18/27 on the PHQ-9 test on 12/25/22, and any supportive visits being completed. Staff RR confirmed they started their position at the facility on 09/06/22, and were not aware of what a score of 18/27 meant on the PHQ-9, and did not know where to find this information, as they did not have it anymore. (This information is readily available, and a part of the MDS assessment.) Staff RR acknowledged they were aware of Resident #4's misappropriation incidents (two), and Resident #4's son and mother had both passed away in the last year. Staff RR was asked why there were no Social Services visits or other notes from September 2022 through 01/11/23 for Resident #4 (when they were employed at the Social Services designee). Staff RR acknowledged they were terrible at taking notes, and stated, There may not be many [notes] from me. Staff RR confirmed they did not complete a quarterly SS assessment for Resident #4, which was due on 12/25/22. The SS designee reported they spoke with Resident #4 occasionally, and did a couple bed visits, but talked about nothing important, such as talking about hair and nails. Staff RR acknowledged they did not understand they could provide supportive visits, as they were not a counselor, and would refer Resident #4 to counseling again. Review of Resident #4's Care Plan, accessed 01/10/23, showed no interventions to prevent other staff from perpetrating misappropriation towards this vulnerable resident, Resident #4, which was confirmed by the DON, as misappropriation had occurred towards her twice, and attempted on numerous occasions. The Care Plan further revealed, I have the potential for alteration in mood, behavior r/t [related to] dx [diagnosis of] Major Depressive Disorder, anxiety .Social worker to provided [sic] supportive visits as needed, [behavioral care provider visit] as needed .Revision on 12/29/2021 . (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 0602 Level of Harm - Actual harm Residents Affected - Few	Review of NA NN's investigation file revealed NA NN was suspended from employment on 07/21/22, and terminated on 07/26/22. NA NN's investigation file showed no abuse training since date of hire on 10/22/20. Both were confirmed by the NHA and the Regional Human Resources Manager, Staff MM. Review of CNA OO's investigation file revealed CNA OO was suspended from employment on 07/21/22, and terminated on 07/26/22, which was confirmed by the NHA and Staff MM. Review of NA NN's Job Description, titled, Residential Assistant, dated 10/22/20, revealed, .Duties and Responsibilities .4. Assists residents with personal needs including bathing, grooming, dressing .Ensures an atmosphere which allows for privacy, dignity, and well being of all residents in a safe, secure environment . Must function independently and have flexibility, personal integrity, and the ability to work effectively with residents, personnel . Review of the policy, Abuse, Neglect, and Exploitation, revised 06/(20)22, revealed, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .'Exploitation' means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. 'Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful temporary or permanent, use of a resident's belongings or money .'Mistreatment' means inappropriate treatment or exploitation of a resident .Prevention of Abuse, Neglect, and Exploitation: The facility will implement policies and procedures to prevent and prohibit abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with deployment of trained and qualified [sic] to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs .IV. Identification of Abuse, Neglect and Exploitation. A. The facility will assist staff in identifying the different types of abuse .Possible indicators of abuse include, but are not limited to: .4. Resident reports of theft of property, or missing property .Protection of Resident: .E. Providing emotional support and counseling to the resident during and after the investigation, as needed .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 potential abuse and neglect for eight Residents (#2, #3, #5, #12, #16, #17, #33 and #34) of 17 residents reviewed for abuse and neglect. This deficient practice resulted in the continuation of potential abuse and neglect for all 48 facility residents. Findings include: This citation pertains to Intake #MI00132379 and MI00126137. On 12/14/22 at approximately 2:30 a.m., Resident #12 was found half on the floor (kneeling) and upper body on the bed (unwitnessed fall) without a pulse or respirations. Resident #12 was a full-code, and emergency medical services were not contacted until 2:52 a.m., arriving at approximately 3:00 a.m. During an interview on 1/11/23 at 12:48 p.m., the Nursing Home Administrator (NHA) was asked if Resident #12's fall, when found unresponsive without pulse or respirations was reported to the NHA or the DON during the night shift on 12/14/22. The NHA confirmed that neither the NHA, nor the DON were contacted regarding Resident #12's unwitnessed fall with absence of vital signs on 12/14/22. When asked if it was expected that staff would notify administration in such circumstances, the NHA stated Absolutely they should have called, so we could report the incident. This unwitnessed fall with an unusual occurrence of an unanticipated death for Resident #12 was not reported to the State Agency. During an interview on 1/4/23 at 1:15 p.m., Licensed Practical Nurse (LPN) Q confirmed she worked on 10/21/22 and left the facility at 6:30 p.m., at the end of her shift, without a replacement nurse to administer medications and oversee the well-being of Residents on the 200 and 300 halls. LPN Q said she told the Director of Nursing (DON) that she was done (quit) because she had to leave, and she could not always be expected to pick up shifts. Review of Medication Administration Audits revealed medications were not administered as prescribed by their physician for the Residents #2, #3, #5, #16, #17, #33 and #34 on 10/21/22 until between 10:30 a.m. and approximately 1:00 a.m., after the oncoming nurse began her shift at 10:30 p.m. During an interview on 1/5/23 at 12:18 p.m., when asked about LPN Q's abandonment of the Residents on the 200 and 300 halls on 10/21/22, the NHA stated, It was definitely unprofessional. (It) definitely had the potential to leave vulnerable residents without medications that had the potential to affect their health. During an interview on 1/5/23 at 3:47 p.m., when asked if Resident #12's unwitnessed fall and unusual occurrence death and LPN Q's abandonment (potential neglect) of the 200 and 300 hall Residents were reported to the State Agency, both the NHA and DON acknowledged the incidents had not been reported to the State Agency. 40330 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy, Abuse, Neglect, and Exploitation, revised 06/(20)22, revealed, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .VII. Reporting/Response. A. The facility will implement the following: 1. Reporting of all alleged violations to the Administrator, State Agency .within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the event that cause (sic) the allegations involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 35103 Based on interview and record review, the facility failed to fully investigate allegations of potential abuse and neglect for eight Residents (#2, #3, #5, #12, #16, #17, #33 and #34) of 17 residents reviewed for abuse and neglect. This deficient practice resulted in the continuation of potential abuse and neglect for all 48 facility residents. Findings include: This citation pertains to Intake #MI00132379 and MI00126137. On 12/14/22 at approximately 2:30 a.m., Resident #12 was found half on the floor (kneeling) and upper body on the bed (unwitnessed fall) without a pulse or respirations. Resident #12 was a full-code, and emergency medical services were not contacted until 2:52 a.m., arriving at approximately 3:00 a.m. During an interview on 1/4/23 at 1:15 p.m., Licensed Practical Nurse (LPN) Q confirmed she worked on 10/21/22 and left the facility at 6:30 p.m., at the end of her shift, without a replacement nurse to administer medications and oversee the well-being of Residents on the 200 and 300 halls. LPN Q said she told the Director of Nursing (DON) that she was done (quit) because she had to leave, and she could not always be expected to pick up shifts. During an interview on 1/5/23 at 12:18 p.m., when asked about LPN Q's abandonment of the Residents on the 200 and 300 halls on 10/21/22, the NHA stated, It was definitely unprofessional. (It) definitely had the potential to leave vulnerable residents without medications that had the potential to affect their health. Review of Medication Administration Audits revealed medications were not administered as prescribed by their physician for the Residents #2, #3, #5, #16, #17, #33 and #34 on 10/21/22 until between 10:30 a.m. and approximately 1:00 a.m., after the oncoming nurse began her shift at 10:30 p.m. During an interview on 1/5/23 at 3:47 p.m., when asked if Resident #12's unwitnessed fall and unusual death occurrence on 12/14/22 and LPN Q's abandonment (potential neglect) of the 200 and 300 hall Residents on 10/21/22 were fully investigated, both the NHA and DON acknowledged there was no incident report or written investigation summary related to either Resident #12's unwitnessed fall and unusual death occurrence on 12/14/21 or LPN Q's abandonment (neglect) of facility residents on 10/21/22. Regarding LPN Q's resident abandonment, the DON stated, I guess I hadn't really thought about it in that way (as potential neglect) . The DON acknowledge they did not follow the facility abuse policy related to allegations of neglect. Regarding Resident #12's unwitnessed fall and unusual death occurrence the DON stated, I did some investigation, but I didn't write it down . No investigation documentation was received from the facility for either incident. 40330 (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy, Abuse, Neglect, and Exploitation, revised 06/(20)22, revealed, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .V. Investigation of Alleged Abuse, Neglect, and Exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. A. Investigation may include but not limited to: 1. Identifying staff responsible for the investigation 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others 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. VI. Protection of Resident. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples including but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. C. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator, D. Protection from retaliation. E. Providing emotional support and counseling to the resident during and after the investigation, as needed .

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation pertains to Intake: MI00131701. Based on observation, interview, and record review, the facility failed to ensure a planned discharge for one Resident (#14) of six residents reviewed for discharge planning. This deficient practice resulted in an unplanned discharge to the community for Resident #14, to the care of a non-designated representative, without proper representative and facility discharge preparation. This deficiency had the potential for adverse outcomes including injuries, rehospitalization , significant physical, mental, emotional, and psychosocial decline, and lack of referral to community and medical resources. Findings include: Review of the MDS assessment, dated 08/19/22, revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including cerebral vascular disease (disease affecting blood supply to the brain), atrial fibrillation (irregular heart rhythm), encephalopathy, dementia, dizziness, and repeated falls. The assessment revealed Resident #14 required supervision for walking, transfers, dressing, and toileting.The BIMS assessment revealed a score of 14/15, which showed Resident #14 was cognitively intact. The sensory assessment revealed Resident #14 had severely impaired vision. Review of Resident #14's Accident and Incident report, dated 08/20/22 at 14:05 p.m. (2:05 p.m.) revealed, DON contacted at 1405 [2:05 p.m.] that [Resident #14] had left the building with a gentleman [Visitor PPP] at approximately 11:40 a.m. and entered a vehicle, leaving the premises. DPOA [Durable Power of Attorney] called immediately and did not answer; [DPOA] did return call to facility stating the [sic] he was not aware of [Resident #14] leaving and the gentlemen who took him is an old friend. [Resident #14's] cellphone called and resident stated he was at home on [road] and safe and that he has been held captive at facility for long enough, and he was just going to stay at home and not return to the facility .Law enforcement called . [Resident #14] has been expressing he would like to leave the facility; Care Conference held with DPOA this past week and [DPOA] did not want him to leave the facility at this time due to cognitive factors and choices . Review of Resident #14's face sheet revealed Resident #14 had an activated DPOA, who was the primary contact for health care and finances. The diagnoses also showed Resident #14 had homonymous bilateral [both eyes] field deficits, right side. [A condition where a person sees only one side [right or left] of the visual world of each eye from brain dysfunction, after a stroke or other neurological brain condition, which requires training in compensatory strategies, vision adaptations, and limits driving safety without intensive retraining.] (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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's facility Investigation report, dated 08/20/22, revealed, At approximately 11:25 a.m. on 08/20/22, [Resident #14] had [Visitor PPP] enter the facility. [Visitor PPP] spoke with [LPN KK] who stated he was there to see [Resident #14]. [Visitor PPP] stated he knew where [Resident #14's] room was and did not need assistance finding it. Approximately 15 minutes later [Visitor PPP] and [Resident #14] came up to the 100 nurses [hall] [sic] stated with some paperwork and belongings of [Resident #14's]. [Visitor PPP] stated he had the walking papers, referring to discharge. [LPN KK] was under the impression this was a discharge for [Resident #14], as the Medical Director was in the facility at the time. [LPN BBB] the nurse caring for [Resident #14] went to give [Resident #14] his lunch tray when they noticed he was not in his room at approximately 1:30 p.m . [LPN BBB] immediately began looking for [Resident #14] at which time [LPN KK] had explained she thought he had discharged [from the facility]. [LPN BBB] called the DON at approximately 2:05 p.m. to explain the incident .[DON] notified [NHA] of the incident at approximately 2:12 p.m . [LPN BBB] attempted to contact [Resident #14's DPOA] and he did not answer. [LPN BBB] contacted [Resident #14's] cell phone and [Resident #14] answered, stating a friend had taken him to [Resident #14's] house .[DPOA] returned phone call to facility at approximately 2:50 p.m. and spoke to [LPN KK] who informed him of the incident .[DPOA] returned call to facility at approximately 5:08 p.m., and was in agreement with bringing [Resident #14] back to the facility. At approximately 06:04 p.m., facility received a call from [Police officer] with the [State] State Police, informing he was on his way to [Resident #14's] home. The DON spoke with [DPOA] at approximately 07:48 p.m., [newly] stating he did not want the 'cops' to force [Resident #14] to leave his home so [DPOA] is interested in having [Resident #14] stay at home. At approximately 8:00 p.m. the NHA made a referral to Adult Protective Services (APS) for [Resident #14]. Review of the investigation report and attached timeline revealed Resident #14 left the faciity on [DATE] at 11:40 a.m. and was discovered missing by their nurse [LPN BBB] at 1330 [1:30 p.m.], nearly two hours later. The DON was not in the building when the incident occurred, and the NHA was notified at 2:12 p.m. The Medical Director was notified at 3:50 p.m. Review of Resident #14's nursing progress note, dated 08/20/22 at 21:09 [9:09 p.m.], signed by the DON, revealed, .This writer asked [DPOA] if he would give verbal consent or sign AMA [Against Medical Advice] paperwork after explaining document, and stated, 'No, I am not signing anything because I don't feel he [Resident #14] was ready to leave and the doctor didn't feel he was ready to leave .He's an old man and is going to do what he wants to do but I will not be signing any further documents from your facility .' [DPOA] asked [if they] would want us to provide anymore discharge plans from facility such as homecare and stated, 'I don't want anything more from [sic] facility .' [Physician GGG] notified of [DPOA] not having police escort back to the facility and asked if [they] felt it was a safe discharge. [Physician GGG] stated [sic] not a safe discharge with resident's vision and driving, no home care, and alcoholism. Police also notified of resident's vision impairment and driving concerns . Review of Resident #14's Care Plan, accessed 01/12/23, revealed, I am at risk for elopement r/t [related to]: Impaired safety awareness. Date Initiated: 08/12/2022 .Cancelled [Resident #14 discharged]: Educate resident/family/friends on LOA [Leave of Absence] procedure. Date initiated: 08/12/2022 .I am not to leave the facility with anyone other than staff or my guardian. Date initiated: 08/20/2022 (after Resident #14's elopement with Visitor #PPP) .I need direct supervision while outside the facility. Date initiated: 08/12/2022 . [Wander alert anklet] to right ankle .Date initiated: 08/12/2022 . (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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/11/23 at 10:55 a.m., LPN KK was asked about Resident #14's elopement on 08/20/22. LPN KK acknowledged they were the staff that allowed Resident #14 to leave the facility with Visitor PPP. LPN KK reported they had been off work a few days when the incident occurred and did not know Resident #14 personally. LPN KK reported a well-dressed man [Visitor PPP] entered the facility and said, I'm here to pick up [Resident #14] . LPN KK reported Visitor PPP returned to the main entrance with Resident #14, and had Resident #14's paperwork, including a medication paper with a name and description of a medication, but did not see discharge paperwork. Visitor PPP had bags in his arms (Resident #14's belongings), and this paperwork, however LPN KK acknowledged it was not a medication list, but a medication page one would receive upon hospital discharge, with the name of the medication and the description. Resident #14 was reportedly dressed in a sweater or jacket and was leaving willingly. Visitor PPP showed LPN KK that they had tried to remove Resident #14's wander alert; Resident #14's wander alert anklet was removed, and Resident #14 left with Visitor PPP. LPN KK confirmed they did not call or contact Resident #14's nurse, LPN BBB, or Resident #14's DPOA, either prior to Resident #14 leaving, or after they left the facility. During further interview, LPN KK was asked about the typical resident discharge process. LPN KK stated they would need a doctor's order, and run a list of medications, and there would typically be a paper with each department's discharge recommendations, and any follow-up appointments would be listed. LPN KK reported a resident being discharged is discharged to the guardian, stating, The guardian has to be here. When asked if any of this occurred, LPN KK stated, I didn't have [Resident #14] as a patient. LPN KK continued, A couple hours later [LPN BBB] came down the hall with a CNA [unnamed] and said, 'I can't find [Resident #14].' LPN KK reported what had occurred and then asked, 'Is he his own person [responsible party]?' (And learned he was not) and called his DPOA. LPN KK reached the Resident #14's DPOA, and then called the DON and NHA. LPN KK reported they understood the discharge process and had received a reeducation from the DON, however received no disciplinary action. LPN KK stated, I will never do this again [allow a resident to leave the facility without medical authorization and following facility processes] .I am upset with myself. I knew better . During an interview on 01/13/23 at 11:21 a.m., the NHA, with the DON present, was asked about Resident #14's elopement, and LPN KK allowing Resident #14 to leave the facility without checking paperwork for physician discharge, not following the facility process for discharge, not contacting the DPOA, and not following the facility process for representative notification with change in status. Reviewed concern regarding LPN KK essentially allowing [Resident #14] to walk out of the facility with no medical clearance, no management clearance, leaving with a non-family member or representative, and lack of supervision in the facility without assigned staff being aware of Resident #14's absence for nearly two hours. It was also noted LPN KK received no disciplinary action, which the DON confirmed. The NHA and DON reported they understood the concerns. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, Transfer and Discharges (including AMA), dated 10/2021, revealed, It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered .Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected . The facility permits each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered. 3. The facility may initiate transfers or discharges in the following limited circumstances: a. The transfers or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. b. The resident's health has improved sufficiently so that the resident no longer needs the care and/or services of the facility .c. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good grooming, and personal hygiene for 10 Residents (#2, #3, #4, #5 #7, #10, #11, #12, #13, and #35) out of 12 residents reviewed for provision of activities of daily living (ADLs). This deficient practice resulted in the lack of personal hygiene, unkempt appearance, and frustration when showers were not completed as scheduled. Findings include: This citation pertains to Intake #MI00125915, #MI00131908, #MI00132303, #MI00132709, and #MI00130432. Resident #5 During an interview on 1/5/23 at 9:24 a.m., Resident #5 stated, My shower day is Tuesday, but I didn't get my shower on Tuesday (this week). Review of Resident #5's POC (Point of Care) Shower Task documentation for the last 30 days, as of 1/12/23, revealed Resident #5 had received two showers in the last 30 days, on 12/27/22 and 1/10/23, with a bed bath provided on 1/3/23 (Tuesday). The POC Shower Task indicated Resident #5 was to be bathed every Tuesday. Resident #11 During an interview on 1/5/23 at 11:12 a.m., when asked if there was any concern about care provided by the facility, Resident #11 stated, Showers . There is only one CNA (Certified Nurse Aide) on for the whole building so I would wait (for my shower). (It) ended up in my never getting a shower. I end up only getting one (shower) now, but I would like two showers. The reason I don't get them is because they don't have enough staff. Review of Resident #11's POC Shower Task documentation revealed Resident #11, Resident #11 received one shower on 12/16/22, with no other documentation present for the previous 30 days, as of 1/12/23. The Shower Task indicated Resident #11 was to receive showers twice weekly, on Tuesdays and Fridays. Resident #2 During an observation and interview on 1/5/23 at 11:46 a.m., Resident #2 stated, You get a bath every two weeks or something like that . Sometimes they will comb my hair if I have a bath. They will once in a while clip my fingernails. Resident #2's hair was observed uncombed, sticking straight out in the back, and his moustache was long, hung over his top lip with facial stubble giving the Resident an ungroomed appearance. Review of Resident #2's POC Shower Task for the past 30 days as of 1/12/23, revealed Resident #2 received one shower in the past 30 days on 12/28/22. Resident #7 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/23 at 5:21 p.m., Resident #7 stated, It is frequent that we have one aide and one nurse for this hall. I have aides come into my room in tears saying they can't get to me, and they feel so badly. I try to be compassionate, and patient, but I have needs to and when the staffing is like that, I don't get showers. I don't get my needs met. You don't get washed up. You don't get out of bed . Review of Resident #7's POC Shower Task documentation for the past 30 days, as of 1/12/23, revealed Resident #7 did not receive a shower and/or bed bath every Wednesday and Sunday as scheduled per the Task. Resident #5 received five showers during the 30 days. Review of additional Residents, including #3, #4, #10, #12, and #13's POC Shower Task documentation revealed the showers were not completed per the schedule noted in the electronic medical record. During an interview on 1/5/23, at 12:59 p.m., Licensed Practical Nurse (LPN) EE agreed showers were not completed as scheduled when staffing was short. LPN EE stated, Even when we have two aides on each side it is not enough (staff) . During an interview on 1/7/23 at 1:34 a.m., Confidential Staff #C3, when asked about resident showers, stated, The residents are not getting their showers, they are not getting their nails done. During an interview on 1/7/23 at 3:13 p.m., when asked about completion of resident showers, Staff #C9 stated, Sometimes showers get done, sometimes they don't have enough people (staff) to do the showers. During a telephone interview on 1/10/23 at 4:23 p.m., Family Member (FM) SS said Confidential Resident #C9, . was supposed to get a bath twice a week, and there were numerous times she went for two weeks without a shower. During an interview on 1/23/22 at 11:20 a.m., the Director of Nursing (DON) confirmed resident showers were not being completed as scheduled. 40330 Resident #35 Review of Resident #35's Electronic Medical Record (EMR) revealed Resident #35 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, early onset, and other depressive disorders. During an observation on 01/13/23 at approximately 1:05 p.m., and a second observation at 1:35 p.m., Resident #35 was observed in the facility hallway, seated in a manual wheelchair. Resident #35 had long facial stubble, at least 1/4 in length, with a mustache and beard growing. Food spillage was observed on Resident #35's face a dark brown drip of dried liquid from his lip down to his chin and neck, with crumbs on his chin and shirt. Resident #35 was discretely asked if he preferred to be shaven. Resident #35 responded, I want to be shaven. I've gone 5 days without [being shaved]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation at approximately 1:45 p.m., Licensed Practical Nurse (LPN) EE walked by Resident #35, and did not stop or offer to assist Resident #35 with hygiene. Surveyor stopped LPN EE after they had passed by Resident #35, and asked about Resident #35's appearance. LPN EE reported they observed the concern, and had planned to assist Resident #35 when they had an opportunity. Review of Resident #35's EMR task documentation for shaving revealed during the past 30 days, Resident #35 was shaved twice, with no refusals marked.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 This citation pertains to intake #MI00126137 Based on observation, interview, and record review, the facility failed to immediately initiate effective Cardiopulmonary Resuscitation (CPR) and promptly call 911 for one Resident (#12) of one Resident reviewed for the provision of CPR based on a documented full code status (an advanced directive to rescue the resident using all necessary medical interventions, including CPR, when the heart or breathing stops) resulting in an Immediate jeopardy (IJ) when Resident #12 was found unresponsive with no pulse or respirations. This deficient practice had the likelihood to cause serious injury, harm and/or death. Findings include: The IJ started on [DATE] at approximately 2:30 a.m., when Resident #12 was found half on the floor (kneeling) and upper body on the bed without a pulse or respirations. The IJ was identified, and facility notification provided on [DATE] at 10:38 a.m. The immediacy was removed on [DATE] at 5:40 p.m., based on the facility's implementation of an acceptable plan of immediacy removal as verified on-site by the survey team. Although the immediacy was removed the facility's deficient practice was not corrected and remained isolated with actual harm that is not an immediate jeopardy. During an interview on [DATE] at 1:03 p.m., Certified Nurse Aide (CNA) G, said she had left the building, leaving only two nurses and one CNA (K) in the building, to drive a CNA home following the completion of the shift at approximately 2:30 a.m. on [DATE]. CNA G returned to the facility at approximately 2:45 a.m. and found CNA K covering for the nurse and CNA G on the ,d+[DATE] halls. CNA K reported they needed to get back to the ,d+[DATE] hall side because they (Licensed Practical Nurse (LPN) P and Registered Nurse (RN) W) were pronouncing Resident #12's death. CNA G said she told CNA K that Resident #12 was a full code and verified the full-code status in the electronic medical record (EMR) on the computer. CNA G stated, I was not in the building at the time they found [Resident #12] on the floor . it was [LPN P] and [CNA K] . I ran down to the other side (,d+[DATE] halls) and RN W was on the other side (,d+[DATE] halls) and they were trying to clean him up. He had a bowel movement, he was back on the bed, and they were trying to clean him up. They were changing the [incontinence brief] because he had a bowel movement . They did not have him on a backboard. They just had him on the bed. They were not doing CPR when I arrived. I am the one that came in and said, 'Hey, [Resident #12] is a full code' . [RN W] was initially pronouncing him dead (at that time) . CNA G said RN W then began performing CPR while CNA G ran out of the room to call 911. When asked about the appearance of Resident #12 as observed on the bed, CNA G stated, He was completely dead when I walked into the room. There were no signs of life . his eyes were closed, his color grayish-white - he was dead, and they were not doing CPR. CNA G said the other nursing staff, including RN W, LPN P and CNA K did not know the resident was a full code. CNA G stated, [CNA K] was the only aide in the building for about 15 minutes and that is when he was found . I missed the whole thing, and none of them knew they were supposed to be doing CPR . (continued on next page)

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	235349	A. Building B. Wing	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of 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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #12's Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #12 was admitted to the facility on [DATE], with current diagnoses that included: End-Stage Renal Disease (ESRD), diabetes mellitus, hip fracture, peripheral vascular disease, anxiety, depression, respiratory failure, need for assistance with personal care, obstructive sleep apnea, and metabolic encephalopathy. Resident #12 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. Resident #12 was able to understand others and be understood, with clear speech. Resident #12 required one-person support for bed mobility and transfers, and required extensive one-person physical assistance with dressing, toilet use, and personal hygiene. A walker and/or wheelchair was used for mobility. Review of Resident #12's Medical Treatment Decision Form revealed the document was signed [DATE] by the Residents' Guardian, and two witnesses. The Medical Treatment Decision Form was not signed or dated by Resident #12's physician. It was absent any physician signature or date of such signature. The document included the following information: CPR Full resuscitation: I request that in the event my heart and breathing should stop, I am given resuscitating measures was checked for the Selected Option, including In the event that your heart and breathing should stop, we will provide emergency treatment based on your decision. During a telephone interview on [DATE] at 3:25 p.m., LPN P was asked to provide details of the night Resident #12 was found without signs of life on [DATE]. LPN P said Resident #12 was found between 2:00 a.m. and 2:30 a.m., as LPN P was doing a basic wellness check. Resident #12 had fallen several hours previous, and neuro checks were still being performed. Resident #12 was found kneeling on his pad (fall mat) with his face on the bed . face right into the mattress. Upon first explanation, LPN P said CNA K and LPN P had started administering CPR because [Resident #12] was a full-code. [Resident #12] was basically gone, and we had to do what we could before we called 911. LPN P confirmed CNA G called 911 upon return from driving a staff member home, which CNA G estimated to be at approximately 3:00 a.m., (a minimum of 30 minutes after finding Resident #12 without signs of life), per LPN P. LPN P confirmed no backboard was placed under Resident #12 for effective compressions on a harder surface. LPN P said she went to the crash cart and took the ambu-bag but did not bring the crash cart to Resident #12's room. LPN P confirmed the resident was ashen gray and had no signs of life when found on the floor on the side of the bed. LPN P confirmed no vitals were documented in the medical record, and stated, We don't have the staffing to do all the things we are supposed to do. When asked if a progress note was completed, LPN P laughed and stated, I am not positive, and confirmed effective CPR could not be performed without the use of a hard backboard while on a bed mattress. Near the end of the interview, LPN P stated, We had to do compressions about half an hour. At this time, she confirmed CPR was being performed with compressions only, and no respiratory assistance was provided to Resident #12. When asked what effect the lack of respirations would have been over the 30 minutes LPN P reported CPR compressions were performed, LPN P stated, He would have lack of oxygen. He would have brain damage. It was frantic. LPN P, then confirmed CPR was not initiated immediately. LPN P stated, I would have started CPR immediately if I knew he was a full code. When asked how full-code statuses would be verified, LP P stated, It is documented in the EMR. We would have had to go back into the EMR and check. We don't always know the code status of the residents. Review of Resident #12's complete medical record, failed to reveal the completion of a Cardiac/Respiratory Arrest Documentation sheet for the event on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:05 a.m., Regional Clinical Director AAA, in the presence of the NHA and the DON, confirmed that no Cardiac Respiratory Arrest Documentation had been found for Resident #12's critical event on [DATE]. On [DATE] the [State Name] EMS (Emergency Medical Services) Patient Care Report, for the EMS dispatch and services provided to Resident #12 on [DATE], was reviewed and revealed the following, in part: Dispatch Notified: [DATE] 02:52:39 (2:52 a.m.) . At Scene: [DATE] 03:00:11 (3:00 a.m.) .facility told them (dispatch) the pt (patient) crashed, they think he's gone but they need EMS to confirm. When we arrived, staff is doing compression only CPR on the pt on the bed. I confirmed that the pat (patient) was a full code. He was, so we moved the pat to the floor to continue compressions on a hard surface . CPR was continued and now we were using a BVM (Bag/Valve/Mask - a self-inflating resuscitator bag) to assist ventilations . Pt remained in asystole (without a pulse) throughout the code . He (Resident #12) was last seen alive at 0200 (2:00 a.m.). Staff said they found the Resident on his knees next to his bed. They realized that he was not breathing and did not have a pulse . During a telephone interview on [DATE] at 4:10 p.m., Paramedic HH was asked to provide details related to the EMS response to the facility for Resident #12 on [DATE] at 3:00 a.m. Paramedic HH said he would stand by the report submitted following provision of the emergency medical services. Paramedic HH stated, There were three staff in there (in the room) and they were doing compressions on the bed. You are not supposed to do them (compressions) on a soft surface. They were doing compressions only. There was no BVM until we (emergency medical personnel) took ours out. We put him on the floor . He was ashen gray. I would declare him deceased (at that time) (but) he was a full code per protocol (so CPR was initiated) . I was caught off guard when they told me what time they had found him. They said 2:30 a.m. (he was found), and now it is 3:00 a.m., and I remember saying 'What took so long to call?' They called at 2:52 a.m. and we are 2. 9 miles from the facility. Paramedic HH stated, I think the residents should get what they request (related to end of life interventions such as CPR) and I don't think that happened in this instance, and I documented as such. During a telephone interview on [DATE] at 9:59 p.m., CNA K said Resident #12 was found at 2:00 a.m., and stated, . everything was so messed up that night. CNA K stated, I remember [CNA G] saying Resident #12 was a full code . It was 11:30 p.m., the last time I saw [Resident #12] . He did look deceased (after being found without signs on life on [DATE]), and he did not have any vital signs. I can't tell you that [LPN P] checked his vitals. I didn't see anybody trying to take them (vitals) . I cleaned up [Resident #12] . I gave him a full bath like he was going to go to the funeral home. When EMS arrived, I was just finishing (cleaning) him up. When asked if CPR was being performed while the resident was being cleaned up, CNA K stated, No, they were not doing CPR when I was washing him up. When EMs arrived, I helped him with the ambu-bag . The whole situation was disturbing .it was like nobody knew what they were supposed to do. I feel like they didn't know what to do, when to do it, and who to do it with . It has been ,d+[DATE] weeks now, and I still cry over it. When asked if it was typical procedure to clean the body before EMS arrived, CNA K stated, They didn't know he was a full code until [CNA G] came in. They have a full-code book up at the desk, and I don't think LPN P knew where it was that night. Observation of the ,d+[DATE] crash cart in the nurse charting room on [DATE] at 10:50 a.m., found a backboard on the back of the crash cart, and a larger backboard mounted to the wall. The crash cart was locked, and a red binder was located on top of the crash car that included the log for daily checks to ensure the cart contained all necessary equipment for a cardiac/respiratory emergency. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the [Facility Name] Emergency Cart Equipment log for the ,d+[DATE] halls during December of 2022, revealed the crash cart was documented with nurse initials on [DATE], 14, 17, 18, 19, 23, 26, 28, and 30th (10 days out of 31 days in the month). List any items replaced or reordered column was documented by LPN P on [DATE] as Cart needs attention, missing items, which were not specified on the Cart Equipment check sheet. Directions on the sheet revealed, The facility will use a cart secured with a numeric seal. Carts are inspected daily on ,d+[DATE] am shift. If a numeric seal is intact and matches the last seal number, the contents of the cart do not need to be inventoried. The carts must be inventoried weekly against the inventory list, see attached. Manufacture guidelines will be followed for function of the suction unit. Revised [DATE] Instructions for the Emergency Cart Equipment sheet included the following areas of documentation: Date, Inspect Daily (Nurse Initials), Once weekly, open cart, clean & check contents (nurse initials), List any items replaced or reordered, Security lock number, and Nurse Signature. [DATE] was missing 21 days of complete documentation for the crash cart that would have been used if taken to Resident #12's room on [DATE]. Documentation reviewed August through November of 2022 revealed similar absence of documentation. Review of the Cardiopulmonary Resuscitation (CPR) - Adult policy, revised ,d+[DATE], revealed the following, in part: Policy: Appropriate cardiac and respiratory function will be maintained until a definitive treatment can be given. CPR will be initiated on all residents with an Advanced Directive stated, CPR - Full Resuscitation . It is the policy of this facility to respect each resident's individual, informed decision regarding advance directives and code status. Cardiopulmonary Resuscitation (CPR) will be initiated for residents who have requested CPR, for residents who have not formulated an advance directive and for residents who do not have a valid DNR (do not resuscitate) order. Policy Explanation and Compliance Guidelines: 1. In the event a resident is identified unresponsive and upon a thorough assessment determines that there is no pulse or respiratory activity, and the resident has declared a full-code status, A BLS (basic life support) certified staff member will: a. Simultaneously with the initiation of chest compressions direct a staff member to immediately retrieve the emergency cart. b. Continue to administer chest compressions and rescue respirations per the [CPR Education Provider] recommendations. c. Direct a staff member to contact the Emergency Response Team (911) immediately to inform them of a full code requiring life support interventions and possible transportation to the emergency department . e. Identify a member of the response team to be responsible for documenting the time of each intervention and resulting response. Documentation should include but not limited to: 1. Date and time of arrest and name(s) of person(s) . assisting with CPR, including the recorder . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Assessment done . 9. A debriefing with staff involved in the code response as needed . During an interview on [DATE] at 12:48 p.m., the Nursing Home Administrator (NHA) was asked if Resident #12's fall, when found unresponsive without pulse or respirations was reported to the NHA or the DON during the night shift on [DATE]. The NHA confirmed that neither the NHA, nor the DON were contacted with the unwitnessed fall, lack of vital signs, and failure to immediately and effectively perform CPR. When asked if it was expected that staff would notify administration in such circumstances, the NHA stated Absolutely they should have called, so we could report the incident. This failure to perform timely and effective CPR to full-code Resident #12 was not reported, investigated, nor was any disciplinary action taken prior to identification of this deficiency during the abbreviated complaint survey. On [DATE] at 4:40 p.m. the facility submitted the following acceptable abatement plan to remove the immediacy: The facility identified the Administrator and DON did not follow [Facility Name] expectations related to investigations and the systemic reporting of adverse events. Upon reviewing the electronic medical record, the progress notes for the incident, it did not indicate that CPR had not been performed appropriately. 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. -Facility Medical Director was notified of the incident on [DATE]. -The DON or designee completed a chart audit on current residents and compared the advance directives to the physician order for accuracy on [DATE]. Inaccuracies were not identified. -On [DATE], the emergency carts at the facility were audited by the DON/designee to ensure all necessary items are present - no concerns were identified. -On [DATE], the involved licensed nurse was suspended pending investigation. Disciplinary action and education will be provided as applicable post investigation prior to employee's return to facility. -On [DATE], the Administrator and DON were provided counseling by the Regional Director of Operations on the Mission Point expectations related to investigations and the systemic reporting of adverse events to ensure appropriate personnel are notified of such matters. 2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The Administrator and DON were educated by the Regional Clinical Director on reviewing the 24-hour report if an adverse event is noted that a risk management investigation is to be completed in a timely manner. -Beginning on [DATE], the DON or designee educated all clinical staff on the facility's policy and procedure for initiating CPR, to include CPR initiation in the case of a possible adverse event, the location of code status for each resident in the electronic health record, and proper use of emergency equipment. Clinical staff were not permitted to work a shift until education was completed. Clinical Staff on leave will receive education prior to their next scheduled shift. -Beginning on [DATE], DON or designee performed a Code Blue drill which was performed with clinical staff on all shifts until every nurse had participated at least once. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: [DATE]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation pertains to Intakes: #MI00131701, #MI00132139. Based on observation, interview, and record review, the facility failed to provide adequate supervision for three Residents (#9, #14, and #15) out of six residents reviewed for elopement. This deficient practice resulted in the elopement of Resident #9 and the potential for adverse outcomes related to inclement weather, and the risk of falls, accidents, and injuries. Findings include: Resident #9 Review of Resident #9's Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including hypertensive encephalopathy (brain dysfunction from significant elevated blood pressure), atrial fibrillation (irregular heart rhythm), cerebral infarction (stroke), depression, anxiety disorder, and frequent falls. Resident #9 required one-person assistance with walking, dressing, and hygiene, and two-person assistance for bed mobility, transfers, and toileting. The Brief Interview for Mental Status (BIMS) assessment revealed a score of ,d+[DATE], which indicated Resident #9 had severe cognitive impairment. Review of Resident #9's Incident Summary, dated [DATE] at 6:47 p.m., revealed, Date/Time Incident Occurred: [DATE] at 06:30 a.m . Incident Summary: Staff member arrived to find [Resident #9] outside of the facility on the sidewalk in front of facility dining room. Investigation started and 5-day investigation to follow . Review of Resident #9's nursing progress note, dated [DATE] at 06:30 a.m., revealed, Behavior Notes .This nurse [Licensed Practical Nurse (LPN) EE] was sitting down for report/handoff [shift change] when it was brought to my attention [Resident #9] was found in the parking lot outside the facility .I ran outside to witness [Resident #9] vehemently refuse coaxing to follow an aid [sic] to make a phone call to [Family Member (FM) NNN]. [Resident #9] was angry/agitated and was not going to go back into the building at that time .[Resident #9] stated that he was going to go wherever he wanted . Review of Resident #9's Care Plan, accessed [DATE], revealed, Cancelled: [Resident #9] discharged from facility] I am at risk for elopement r/t [related to]: Adjustment problems, has made 1 or more attempts to elope in the past 90 days. History of working outdoors or spending time in an outdoor setting. Resident [#9] makes statements regarding wish to leave, go home, or actions such as packing their belongings. Date Initiated: [DATE] .Cancelled: If I am exhibiting exit-seeking behavior, provide me with close observation and distract me by offering activity, conversation, snack, or drink. Assist me with calling [FM NNN] as she is able to redirect me at times . Review of Resident #9's elopement assessment, dated [DATE], revealed Resident #9 had risk factors for elopement, including a history of working outdoors, had made one or more attempts to elope from previous or current facility in the past 90 days, and made statements about wishing to leave, going home, and/or packing up his belongings, or attempting to do so. The assessment determined Resident #9 to be at risk for elopement, and the intervention was a wander alert anklet was placed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Laundry Staff LL's witness statement, dated [DATE], revealed, Around 6:15 a.m., I was by the [Unit name] desk. I could see [Resident #9] down by his room in the hallway, walking around, trying to open office doors. I did not hear any alarms at this time. Shortly after, I was walking to the [nursing unit] desk and heard staff say that [Resident #9] was outside the building . Signed by Staff LL. Review of Certified Nurse Aide (CNA) JJ's witness statement, dated [DATE], revealed, I was pulling into the parking lot at 6:30 a.m. when I saw someone [Resident #9] walking by the dining room windows outside. I then parked, got out, and realized it was [Resident #9]. [Resident #9] did have a jacket and shoes on. I tried to get him back in [to the facility] .but he wouldn't. I called inside the facility and the nurses came out. Signed by CNA JJ. Review of CNA JJJ's witness statement, dated [DATE], revealed, I went to enter the facility around 6:30 a.m. ; another staff [unnamed] met me at the door and said [Resident #9] was out of the building .[Resident #9] was out front on the sidewalk. We tried redirecting, and he said, 'I like the dark, I don't want to come back inside, I hate this place, I don't want to be here .' Review of an Investigation report, dated [DATE], Description of Incident section, revealed Resident #9 resided in [a room on the 200 hall]. The report stated, During an audit of exterior windows it was noted that there were tables and a screen pushed of [sic] it's bracket outside of the facility in room [a room on the 200 hall], and that the screw securing the window from open more than a few inches were [sic] missing .At approximately 2:14 p.m., [Name] Hospital returned with [Resident #9] in a transport vehicle. The transporter for [hospital] tried to direct [Resident #9] back into the facility, where [sic] he refused to enter. [Social Services (SS) designee, Staff RR] went outside to stand with [Resident #9], and he continued to refuse to enter the facility. [Resident #9] then started walking away from the facility towards the forest . The report further described Resident #9 tried to climb into an ambulance dropping off another resident, and then Resident #9 began walking towards the street. Law enforcement was called and Resident #9 was assisted back to the hospital by Emergency Medical Services (EMS). Review of Resident #9's progress note, dated [DATE], by the Director of Nursing (DON), revealed Resident #9's family member (FM NNN) had asked the Nursing Home Administrator (NHA), Staff RR, and Administrator in Training (AIT) TT if they could pack up his belongings, as she did not feel it was best for Resident #9 to return to the facility, and was not in agreement for Resident #9 to return to the facility (from the hospital). The note showed, .[FM NNN] stated resident [#9] has PTSD (Post Traumatic Stress Disorder) from his childhood and she feels [the facility] triggers these issues due to the appearance of the building in which [sic] makes [Resident #9] feel he is in a school in the woods [sic] also triggers his PTSD as he found his younger brother in a barn deceased that was located in the woods causing him to not want to be in or near this facility. When [Resident #9] is in the hospital which is located in more of a city setting, he is okay, and actually expressed that he enjoys the hospital .[FM NNN] expressed .that she did not want [Resident #9] to return to the facility at this time and maybe not even in the future . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on [DATE] at 3:32 p.m., Staff #C-4 was asked about Resident #9's elopement on [DATE], when they were found outside the facility in the parking lot by CNA JJ. Staff #C-4 confirmed they did work on the shift before Resident #9's elopement and reported Resident #9 had been agitated on the night shift and wanted to go home. Staff #C-4 reported it was rainy and icky outside, and Resident #9 was wearing his coat, and stated Resident #9 should not have been outside, would not reenter the facility, and law enforcement was called. Staff #C-4 added, I think those residents that are elopement problems [risk] [sic]; we should be doing safety checks on them .[Resident #9] was exit seeking . Staff #C-4 confirmed Resident #9 was not injured, and reported they had only been instructed to check on Resident #9 every two hours, as they did on all their residents. During an interview on [DATE] at 9:47 a.m., CNA JJ was asked about Resident #9's elopement. CNA JJ described how they arrived at the work parking lot between 6:00 a.m. and 6:30 a.m. and confirmed they saw someone walking on the sidewalk by the dining room, and discovered it was Resident #9. CNA JJ reported they tried to get Resident #9 to return to inside the facility, but he refused so they had to leave him to ask the nurses for assistance. CNA JJ explained no staff were looking for Resident #9 or were aware he was outside the facility. CNA JJ stated it was 30 to 40 degrees outside, and Resident #9 had no gloves or hat on, and was wearing a sweatshirt, pants, and a shirt. CNA JJ added, .It was rainy, not a good day. When asked if Resident #9 stated why he left the facility, CNA JJ indicated Resident #9 kept saying, 'I don't want to go back in there.' CNA JJ reported the staff were unsuccessful at getting Resident #9 back into the facility, and law enforcement was called, who were also unable to get Resident #9 back into the facility. CNA JJ said Resident #9 was agitated, confused, and had exiting seeking behaviors prior to this elopement. CNA JJ clarified they heard from other staff Resident #9 had tried to get out facility windows as they were not screwed in properly, and they forgot to fix Resident #9's window, and this was also how Resident #9 eloped from the facility. CNA JJ added, The rooms [resident rooms] are not getting the attention you [sic] need and are not up to date .There is a lot that could have been done better . When asked if they were checking on residents at risk for elopement more frequently, CNA JJ reported neither Resident #9 nor Resident #15 were on 15-minute checks or frequent visual checks due to their exit-seeking behaviors, but they did two-hour checks on them. During an interview on [DATE] at 4:47 p.m., LPN S was asked about Resident 9's elopement on [DATE]. LPN S confirmed they arrived for their shift at 6:25 approximately, and Resident #9 had eloped from the facility on the night shift. LPN S reported a screen was out of one of the windows, and LPN EE looked out the window, and they believed he saw footprints outside a resident room window. LPN S reported Resident #9 was outside the building in the front [parking lot] when they arrived, and there were multiple staff outside with him. LPN S reported it was 'drizzling' outside [raining], and Resident #9 was wearing a coat and jeans. They reported Resident #9 was calm and in no distress. (continued on next page)

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	235349	A. Building B. Wing	01/18/2023

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:42 a.m., Laundry Staff LL was asked about Resident #9's elopement from the facility on [DATE]. Staff LL responded they worked on [DATE], and were taking resident weights, which was their assignment once a week. Staff LL reported they saw Resident #9 on their hallway, trying to open doors on the unit, including the shower room and the nursing office. Staff LL stated, I didn't think too much of it, until we were told [Resident #9] booked out the front door. Staff LL reported when they had seen Resident #9 trying to exit the facility by trying the doors, stating, [Resident #9] was not doing anything out of the ordinary. When asked if they had told the nurse or a manager, Staff LL reported Resident #9's aide (CNA K) was with her and also observed his exit-seeking behavior and didn't know if they had done anything about this behavior, and they did not address further. Staff LL denied any interventions from Resident #9's Care Plan had been implemented, such as distraction with activities, a snack, etc. During an interview on [DATE] at 1:23 p.m., LPN EE was asked about Resident #9's elopement on [DATE]. LPN EE reported Resident #9 was already outside when they arrived at the facility, and he was resistant to entering the facility as he was agitated, and only returned inside to the facility foyer with maximal encouragement. LPN EE reported Resident #9 stated, I was bored. I don't like it here. I want to get back to [FM NNN]. LPN EE stated this was typical behavior for Resident #9, and the week prior he had made several elopement attempts, adding, He was one of those individuals who were testing doors and pushing the boundaries and trying to escape. LPN EE confirmed when Resident #9 returned to the facility the same day from the hospital, the transporter left him outside and Resident #9 started walking away from the facility, and two staff walked with him and coaxed him back to the facility. LPN EE reported there was no increased supervision in Resident #9's Care Plan. LPN EE confirmed Resident #9's family member [FM NNN] reported she could not take care of him, and had reservations about taking him home, as Resident #9 returned to the facility after psychiatric evaluation at the hospital. LPN EE was asked how Resident #9 left the faciity on [DATE] and stated he had exited from a window on the 200 hall, two doors down from his room, by pushing the screen out of the window. During an interview on [DATE] at 2:14 p.m., SS designee, Staff RR, was asked about Resident #9's elopement. Staff RR reported [Resident #9] was exit-seeking when they arrived at the facility, and clarified he was wearing a wander alert anklet, so when he was trying to push a door open, the door would lock and an alarm would sound. Staff RR stated Resident #9 would not enter the building after he came back from the hospital [on [DATE]], and he started walking towards the garage on the premises with herself, and kept saying he was going to the other house. They reported Resident #9 kept walking up the hill, into the dirt and trees (away from the facility), and was very agitated. Staff RR stayed on the phone with Resident #9's [FM NNN] during the incident, who was trying to convince him to go back to the facility. After talking to Resident #9's wife, Staff RR reported they learned about a past traumatic event that occurred in a barn, and believed every time he saw their garage, it looked like a barn and was a massive PTSD trigger, as the back part [of the garage] was in the woods . Staff RR reported Resident #9 did return to the facility with them, and was sent back to the hospital, and they recalled they either couldn't or didn't take him back [to the facility] after he was hospitalized the second time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 3:10 p.m., Staff Z, accompanied Surveyor to the 200 hall and showed Surveyor the window Resident #9 had eloped through from the facility. The window was a large double paned, side-opening window, which slid open left to right, without a screen. The window opened to the outside of the facility, to the front parking lot. A screw was observed about 6 from the left windowpane frame, preventing the window from being opened fully in the unoccupied resident room. Staff Z stated, It's rigged. It should have the proper thing [locking mechanism] on it .I tried to order the window [slide] blocks [stoppers] that sit up higher [to prevent the window from opening] .Staff Z described how Resident #9 would have lifted the removeable left windowpane frame over the screw. Staff Z reported they ordered the window blocks and understood the facility corporate was not paying their bill, so the window blocks never arrived. Staff Z explained how the window design was also part of the issue, as the left windowpane frame could be lifted off the track and tilted inward (such as for cleaning), to create a large opening, wide enough for a person to easily exit out the window. Staff Z reported they would like to also add an alarm or an additional window block at the top of the windows, to fully ensure they could not be removed. Staff Z clarified the screws were not a standardized measure which was made for this purpose, rather a temporary safety measure they had implemented in the interim of receiving the window blocks. During a phone interview on [DATE] at 10:35 p.m., LPN P clarified they preferred to be interviewed on the night shift, rather than return a call in the morning. LPN P confirmed they were Resident #9's nurse on the midnight shift on the 200 hall when the [DATE] elopement occurred. LPN P reported Staff #C-8 was Resident #9's aide that night. LPN P stated [Resident #9] was a little escape artist, and he had packed his belongings and started wandering down the hall at the beginning of their shift (around 6:15 to 7:00 p.m.). LPN P reported Resident #9 had moderate to severe cognitive impairment, and was oriented to his name only, and stated, It [the elopement] was unexpected. LPN P confirmed there were no scheduled 15 minute or visual checks on Resident #9, despite the behaviors they reported prior to the elopement, and reported their standard [for nursing supervision] was to check every resident every two hours, including Resident #9. LPN P reported they did not know Resident #9 exited the building until they were walking out of the building as their shift had ended. LPN P clarified they did not go back to check on Resident #9, and stated, Maybe I should have gone back .thinking back [Resident #9] might have been aggressive . There was no mention of Care Planned interventions to distract Resident #9 from exit-seeking. During a phone interview with [DATE] at 11:00 p.m., Staff #C-8 also preferred to be interviewed on the night shift. Staff #C-8 reported they were working on [DATE], the night of Resident #5's elopement. Staff #C-8 stated, [Resident #9] was kind of agitated that night .being vulgar .[Resident #9] was angry ., and I went in there every hour and a half, to make sure he was in the room . Staff #C-8 clarified they last checked on Resident #9 at 4:30 a.m., bathed another resident, who took a longer time, and at 6:25 a.m learned Resident #9 was outside the facility. Staff #C-8 was asked if Resident #9 had been exit seeking on their shift. Staff #C-8 responded, Yes, during the night [Resident #9] was in the dining room, trying to get out of the dining room door .It was an emergency door. I told [LPN P]. I said, 'You're going to have to help me keep an eye on him' .That was about 2:15 a.m . Staff #C-8 added Resident #9 tried to open the dining room windows and tried to put a couple chairs through the window, which did not break, however one chair was caught in the window blind cord. LPN P was heard in the background saying she was not the nurse on shift that night. Staff #C-8 stated, I know she [LPN P] was the nurse that night . They reported Resident #9 kept repeating, I've got to get out of here . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview revealed Staff #C-8 reported if there had been another staff, they could have stayed with Resident #9, but she was assigned to the 200 and 300 hallway and had between 25 and 29 residents they were responsible for, which was typical on the night shift. Staff #C-8 clarified they had one nurse and one aide each for two halls, for a total of two nurses and two aides in the building for four halls on the night shift. Staff #C-8 was asked if they (nurse and aide) could have called a manager for more assistance. Staff #C-8 responded, [When they] Call the [DON] or [NHA]; they don't answer our calls .they don't call back and we just leave messages .I believe we did call them that night. LPN P was again heard in the background and stated another nurse was working that night. Staff #C-8 responded, You came in to help me with [Resident #9] in the dining room . Staff #C-8 reported there was also a nurse on call, and they don't generally answer the calls. Staff #C-8 stated incidents were swept under the rug by the DON and the NHA. Staff #C-8 was asked if they suspected Resident #9 (or any facility resident) was being abused in any way. Staff #C-8 denied any abuse and reported Resident #9 was a younger man who did not want to be in the nursing facility. There was no mention of implementing any Care Plan interventions to distract Resident #9 from his exit-seeking behaviors. A text message received on [DATE] at 11:20 p.m. from LPN P read: I'm sorry for interrupting [Staff #C-8's interview] but I wasn't the nurse that night. I was working on 100 [hall] and everything I heard was hearsay. The nurse was [Registered Nurse (RN) OOO]. [RN OOO] packed up and left so I don't know how she handled the situation [Resident #9's aggression in the dining room]. I just knew [RN OOO] was upset and so was [Staff #C-8]. I forgot about that incident . During a follow-up phone interview on [DATE] at 11:28 p.m. per their request., LPN P stated, If it was the same night [Resident #9] got abusive I wasn't the nurse on [shift]. [CNA K] thought it was me. [RN OOO] was the nurse; I'm almost positive. During an interview on [DATE] at 12:31 p.m., Staff A reported they were working when Resident #9 eloped from the facility during the afternoon when he returned to the facility. Staff A reported Resident #9 was trying to get into cars in the parking lot, and confirmed he tried to get into an ambulance. Staff A observed Resident #9 walking down the street towards the facility with Staff RR and the AIT, Staff TT. Staff A reported on this occasion Resident #9 had exited the facility via a facility side door, as he knew how to hold the door bar down to exit, the door by the Director of Nursing (DON)'s office, which was an emergency door. During a phone interview on [DATE] at 12:13 p.m., Resident #9's Family Member, FM NNN, was asked about Resident #9's elopements from the facility. FM NNN stated, .There were three incidents [elopements]. Basically, [Resident #9] wanted to leave there .The one time [elopement] they got him back in [to the facility]. The other two times I had to go over there and get him back in .Anytime I was there they [nursing staff] are [sic] gathered at the front desk, on their phones, laughing, joking .they [staff] went as far as to say [Resident #9] was escaping from a bedroom window . FM NNN reported Resident #9 walked out the front door each time he left the facility. FM NNN stated, [Resident #9] doesn't know how to work the [television] remote [control], let alone how to unlock the window. I don't believe that at all. If you wait, there's a trick [to open the exit doors], and [Resident #9's] heard people talk about it . FM NNN reported they were told, We can't watch him every day, all the time. They [facility staff] never told me about [Resident #9] removing screws or screens. After the third elopement, they [facility staff] were the ones who didn't want him back . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's Accident and Incident report, dated [DATE] at 14:05 p.m. (2:05 p.m.) revealed, DON contacted at 1405 [2:05 p.m. [Resident #14] had left the building with a gentleman [Visitor PPP] at approximately 11:40 a.m. and entered a vehicle, leaving the premises. DPOA [Durable Power of Attorney] called immediately and did not answer; [DPOA] did return call to facility stating the [sic] he was not aware of [Resident #14] leaving and the gentlemen who took him is an old friend. Resident [#14's] cellphone called and [Resident #14] stated he was at home on [road] and safe and that he has been held captive at facility for long enough, and he was just going to stay at home and not return to the facility .Law enforcement called [Resident #14] has been expressing he would like to leave the facility; Care Conference held with DPOA this past week and [DPOA] did not want him to leave the facility at this time due to cognitive factors and choices . Review of Resident #14's face sheet revealed Resident #14 had an activated DPOA, who was the primary contact for health care and finances. The diagnoses also showed Resident #14 had homonymous bilateral [both eyes] field deficits, right side. [A condition where a person sees only one side [right or left] of the visual world of each eye from brain dysfunction, after a stroke or other neurological brain condition, which requires training in compensatory strategies, vision adaptations, and limits driving safety without intensive retraining.] Review of Resident #14's facility Investigation report, dated [DATE], revealed, At approximately 11:25 a.m. on [DATE], [Resident #14] had [Visitor #PPP] enter the facility. [Visitor #PPP] spoke with [LPN KK] who stated he was there to see [Resident #14]. [Visitor PPP] stated he knew where [Resident #14's] room was and did not need assistance finding it. Approximately 15 minutes later [Visitor #PPP] and [Resident #14] came up to the 100 nurses [hall] [sic] stated with some paperwork and belongings of [Resident #14's]. [Visitor #PPP] stated he had the walking papers, referring to discharge. [LPN KK] was under the impression this was a discharge for [Resident #14], as the Medical Director was in the facility at the time. [LPN BBB] the nurse caring for [Resident #14] went to give [Resident #14] his lunch tray when they noticed he was not in his room at approximately 1:30 p.m . [LPN BBB] immediately began looking for [Resident #14] at which time [LPN KK] had explained she thought he had discharged [from the facility]. [LPN BBB] called the DON at approximately 2:05 p.m. to explain the incident .[DON] notified [NHA] of the incident at approximately 02:12 p. m . [LPN BBB] attempted to contact [Resident #14's DPOA] and he did not answer. [LPN BBB] contacted [Resident #14's] cell phone and [Resident #14] answered, stating a friend had taken him to [Resident #14's] house .[DPOA] returned phone call to facility at approximately 2:50 p.m. and spoke to [LPN KK] who informed him of the incident .[DPOA] returned call to facility at approximately 5:08 p.m., and was in agreement with bringing [Resident #14] back to the facility. At approximately 06:04 p.m. facility received a call from [Police officer] with the [State] State Police, informing he was on his way to [Resident #14's] home. The DON spoke with [DPOA] at approximately 07:48 p.m., [newly] stating he did not want the 'cops' to force [Resident #14] to leave his home so [DPOA] is interested in having [Resident #14] stay at home. At approximately 8:00 p.m. the NHA made a referral to Adult Protective Services (APS) for [Resident #14] . Review of the investigation report and attached timeline revealed Resident #14 left the faciity on [DATE] at 11:40 a.m. and was discovered missing by their nurse at 1330 [1:30 p.m.], nearly two hours later. The DON was not in the building when the incident occurred, and the NHA was notified at 2:05 p.m. The Medical Director was notified at 3:50 p.m. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staffing to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice has the potential to affect all facility residents. Findings include: This citation pertains to Intakes #MI00132379, #MI00132709, #MI00125915, #MI00140432, #MI00131908, #MI00126137 and #MI00132303. The above complaint intakes all alleged insufficient staff to meet resident needs. Observation of staffing per the Shift Schedule Sheet for Thursday 1/5/23, and as observed on the floor between 9:00 a.m. and 10:00 a.m. that same day, found Licensed Practical Nurse (LPNs) S and EE working as floor nurses, and LPN O working as a float Certified Nurse Aide (CNA). CNAs included CNA MMM and CNA KKK, who were working the floor. CNA I had called in to say she would not be in that day. Staffing numbers included one nurse per the 100/400 halls, and 200/300 halls, with one dedicated CNA for the 100/400 halls and the 200/300 halls, respectively, with a float CNA going between all the residents. During a complainant telephone interview on 1/3/23 at 2:21 p.m., Guardian BB confirmed Resident #1 had been observed by Guardian BB saturated with urine and dried feces, with urine all the way down into his shoes. Guardian BB stated, What are you going to do? They don't have enough staff to take care of all of these people (residents). During a complainant telephone interview on 1/10/23 at 4:23 p.m., Family Member (FM) SS stated, They (facility) seem to be gravely understaffed . She (Resident #C9) is supposed to get a bath twice a week, and there were numerous times she went for two weeks without a shower . On 1/11/23 at 12:37 p.m., a list of residents who required two-person assistance was requested. The typed form was provided by the Nursing Home Administrator (NHA) and included 25 residents; nearly half of the facility required two-person assistance for at least one activities of daily living (ADLs). Staff interviews related to insufficient staff occurred on: 1/4/23 at 1:15 p.m., Licensed Practical Nurse (LPN) Q stated, . [The DON] said they were going to be working out staffing, but they still have not done that. People are having to pick up shifts and be mandated (to work) all the time . 1/5/23 at 12:59 p.m., Confidential Staff #C1, stated, Staffing is underwhelming or overwhelming. It is one of the most frustrating things in the facility. Even when we have two aides on each side, it is not enough . There were several days last week and the week before - there were days when we only had one aide, or one aide for the entire floor . Staffing has lowered the morale in this whole place . It doesn't seem like there is a panic when we are short-staffed . (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1/5/23 at 3:10 p.m., Staff #C2, stated, Staffing is horrible. Not good. We need staff. It is really debatable if day shift or night shift are worse with staffing . 1/5/23 at 1:34 a.m., Staff #C3 stated, Staffing is awful. I am here this weekend, picking up (shifts) because they did not have anybody . There are days when there is only one aide on day shift . We have people that take off in the middle of their shift for 2-3 hours and they stay on the clock, and they are never reprimanded . They go right out the front door. They just get in their cars and go . I have worked here for [AGE] years, and this is the worst I have seen it . The residents are not getting their showers. They are not getting their nails done . Day shift we do not have enough staffing. We have people calling in all the time . Last week - Monday Resident #26 had rang, and I went to see what she needed. I threw her pillows out. She was puddled in urine, her pillows right up to her hairline. I said, 'This is why we have (skin) breakdown, and it happens more frequently than it should.' We have people (staff) who just take off on break and they are not being watched. 1/7/23 at 1:03 p.m., Staff #C4 stated, .Staffing is terrible . usually I have two aides until 10:30 p.m., and throughout the night I am completely alone (with the nurses). It is terrible. We just don't have help, and then there will be nights when there are two aides in the whole facility . 1/7/23 at 1:44 p.m., Staff #C5 stated, Staffing is a bit crazy these days . Their day shift and their early afternoons are suffering (short-staffed) right now . Staff #C5 said administrative staff do not help when the facility is short staffed. Staff #C5 stated, I never really see them . 1/7/23 at 3:46 p.m., Staff #C6 confirmed there were residents that were staying in bed all day because there was not enough staff to get them out of bed. Staff #C6 stated, If we are short (staffed) and administration knows - they just don't come in. On [date] I was the only nurse in the building . I don't think [the DON] is capable of doing the (medication) cart . Any staff member can come in late, leave early . absolutely it is like a free for all . 1/9/23 at 3:25 p.m., Staff #C7 stated, Staffing has been poor and it has for a while .but now it is day shift - they only have one aide per side . They (residents) are not getting the cares they should be getting . 1/9/23 at 9:59 p.m., Staff #C8 when asked about staffing stated, It is the pits on all of them (shifts). We are lucky if we have one aide on each side (covering 1/2 of the facility residents each) . Administration does not come out on the floor and help. They will not even pass a (meal) tray unless the State people come in, and that is the only time they come out on the floor . 1/10/23 at 3:13 p.m., Staff #C9 stated, A lot of time I have one aide for both halls during day shift. It is very frustrating . Sometimes showers get done, sometimes they don't have enough people (staff) to do the showers .It is frustrating when I am starting my next shift and I have one CNA, and I have sometimes three to four people who need assistance with their meals. If I am in the middle of stuff, I can't just drop everything and go and help . One CNA, there is only one CNA! Sometimes the CNA just leaves for the day and nobody reports it. Every day at 2:30 p.m., I have to say, 'Where is my staff?' I should not have to do that. Management is supposed to be in the building. They should tell me who I have to start my next shift . (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/13/23 at 8:00 p.m., Staff #C10 stated, .One night I literally had no aides, and they (management) were okay with that. They are having one aide on two halls (and) they are okay with that. They may tell you they are not . ask any aide . They are doing these (mechanical lift) transfers with one person. Some will ask the nurse. It's busy. It's a zoo . Resident interviews related to sufficient staffing included the following: 1/5/23 at 9:09 a.m., Resident #25 said staff try to bring him fresh water, but he waits to be out of all his beverages then he rings his light, and they will bring him fresh water to drink then. He said he waits because they (staff) are all so busy out there (in the facility) that he doesn't want to bother them. 1/5/23 at 9:17 a.m., Confidential Resident #1 stated, Just about every day they have only one aide working the halls on 200/300 (halls). Sometimes there is a float, and she floats between the halls. I use the Hoyer (mechanical) lift, and if there is only one aide, then I can't get up because it takes two people to operate that lift . The biggest thing here is that there is no staff . I don't get my medication timely . My sheets are only changed on shower days . The bed has not been changed for two weeks . I did not get changed (incontinence brief) last night and I did not get changed until 7:30 a.m., so it can go 10 to 12 hours. There is someone at night that is supposed to check me . but she is 'old and tired', and that is what she tells me .They do not replace our water every shift. I have to ask for more water, and I don't get a clean mug. I am drinking water from last night . 1/5/23 at 10:05 a.m., Resident #C2 stated, The staffing is terrible. They don't have enough staff to do what they need to do . Resident #C2 said he had a bowel movement that took two hours for someone to come and clean him up. 1/5/23 at 10:27 a.m., Resident #C3 stated, I told Business Office Manager (BOM) WW . that I was not going to pay my bill until they get more CNA staff . I was devastated, but I had not been changed yesterday. I had not been changed and my bed was wet . There are not enough staff. There are seven or eight CNAs for the entire building for all three shifts . For the last month there has only been one CNA on the 100/400 halls . 1/5/23 at 11:12 a.m., Resident #C4 stated, I can go 24 hours without my water being changed. I need fresh water . I end up only getting one (shower) now, but I would like two showers. The reason I don't get them is because they don't have enough staff . There is not enough staff to care for all the residents in the facility. It is all shifts (that are short staffed) . 1/5/23 at 1:46 a.m., Resident #C5 stated, .they are short of help here and I might have to wait three or four hours for someone to come and wait on me - like if I poop my pants . sometimes they will comb my hair . once in a while they will clip my fingernails . It has been quite a while since my toenails have been trimmed - maybe at least a month . 1/7/23 at 5:15 p.m., Resident #C6 stated, They are short on staff . I really don't get showers. I haven't been able to get into the shower. I can't walk . (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1/7/23 at 5:21 p.m., Resident #C7 stated, For the 100/400 halls they often have only one nurse and one aide. It is frequent that we have one aide and one nurse. I have aides come into my room in tears saying they can't get to me, and they feel so badly. I try to be compassionate, and patient, but I have needs too, and when the staffing is like that, I don't get my showers. I don't get my needs met. You don't get washed up; you don't get out of bed. Some days I am in the same diaper for two days and two nights in a row . 1/10/21 at 2:01 p.m., Resident #C8 stated, . There are not enough staff, especially on days and second shift (afternoon shift). Sometimes they only have one CNA on the two halls . I don't feel safe here; not anymore. We don't have the staffing . During an interview on 1/5/23 at 12:18 p.m., the Nursing Home Administrator (NHA), when asked about facility staffing stated, Staffing has been a struggle. Review of the Facility Assessment, updated December 1st, 2022, revealed the following staffing information, in part: Position - Total Number Needed or Average or Range Licensed nurses providing direct care - 2 per shift Nurse Aides - 4 average per shift . .Note: Clinical Management team will support as needed. 3.3 Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and assess these staff assignments. Facility incorporates PPD (cost per patient day), census and acuity of care in determining the amount of staff scheduled. During an interview on 1/12/23 at 12:50 p.m., the NHA was asked to review the Facility Assessment for the level of staffing currently required for the facility. When asked how many aides were required on day shift, the NHA referred to the Facility Assessment and said the information in the facility assessment said four aides per shift. 2 aids on the 100/300 halls, and 2 aides on the 200/300 halls. When asked if the NHA was aware of how many residents currently required two-person assistance, the NHA said he did not know. When the number of residents who required two-person assistance with ADLs of 25 was provided from the list previously received from the NHA, the NHA stated, Oh, my. When asked how the calculation, with the inclusion of resident acuity, was made to determine four aides (one per hall) would be an acceptable number on day shift, the NHA stated, I was trying to put a number that was reasonable, and I did not do any calculation based on any algorithm based on what our actual staffing needs are. When rephrased for clarification, that no calculation was performed, and the number was what he thought reasonable - the NHA agreed. When asked if two nurses with four aides was enough staff to provide for resident needs, the NHA stated, It would be very, very slim. I went off the old 1-15 calculation. One nurse and two aides (per two halls) is not enough.

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

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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 observation, interview, and record review, the facility failed to verify the appropriate competencies and skills sets to provide nursing services and failed to ensure nurse aides demonstrated competency in skills and techniques necessary to care for residents, for four Certified Nursing Aides (CNAs) (H, NN, OO, and K) and three Licensed Practical Nurses (LPNS) (P, UU, and KK) of seven staff reviewed for competency evaluations. This deficient practice resulted in the likelihood for nursing personnel to lack training and skills needed to care for all 48 residents who reside in the facility. Findings include: This citation pertains to Intakes #MI00132379, #MI00132709, #MI00125915, #MI00130432, #MI00131908, and #MI00132303. During an interview on 1/11/23 at 4:10 p.m., the Certified Nurse Aide Annual Competency Checklists, received from the Director of Nursing (DON) were reviewed. The CNA Competency Checklists included the following guidance on the form Demonstration is preferred however a verbal explanation is acceptable. The Licensed Nurse Annual Competency Checklists included a column, entitled, Return Demonstration Date. All dates on all seven competencies reviewed were consistently the same date for all competencies checked as completed. For example: - LPN KK's competency for every item was completed on 3/11/22, with Return Demonstration Date all the same for every competency dated 3/11/22. - CNA K's competency for every item in the column entitled Date Passed Verbally, was dated 8/3/22. Every competency for every item in the Column entitled Date Passed by Demonstration was dated 8/3/22. Both columns were checked for every competency reviewed; that they were both verbally passed and passed by demonstration. - LPN UU, return demonstration date for all listed competencies was 12/5/22, except at the end of the column where 12/20/22 was notated. The Competency Form was signed on 12/5/22 by LPN UU and on 12/10/22 by the DON as completed, even though 12/20/22 was present on three nursing competencies. - LPN P, return demonstration for all listed competencies dated 7/15/22. - CNAs H, NN, and OO had respective dates for all competencies of 3/11/22, 4/5/22, and 11/24/21. During an interview at this same time, the DON confirmed she had documented all the staff Competency Checklists and said not all the competencies were demonstrated. The DON stated, I don't spend the whole day with them (staff person being observed for competency). They explain some of the competencies. The DON said that no performance evaluations were completed for the nursing staff. During an interview on 1/7/23 at 1:44 p.m., when asked about evaluation of competencies, CNA XX stated, I have only met with my DON in person three to four times while working. They did competencies last month. Nobody even met with me. It was just a performance evaluation. I have never had a competency evaluation while working here. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/7/23 at 3:46 p.m., when asked about competency evaluations, Confidential Staff #C6 said there had been no competency evaluations completed in the last year. Staff #C6 stated, She (DON) gave us performance evaluations in December, but no competencies have been done. Staff #C6 said she felt there were some nurses who did not have the competencies required to provide skilled care to the residents. When asked how it felt to work with staff, she felt were not competent, Staff #C6 stated, It is terrible. I am not sleeping. I am losing weight. I am terrified. Review of the Facility Assessment, reviewed 12/1/22, revealed the following, in part: Nurses & CNA's (sic) are given yearly competencies .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35103 Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. This deficient practice resulted in the potential for inadequate coordination of care and negative clinical outcomes, affecting all 48 residents currently residing in the facility. Findings include: This citation pertains to Intakes: #MI00132379, #MI00132709, #MI00125915, #MI00130432, #MI00131908, and #MI00132303. Review of the facility Staffing List, including position titles, revealed the presence of two Registered Nurses (RNs) that worked the floor in the facility; RN W who worked full-time, and RN LLL who recently went to PRN (as available and needed) and was scheduled for two four-hour shifts in January of 2023. Review of the 12 HR (hour) Nurse Schedule for October 2022 through January 2023 revealed the following number of days the facility was scheduled without an RN for eight hours: October - 14 days. November - 10 days. December - 15 days. January (as scheduled for the entire month) - 15 days. During an interview on 1/13/23 at 11:23 a.m., when asked about the use of facility administrative Registered Nurses, such as the Director of Nursing (DON) to cover shifts when an RN was not available to be scheduled, the NHA stated, I would expect the DON to cover alternatively. During an interview on 1/11/23 at 12:48, when asked if administration was aware the facility was out of compliance related to the requirement of having a RN working in the facility eight hours, seven days per week, and had been out of compliance for months, the NHA stated, I did know that we were out of compliance with having an RN working for eight hours a day .

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 35103 Based on observation, interview, and record review, the facility failed to accurately post nurse staffing information daily. This deficient practice resulted in the lack of staffing information for resident, visitor, and staff review. Findings include: This citation pertains to Intakes #MI00132379, #MI00132709, #MI00125915, #MI00130432, #MI00131908, and #MI00132303. On 1/4/23 at 8:30 a.m., the Nursing Department Daily Staffing posting, dated 1/3/23, was observed on the bulletin board in the administrative entrance, and on the entrance nursing desk bulletin board. A copy of the 1/3/23 Nursing Department Daily Staffing posting was requested at that time. On 1/4/23 at 8:45 a.m., Scheduler (Staff) C was observed walking down the hall to post the 1/4/23 Nursing Department Daily Staffing sheet. During an interview on 1/4/23 at approximately 9:00 a.m., Scheduler C was asked to review and compare the Nursing Department Daily Staffing sheets for 12/25/22 through 1/4/23 with the Shift Schedule sheets which were said to be the most accurate reflection of the staff who were working on the reviewed dates by Scheduler C. Upon completion of the comparison between the two staffing forms, Scheduler C acknowledged the Nursing Department Daily Staffing postings did not accurately reflect the listed staff on the Shift Schedule forms for the same days. Differences reflected included, inaccurate calculation of hours worked, and the daily nurse posting was not updated with actual worked hours to reflect call-ins, replacements, and partial shifts. Review of the Nurse Staffing Posting Information policy, revised 12/20, revealed the following, in part: Policy: It is the policy of this facility to make staffing information readily available in a readable format to residents and visitors at any given time. Policy Explanation and Compliance Guidelines: 1. The nurse staffing information will be posted on a daily basis and will contain the following information .d. the total number and the actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift: i. Registered Nurses, ii. Licensed practical Nurses/Licensed Vocational Nurses, iii. Certified Nurse Aides . 4. The information posted is up-to-date and current. a. The information shall reflect staff absences on that shift due to callouts and illness. After the start of each shift, actual hours will be updated to reflect such .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation pertains to intake MI00131701 Based on observation, interview, and record review, the facility failed to provide adequate medically related social services to 26 Residents reviewed for social services care, including Residents #4, #9, #14, and #15, with the potential to affect all facility residents. This deficient practice resulted in a lack of admission assessments, lack of supportive visits, and delayed referral to a behavioral care provider and psychosocial decline for Resident #4. Findings include: Resident #4 Review of the Minimum Data Set (MDS) assessment, dated 06/26/22, revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including seizure disorder, myoclonus (quick, jerking movements), myopathy (muscle disorder with weakness), chronic pain, depression, and anxiety disorder. Review of the Brief Interview for Mental Status (BIMS) assessment showed Resident #4 scored 15/15, which indicated Resident #4 had intact cognition. Review of the PHQ-9 score [a depression assessment scale] revealed a score of 6/27, which placed Resident #4 in the mild depression score range. Review of Resident #4's Accident and Incident Report, dated 07/21/22 at 16:10 (4:10 p.m.), completed by the Director of Nursing (DON), revealed, [Resident #4] reported incident to nurse and nurse reported it the Administrator [Nursing Home Administrator (NHA)] immediately, in regards to a staff member [Nursing Aide (NA) NN] borrowing money from [Resident #4]. [Resident #4] alleged that a staff member [NA NN] borrowed money from [Resident #4] via app on social media and had not paid her back . The report showed law enforcement was notified of the occurrence, and the staff [NA NN] was removed from the facility pending investigation. Review of Resident #4's Accident and Incident Report, dated 07/21/22 at 16:25 (4:25 p.m.), completed by the DON, revealed, Staff member [unnamed] reported to the [NHA] that another staff member [CNA OO] had allegedly borrowed money from the [Resident #4] in the past. [Resident #4] confirmed that staff member [CNA OO] had borrowed money in the past, and later requested more money but [Resident #4] did not give [CNA OO] the money the 2nd time . The report showed law enforcement was notified of the occurrence, and the staff [CNA OO] was removed from the facility pending investigation. During an observation on 01/10/23 at 2:00 p.m., Resident #4 was observed in their hospital bed. Resident #4 was observed with pronounced tremors of her arms and hands. Resident #4 agreed to be interviewed. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/10/23 at 2:32 p.m., Resident #4 was asked about any missing property. Resident #4 confirmed she had money taken from her by two former staff members, NA NN, and CNA OO, with a total of $190.00. Resident #4 reported the former Social Services (SS) Director, Staff QQ, provided supportive visits in the past, including immediately after she reported the (misappropriation) incident, and reported the current SS representative, Staff RR, had only been in to see her twice since Staff QQ left their position (in early August, 2022). Resident #4 reported Staff RR stood at the end of her bed, greeted her, and would leave without providing emotional support or a visit, or promised to return the next week and did not return. Resident #4 reported she still wanted supportive visits, as Resident #4 felt stressed after this occurred, and more recently as her son had passed away in the past few months. Review of Resident #4's Social Services (SS) visit note, dated 07/22/22, by SS designee, Staff QQ, revealed, Contact with [Resident #4] in regard to psychosocial well-being from misappropriation of funds/abuse allegation. [Resident #4] stated, ' .My feelings are hurt.' .' Review of Resident #4's SS visit note, dated 07/25/22, by Staff QQ revealed, .[Staff QQ] asked [Resident #4] how she was doing with [misappropriation] incident that happened. [Resident #4] did say it did affect her psychosocial well-being, especially with one of the aides, because [Resident #4] felt they were friends and [Resident #4] loved her . Review of Resident #4's SS visit note, dated 07/27/22, by Staff QQ, revealed, .[Resident #4] said it [the misappropriation incident] does affect her psychosocial well-being because it hurt her feelings. [Resident #4] also said sometimes it makes her feel depressed . The note referenced the behavioral care provider would be seeing her the first week of August [2022] to provide additional psychosocial support. Review of Resident #4's SS visit note, dated 07/28/22, by Staff QQ revealed .SSD [Social Services Director, Staff QQ] discussed [Resident #4's] psychosocial well-being today in regards to [misappropriation] abuse allegation. [Resident #4] said it does affect her psychosocial well-being because it hurt her feelings and she has lost trust. [Resident #4] also said sometimes it makes her feel depressed . Review of Resident #4's MDS PHQ-9 assessments dated 09/24/22 and 12/25/22 revealed Resident #4 scored 9/27 (minimal depression) and 18/27 (moderate depression), respectively. It was noted Resident #4's depression assessment scores showed worsening depression on each assessment after the incident. Review of the Electronic Medical Record (EMR) revealed the behavioral care provider visit did not occur until 09/22/22, when Resident #4 was seen for depression. There was no mention of the misappropriation incident, or any support provided. SS representative, Staff RR confirmed there were no other behavioral care provider visits after the incident, including in August (2022), as referred per Staff QQ notes. Further review of the EMR including Resident #4's Social Services progress notes showed no SS visit was completed with Resident #4 from 07/31/22 until 12/12/22, which SS representative Staff RR confirmed. The 12/12/22 visit was a referral for discharge planning and for counseling services. No emotional support was documented as provided during this visit, or during this time period. (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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #4's Care Plan, accessed 01/10/23, showed no interventions to prevent other staff from perpetrating misappropriation towards this vulnerable resident [who had misappropriation perpretrated towards her twice], which was confirmed by Unit Manager, Licensed Practical Nurse (LPN) F. The Care Plan further revealed, I have the potential for alteration in mood, behavior r/t [related to] dx [diagnosis of] Major Depressive Disorder, anxiety .Social worker to provided [sic] supportive visits as needed, [behavioral care provider visit] as needed .Revision on 12/29/2021 . During an interview on 01/11/23 at 1:54 p.m., the (current) SS designee, Staff RR, was asked about Resident #4's depression score of 18/27 on the PHQ-9 test on 12/25/22, and any supportive visits being completed. Staff RR confirmed they started their position at the facility on 09/06/22, and were not aware of what a score of 18/27 meant on the PHQ-9, and did not know where to find this information, as they did not have it anymore. (This information is readily available, and a part of the MDS assessment.) Staff RR was aware of Resident #4's misappropriation incidents (two), and their son and mother both passed away in the last year. SS designee RR was asked why there were no SS visit or other notes from September 2022 through 01/11/23 for Resident #4. Staff RR acknowledged they were terrible at taking notes, and stated, There may not be many [notes] from me. Staff RR reported they were still learning what they needed to do (their role as the SS designee), yet reported they had been in the same position at this facility, from 2018 to 2020. Staff RR clarified they had not received training in their role as the SS designee, and explained when they were new, they had not done any admission assessments for new facility residents. StaffRR reported they were not completed from August 2022 through October 2022, and they only began completing them routinely in November 2022. Staff RR confirmed they did not complete a quarterly SS assessment for Resident #4, which was due on 12/25/22. The Staff RR reported they spoke with Resident #4 occasionally, and did a couple bed visits, but talked about nothing important, such as talking about hair and nails. Staff RR acknowledged they did not understand they could provide supportive visits, as they were not a counselor, and would refer Resident #4 to counseling again. During an interview on 01/11/23 at approximately 2:50 p.m., Surveyor asked the NHA if they were aware the SS designee, Staff RR, was unclear about her job responsibilities, not providing supportive visits and a quarterly assessment for Resident #4, their lack of understanding of the PHQ-9 scoring, not completing admission assessments for newly admitted residents to the facility since the prior SS designee left (Staff QQ) through November 2022, and the quality of the visits. The NHA understood each of the concerns and planned to address the concerns. Resident #14 During an interview on 01/12/23 at 9:42 a.m., Staff RR was asked if they could find an admission assessment (not found in the EMR) for Resident #14, who was admitted to the facility on [DATE], and had eloped from the facility. Staff RR confirmed there was no SS admission assessment completed for Resident #14. Staf RR was asked if this would be a concern. Staff RR explained the admission assessment showed reason for admission, discharge plan, mental health assessment, payer, communication, power of attorney, mood assessment, cognitive status, mood, behavioral concerns, sleep pattern, trauma history, the sensory system, and any referrals. Staff RR added, It [the admission assessment] talks about how they [residents] communicate .It gives us a baseline for us to start [care] . Staff RR understood this was an important part of the faciltiy admission process, and integral to treatment planning for facility residents. Resident #9 and #15 (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the interview, Staff RR was also asked if they could find SS admission assessments for the other two residents who had eloped from the facility, Resident #9, who was admitted on [DATE], and Resident #15, who was admitted on [DATE]. SS designee RR acknowledged there were no admission assessments for these two residents who had eloped from the facility. Staff RR was asked about the three residents [Resident #9, Resident #14, and Resident #15] not having admission assessments and eloping from the facility. Staff RR understood the concern, and how the assessments guided staff in care planning. Review of admissions from 8/01/22 through 10/31/22, provided by Staff RR, revealed there were 23 additional residents who did not have an SS admission assessments, including Resident #4, with all missing assessments confirmed by Staff RR. Review of Staff RR's personnel file including [Vendor name] computer training provided by the NHA revealed Staff RR had no annual dementia care training completed. During an interview on 01/12/23 at 1:49 p.m. Staff RR reviewed their [Vendor name] computer training with the survey team and confirmed they did not have dementia training. When asked about why dementia training was important for their job, Staff RR reported they understood the concern. During an interview on 01/12/23 at 11:35 a.m., the NHA was asked about Staff RR not having dementia training, and the lack of social services assessments. The NHA reported they understood the concerns. Review of The Social Services Advocate, Job Description, revised 01/16/18, provided by the NHA, revealed, The Social Services Advocate is responsible to provide medically related social work services so that each resident may attain or maintain their highest practicable level of physical, mental, and psychosocial well-being. The Social Services Advocate participates as a member of the interdisciplinary team and may assist patients in treatment planning .Assess and evaluate each resident's psychosocial needs and develop goals for providing the necessary service and take part in admission process as needed .Maintains a positive and respectful attitude and all word-related contacts .Treat residents, family members, visitors, and team members with respect and dignity . The NHA confirmed there was no policy specific to the provision of medically related social services by the end of the survey. Review of the policy, Abuse, Neglect, and Exploitation, revised 06/(20)22, revealed, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .'Exploitation' means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. 'Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful temporary or permanent, use of a resident's belongings or money .'Mistreatment' means inappropriate treatment or exploitation of a resident .E. Providing emotional support and counseling to the resident during and after the investigation, as needed .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35103 This citation pertains to Intake #MI00132379 This deficient practice has two Deficient Practice Statements: A and B. A: Based on interview and record review, the facility failed to administer medications per physician orders for seven Residents (#2, #3, #5, #16, #17, #33 and #34), of 16 residents reviewed for late administration of medications. This deficient practice resulted in the delay in medication administration per physician orders and the potential for reduced efficacy of medication due to the time of administration. B: Based on interview and record review the facility failed to ensure controlled substance shift inventory records were reviewed and completed as required for two medication carts of two medication carts reviewed. This deficient practice resulted in the potential for medication diversion. Findings include: Review of the Complaint Intake Information for Intake #MI00132379 revealed the following, in part: On 10/21/22, the nurse on duty [Licensed Practical Nurse (LPN) Q], was pulled from her management duties to work on the medication cart. At 6:30 p.m. [LPN Q] left the facility. A replacement nurse did not arrive until 10:30 p.m. Both the 200 and 300 halls were without a nurse to administer medications for four hours . During an interview on 1/4/23 at 1:15 p.m., when asked if the residents on the 200 and 300 halls received their necessary medications prior to LPN leaving the facility without a replacement nurse, LPN Q stated, I don't know . I am almost sure I did. On 1/4/23 at 2:30 p.m., the Controlled Substance Shift Inventory Log(s) for the 100/400 hall and 200/300 hall medication carts for August 2022 through October 2022 were reviewed with the DON. Review of the 10/21/22 date, for the 200/300 hall medication cart, revealed at 1830 (6:30 p.m.) all columns were absent documentation, but filled in with question marks. In the Outgoing Nurse Signature and Oncoming Nurse Signature columns, No Nurse was written. Review of the Controlled Substance Shift Inventory Logs from 9/2022 through 10/2022 revealed the following dates when two signatures, for the outgoing and oncoming nurse, were not properly documented: 100/400 Hall Medication Cart: 9/6/22 - No Outgoing Nurse Signature 9/10/22 - No Outgoing Nurse Signature 9/15/22 - No Oncoming Nurse Signature (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/29/22 - No Oncoming Nurse Signature 200/300 Hall Medication Cart: 9/5/22 - No Oncoming Nurse Signature 10/2/22 - No Outgoing Nurse Signature 10/6/22 - No Oncoming Nurse Signature 10/28/22 - No Outgoing Nurse Signature When asked about the absent narcotic reconciliation documentation on 10/21/22, and the multiple blank nurse signature lines, the DON said it was not acceptable, confirmed all signature lines were to be completed by the respective nurses, and said she would have to educate her staff. The DON said she had provided education but had not done any education related to the narcotic Controlled Substance Shift Inventory documentation sheets in the last three months. During an interview on 1/5/23 at 12:18 p.m., the Nursing Home Administrator (NHA) was asked about LPN Q's abandonment of the 200/300 hall residents when she left the facility without a replacement. The NHA agreed it had the potential to leave vulnerable residents without necessary medications that could impact their health status. During a telephone interview on 1/5/23 at 1:46 p.m., LPN R said she had worked the 100/400 hall on 10/21/22 when LPN Q left the facility without a nurse replacement. LPN R stated, I told her (LPN Q] I could not accept the keys from her without a count, or without getting report (on the residents' conditions on the 200/300 hall). LPN R said LPN Q wanted her to take the medication cart for the 200/300 halls with no controlled medication count performed. Review of a Medication Administration Audit Report, received 1/10/23 from MDS Coordinator/LPN E, for all current residents on the 200/300 halls revealed seven Residents (#2, #3, #5, #16, #17, #33 and #34) received their evening and/or hour of sleep medications late. The medications were not administered at the correct time by LPN Q, before she left the building at 6:30 p.m. The medications were documented as administered late by LPN U, between her arrival at approximately 10:30 p.m. through 12:58 a.m. Review of the Medication Administration Times, policy, revision dated 1/1/22, revealed the following, in part: Procedure: 1. Facility should ensure that authorized personnel . administer medications according to times of administration as determined by Facility's pharmacy committee and/or Physician/Prescriber. 2. Facility should commence medication administration within sixty (60) minutes before the designated times of administration and should be completed by sixty (60) minutes after the designated times of administration .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 35103 Based on interview and record review, the facility failed to employ a dietary manager with the appropriate skills to carry out the food and nutrition services, as evidenced by the lack of completion of a certified dietary manager's course since employment began 10/5/21, and making clinical decisions related to the menu cycle without oversight by the facility's consultant Registered Dietitian. This deficient practice has the potential to result in menus which are inadequate for the dietary requirements of all 48 residents. Findings include: This citation pertains to Intakes #MI00125915, #MI00131908, and #MI00132303. On 1/5/23 at 3:00 p.m., an interview with Dietary Manager (DM) Y. DM Y was asked if she had completed the Certified Dietary Manager's (CDM) course or had other credentials for the position. DM Y said she was currently enrolled in the class but had not completed the CDM course. When asked how frequently the corporate Registered Dietitian (RD) AAA was available to provide oversight of her work, DM Y said (RD) AAA was in the building approximately once a month and had not signed off any of the menu changes performed in the last several months. A review of the facility's four-week menu cycle was conducted. The facility was requested to provide the dietary department's production menus which documented the actual food prepared and served at each meal for the months of November 2022 and December 2022. The following dated production sheets demonstrated that the menus listed on the prepared menus were not served on the following dates: November (2022): 2, 4, 5, 7, 10, 11, 12, 13, 14, 16, 17, 18, 20, 22, 23, 24, 27, 29, and 30. December (2022): 1, 2, 5, 6, 7, 8, 9, 11, 12, 15, 16, 17, 19, 20, 21, 22, 25, 26, 27, 28, 29, and 30. On 1/5/23 at 3:00 p.m., an interview with Dietary Manager Y was conducted. Dietary Manager Y acknowledged that menus were not being followed all the time and stated that the food vendor did not always deliver what was ordered, and items ordered were not always in stock. Dietary Manager Y was functioning under the supervision of Corporate Registered Dietitian (RD) AAA, who had not signed off on any of the November or December 2022 menu changes to ensure nutritional adequacy for facility residents. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/10/23 at 10:54 a.m., RD AAA acknowledged she had not signed off any of the substitution menus. RD AAA was asked to observe a photo of a resident meal tray provided to this Surveyor from Confidential Staff #C11. The photo showed one rolled-up tortilla that resembled a crepe (thin and folded), two ounces of pudding (half-filling a 4-ounce plastic cup), and two ounces of tossed salad (half-filling a 4-ounce plastic cup), on a meal tray. When asked to visually assess the nutritional adequacy of the photographed meal tray, RD AAA stated, It does not appear that the recipe was followed . it appears to be less than the recipe calls for. RD AAA said she noticed the meals served were not as posted on the menus and expressed total understanding of the deficiency to be cited. RD AAA confirmed DM Y had not completed the CDM course. RD AAA stated, [DM Y] has been in the CDM course, and the (former) dietitian could not get her to progress . DM Y is supposed to be doing the food satisfaction surveys . supposed to have a dining experience committee of residents and staff . RD AAA stated, I absolutely 100% agree with the deficiencies (related to the dietary department), and I am so embarrassed that you have to see this . Review of the facility Director of Food and Nutrition Services job description, revised 4/27/2020, revealed the following, in part: Position Summary: The Food and Nutrition Services Director is responsible for providing nourishing food to residents, guests and employees under sanitary conditions as directed and in accordance with established policies and procedures. They assure meals are prepared according to menus and in accordance with Federal and State regulations. The Food and Nutrition Services Manager plans menus in consultation with dietitian while taking advantage of foods in season and local availability . Required/Desired Qualifications: Educations, Training, and Experience: Certified Dietary Manager. One year of management experience preferred .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35103 Based on observation, interview, and record review, the facility failed to follow prepared menus. This deficient practice has the potential to result in the nutritional needs of residents failing to be met as well as frustration for any or all 48 residents who read and planned on the menus posted. Findings include: This citation pertains to Intakes #MI00125915 and #MI00131908. A review of the facility's four-week menu cycle was conducted. The facility was requested to provide the dietary department's production menus which documented the actual food prepared and served at each meal for the months of November 2022 and December 2022. The following dated production sheets demonstrated that either the menu listed on the prepared menus were not served or the day was absent of any documentation of food being served at one or more of the meals: November (2022): 2, 4, 5, 7, 10, 11, 12, 13, 14, 16, 17, 18, 20, 22, 23, 24, 27, 29, and 30. December (2022): 1, 2, 5, 6, 7, 8, 9, 11, 12, 15, 16, 17, 19, 20, 21, 22, 25, 26, 27, 28, 29, and 30. On 1/5/23 at 3:00 p.m., an interview with Dietary Manager Y was conducted. Dietary Manager Y acknowledged that menus were not being followed all the time and stated that the food vendor did not always deliver what was ordered, and items ordered were not always in stock. Dietary Manager Y was functioning under the supervision of Corporate Registered Dietitian (RD) AAA, who had not signed off on any of the November or December 2022 menu changes to ensure nutritional adequacy for facility residents. During an interview on 1/5/23 at 10:05 a.m., Resident #C2, when asked about the food, stated, The food is not good . you never know what food you are going to get. What is on the menu is not always what is served. During an interview on 1/10/23 at 10:54 a.m., RD AAA acknowledged she had not signed off any of the substitution menus. When asked to observe a photo of a resident meal tray provided to this Surveyor from Confidential Staff #C11. The photo showed one rolled-up tortilla that resembled a crepe (thin and folded), two ounces of pudding (half-filling a 4-ounce plastic cup), and two ounces of tossed salad (half-filling a 4-ounce plastic cup), on a meal tray. When asked to visually assess the nutritional adequacy of the photographed meal tray, RD AAA stated, It does not appear that the recipe was followed . it appears to be less than the recipe calls for. RD AAA said she noticed the meals served were not as posted on the menus and expressed total understanding of the deficiency to be cited. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Food Quality and Palatability policy, implemented 7/23/21, revealed the following, in part: Policy: Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature .Procedures: 1. The Dining Services Director and Cook(s) are responsible for food preparation. Menu items are prepared according to the menu, production guidelines, and standardized recipes .

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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 prepare and serve food that was palatable and attractive. This deficient practice resulted in food dissatisfaction, decreased appetite and the potential weight loss for all 48 facility residents. Findings include: This citation pertains to Intake #MI00132303. During an interview on 1/4/23 at 4:19 p.m., Confidential Staff #C11 said there was a concern with the food being served to facility residents. Staff #C11 said residents were given a meal of one tortilla with one slice of deli turkey and one piece of American cheese, two ounces of (tossed) salad, and two ounces of pudding with a drink. Staff #C11 stated, That is not nutritional. During an interview on 1/5/23 at 9:17 a.m., when asked about satisfaction with the facility food, Confidential Resident #C1 stated, I did not have eggs (for breakfast) and I thought hallelujah! I don't have eggs again. We have eggs almost every meal for breakfast. During an interview on 1/5/23 at 10:05 a.m., Resident #C2, when asked about the food, stated, The food is not good . always eggs for breakfast, and you never know what food you are going to get. During an interview on 1/5/23 at 10:27 a.m., Resident #C3 stated, Food? It sucks! They give eggs for breakfast almost every day . then we got one taco, with just the meat and cheese. It was awful. I have one picture of a breakfast that was burned eggs and burned toast .There are many elderly people who have no skin on their bones and are probably starving with one taco for dinner, and then they don't get snacks . The week before Christmas we had peanut butter and jelly sandwiches five days in a row, and they consider bologna a deli meat. A deli meat! Resident #C3 said she does not believe the residents are getting adequate nutrition. Resident #C3 stated, The vegetables are so overcooked here, and there is spinach from a can that smells bad. We used to get hash browns with breakfast, but we haven't had hashbrowns for months. Everybody talks about, we are putting in the orders and corporate cuts the budget. How much are they allotted? During an interview on 1/5/23 at 11:12 a.m., when asked about the facility food, Resident #C4 stated, The food is horrible! Most of the time I tell them to take it away. I had tuna noodle casserole with large clumps (of something) . During an interview on 1/5/23 at 11:46 a.m., Resident #C5 stated, It is the worst food in the world. Sometimes I won't eat my lunch or dinner. They cook pork chops like it is cardboard . During an interview on 1/7/23 at 3:46 p.m., Staff #C6 stated, The food is horrible. A lot of people (residents) are doing [Food Delivery Service]. There is no variety of food. A white taco shell, with a little meat, and a small thing of stewed tomatoes. We can go for weeks when we don't have milk cartons. They are pouring it out of jugs, and the glasses aren't full. The residents complain about the food all the time . (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/7/23 at 4:20 p.m., Staff #C19 was asked to observe a photo of an apparent fish dinner served to facility residents. Staff #C19 confirmed it was a fish dinner, with fish that had been incorrectly ordered. The fish needed to be deep fried or cooked with oil on it to cook and color properly to look like fish. Staff #C19 agreed the fish looked unappetizing. During an interview on 1/10/23 at 10:54 a.m., Corporate Registered Dietitian (RD) AAA was shown the same photograph of the fish dinner. RD AAA said the photo showed a square piece of fish, and that fish required oil for cooking. RD AAA said she is fully aware of the dietary concerns related to the nutritional adequacy and palatability of the food. RD AAA stated, I absolutely 100% agree when asked about her understanding of the deficiency concerns related to the food served in the facility. Review of the Food Quality and Palatability policy, implemented 7/23/21, revealed the following, in part: Policy: Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperatures. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs. Definitions: Food attractiveness: refers to the appearance of the food when served to the residents. Food palatability: refers to the taste and/or flavor of the food. Proper (safe and appetizing) temperature: food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimizes the risk for scalding and burns .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 35103 Based on interview and record review, the facility failed to ensure the accommodation of food based on resident preferences or appealing options of similar nutritive value food to six Residents (#C3, #C4, #C5, #C8, #C10, and #C19) out of nine residents reviewed for food preferences. This deficient practice resulted in meal dissatisfaction, decreased appetite, and frustration when disliked foods continued to be served on meal trays. Findings include: This citation pertains to Intake #MI00125915. During an interview on 1/4/23 at 4:19 p.m., Confidential Staff #C11 said there was a concern with the food being served to facility residents. Staff #C11 said residents were given a meal of one tortilla with one slice of deli turkey and one piece of American cheese, two ounces of (tossed) salad, and two ounces of pudding with a drink. Staff #C11 stated, That is not nutritional. During an interview on 1/5/23 at 10:27 a.m., Resident #C3 stated, Food? It sucks! . This week they have been giving us casseroles. Tuna noodle casserole with peas, and I wouldn't eat it when I was a kid. It was like, Are you kidding me .I have my meal taken away at lunch time. I am an adult, and I don't have to eat food that I don't like. My grandma used to make me sit and eat tuna noodle casserole and I hate it and I hate peas . Resident #C3 said she does not believe the residents are getting adequate nutrition. During an interview on 1/5/23 at 11:12 a.m., when asked about the facility food, Resident #C4 stated, The food is horrible! Most of the time I tell them to take it away . I don't eat oranges. I don't like brussel sprouts and green beans and I get them all the time. I don't get (they forget to give me) peanut butter all the time. I had two things of oranges, and I didn't eat those (because I dislike them). During an interview on 1/5/23 at 11:46 a.m., Resident #C5 stated, It is the worst food in the world . they put food I don't like on my tray, like fish and asparagus. They gave me fish! During an interview on 1/7/23 at 4:18 p.m., Resident #C4 was asked about her recent meal trays. Resident #C4 said she dislikes green beans, and there were green beans in the soup, so she picked them out. She said there was a little 1/2 container of pears, and that was it. She felt like it was not much food. During an interview on 1/7/23 at 4:20 p.m., Staff #C19 was asked to observe a photo of an apparent fish dinner served to facility residents. Staff #C19 confirmed it was a fish dinner, with fish that had been incorrectly ordered. The fish needed to be deep fried or cooked with oil on it to cook and color properly to look like fish. Staff #C19 agreed the fish looked unappetizing. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/10/21 at 2:01 p.m., Resident #C8 stated, The food is gross! They are putting on a show for you guys (State Agency Surveyors) right now. Tomorrow they will have hamburgers so we will probably have chili made out of hamburgers the next day. Since I have been here a year, they have never put lettuce and tomatoes on a hamburger. I get one ketchup (packet) . I would like to have decent food . The best meal I had (said sarcastically) . was a half tuna fish sandwich. I don't like tuna fish. It is on my dislike list, so I didn't eat it . During an interview on 1/10/23 at 2:14 p.m., Resident #C10 stated, I can't eat noodles and G. D . it, the next thing I know there are noodles on my plate. I told them don't give me spaghetti, no white bread .it is just going into the garbage . During an interview on 1/10/23 at 10:54 a.m., Corporate Registered Dietitian (RD) AAA was shown the same photograph of the fish dinner. RD AAA said the photo showed a square piece of fish, and that fish required oil for cooking. RD AAA said she is fully aware of the dietary concerns related to complaints surrounding resident preferences. RN AAA said Dietary Manager (DM) Y was supposed to be doing food satisfaction survey forms with facility residents, but the survey forms with all fours (food good rating), did not seem to reflect the level of dissatisfaction being expressed by facility residents. RD AAA stated, You (dietary manager) are supposed to have a dining experience committee of residents and staff experience. The residents would get to choose menu items they would prefer. RN AAA expressed understanding of the deficiency concern with food preferences. Review of the Food Preferences policy, revised 1/5/2021, revealed the following, in part; Policy: Nutritional assessments will include an evaluation of individual food preferences . Procedure: 1. Upon the resident's admission or within forty-eight (48 hours) after his/her admission, the dietitian, dietary manager, or designee will identify a resident's food preferences. When possible, this will be done by direct interview with the resident .Alternates will be suggested to help resident accept interventions . 5. The dietary manager will visit residents periodically to determine if revisions are needed regarding food preferences. Any staff can inform the kitchen about resident requests. 6. Every effort will be made to accommodate resident's individual preferences. 7. The dietary department quality assurance (QA) program will perform food satisfaction surveyors to identify more widespread concerns about meal preferences and meals.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to use its resources to effectively and efficiently administer the facility to attain and maintain the highest practicable physical, mental, and psychosocial well-being for all 48 residents that resided at the facility. This deficient practice resulted in insufficient resource utilization and management of facility staffing, resident care supplies, office supplies, needed van repair, utilities, and resident services. Findings include: This citation pertains to Intake #MI00132379, #MI00132709, #MI00125915, #MI00125137, #MI00130432, #MI00131908, #MI00126137 and #MI00132303. ADMINISTRATIVE STAFF FACILITY OVERSIGHT Observation on 1/4/23 at 8:30 a.m., upon entrance into the facility, showed both the Nursing Home Administrator (NHA) and Director of Nursing (DON) were not present and working in the building. During an interview on 1/4/23 at approximately 8:35 a.m., Confidential Staff #C11, was asked when the NHA and DON would be available. Staff #C11 stated, (They) come in whenever they want to. During an interview on 1/4/23 at 1:15 p.m., Staff #C12 was asked how often the DON was present in the building. #C12 fidgeted in the chair, paused, and stated, About 20 hours (a week) maybe. We really don't see her very much. When asked who was available for clinical advice when the DON was not present, Staff #C12 named two facility Licensed Practical Nurses (LPNs). Staff C12 stated, We rarely see [the DON]. During an interview on 1/4/23 at 2:30 p.m., the DON was asked how many hours a week she worked in the building. The DON said 40 (hours) plus. When asked if she worked from home, the DON said she did not. When asked if she filled in on the floor as a charge nurse, the DON said she worked a Saturday in December - five hours as a Certified Nurse Aide (CNA). When asked if a nurse working as a CNA can perform nursing duties during that time, the DON stated, I don't see why not. The DON was asked to provide documentation showing she worked at the facility for 40 hours a week in the building. The DON said she didn't use the time clock to document her time, because she was salaried. Staff interviews related to the DON often working from home, frequently not being present in the building, not answering and/or responding to calls/texts, coming in late and leaving early were corroborated on 1/4/23 at 4:14 p.m., 4:19 p.m., 1/5/23 at 12:59 p.m., 1:46 p.m., 1/7/23 at 3:46 p.m., and on 1/12/23 at 12:15 p.m., by Confidential #C13, #C11, #C1, #C14, #C6, and #C10, respectively. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff #C1 stated, I rarely know when she is here, and I rarely know when she has left. There are times when the weather is good it is not uncommon for them to sneak out the GD window in their office. I at least know it from one standpoint, late summer/early fall when she had forgotten something in the office, and she came back in (after climbing out the window in her office) . There isn't oversight from the DON related to medication errors . there is no heavy-handed parent - they (NHA and DON) are both non-confrontational . During an interview on 1/5/23 at 10:27 a.m., when asked about facility administration, Resident #C3 stated, [The DON] comes to work a few times a week. She does not come to work every day to the facility . I can see who is coming and going . During an interview on 1/7/23 at approximately 1:45 a.m., Staff #C3 was asked about administrative staff support for facility staffing. Staff #C3 stated, [The DON] is never in the building . She is rarely ever here. You are lucky if our management team is even here. [The NHA] works from home a lot. He has taken off more than he is here. He shows up at 9 to 10 o'clock and is gone by 2:00 p.m. He doesn't answer his calls on the weekends when we have emergencies. Staff #C3 said there was rarely an RN in the building . Our management team rarely comes out of their offices unless State or corporate is present. They don't make an extra effort to come out on a weekend. Thy are supposed to have weekend managers. They don't help to be honest . The management staff do climb out the windows . (or) they close the fire doors, and they will sneak out the side entrance doors . They will come in and make it look like they are going to be here all day and then they will be gone . none of the management team has to punch in (on the time clock). During an interview on 1/5/23 at 12:18 p.m., the NHA confirmed he had not given the DON a permanent authorization to work from home. The NHA said if the DON didn't have childcare, or she had medical issues she worked from home. The NHA said the DON works in the building 35 hours a week, minimally. When asked about the DON not being present in the building on 1/3/23, that week, the NHA said her child was sick and she did not have childcare on Tuesday. The NHA confirmed the DON did get paid for working from home on 1/3/23 and did not have to use PTO (paid time off). When asked if other staff members could work from home and not use PTO, the NHA stated, No, not really . The NHA agreed the DONs main job in the facility was to provide clinical support and acknowledged effective clinical support could not be provided if she wasn't in the building. During an interview on 1/9/23 at 1:28 p.m., Staff #C15 was asked about administrative staff working from home. Staff #C15 stated, . The NHA and DON were taking leave and not taking PTO time when they were not in the office. Staff #C15 said she had notified Regional HR Manager MM. Staff #C15 said she told the NHA that everyone else had to use PTO time, other than the NHA and the DON. Staff #C15 asked the NHA to explain why they were not taking PTO time, when everyone else had to use PTO time. Staff #C15 said she thought the management team was horrible in setting an example for the staff. During an interview on 1/9/23 at approximately 3:30 p.m., Staff #C7 was asked about administrative contacts in case of an emergency. Staff #C7 stated, [The DON] does not come in. I think she takes a lot of time off and she works a lot of time at home on the computer . we are separated from the administrative staff, and we are the workers on the floor . I wish [the DON] was there more readily available to us to go to for questions. I feel like we are left fending for ourselves . (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 1/9/23 at 9:59 p.m., Staff #C8 stated, Administration does not come out on the floor and help. They will not even pass a (meal) tray, unless the State people come in and that is the only time they come out on the floor. Our administrator and our DON are useless . I don't feel like we get any support from administration . They don't know what they are doing. [The DON] lets the day shift run the program . When I leave at 7:00 a.m., the only one I see is Health Information Coordinator (HIC) A. [The DON and NHA] are never there. They said to call back at 10:00 a.m., and I told them I can't wait for someone to come in, so I can talk to them . During a telephone interview on 1/10/23 at 12:49 p.m., when asked what amount of time would be appropriate for a DON to work in the facility, rather than at home, Regional HR Manager MM stated, I would say Monday through Friday (should work in facility). Their position requires them to work with residents and with staff. If her child is sick, she needs to take a PTO day. [The NHA] can approve her to work from home for every day she does not have childcare. It he does do that without our knowledge, that is not what should be happening. If you are not working from home, you need to put in a PTO day. During an interview on 1/10/23 at 1:28 p.m., with the NHA, DON, and Regional Clinical Director HHH present, the DON was asked if she had determined what days she had worked from home in December. The DON said she had not given it any further thought. When asked why she worked from home, and what work she performed at home, the DON stated, If I needed to call in sick for any reason, I say that I can work from home. I answer facility calls or questions, work on PCC [Point Click Care - Electronic Medical Record (EMR)], do my hospital review assessments . My personal internet provider is [Internet provider]. I was not here (in the building) every day (for all days) in December. I have not worked as a nurse passing meds in December. Our shortage is generally CNAs .(my) name would be on the assignment sheet if I was working . During an interview on 1/10/23 at 2:45 p.m., Staff #C16 was asked about facility administration. Staff #C16 stated, .I have tried calling the DON and not had her answer. They have a call schedule. There has (sic) been numerous times that I have called [the DON] . and nobody answers the phone . the management is non-existent. There is no support . They are so out of touch I don't think they even know hands on anymore . During an interview on 1/10/23 at 3:35 p.m., Staff #C12 said they had seen the DON going out and/or coming back in through the window in the DON's office. Staff #C12 said it was in the summer of 2022, and they were in the DON's office when she (the DON) was coming back in through the window with [lunch]. The DON told Staff #C12 that she does go in and out the window because she didn't want to be bombarded with questions, and it was too hard to get down the hallway because too many people stop her and ask her questions. During an interview on 1/12/23 at 9:22 a.m., when asked about staff entering or exiting the building through windows, Staff #C17 stated, I have seen it once. I told her, 'That isn't a door'. The DON said she went through the window in her office to avoid getting stopped in the hallway. She had her lunch with her, and it was the window by her desk. The farthest one back on the side wall. (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 1/11/23 at 11:20 a.m., when asked about awareness of the amount of time the DON was working from home, Regional Clinical Director HHH said she was not aware the DON was working from home so frequently. When asked if she had talked with facility staff regarding administrative support, Regional Clinical Director HHH said staff were reporting a miscommunication between staff and management. VAN Observation of the facility van on 1/4/23 at 3:35 p.m., with Transporter DD showed the van appeared operational. Transporter DD said he did not know why people were so concerned with the exhaust system. Transporter DD said the exhaust was fine. During an interview on 1/5/23 at 11:12 a.m., Resident #C4 was asked about the facility van. Resident #C4 stated, The (former) transporter quit because they were not fixing the bus. We were breathing the exhaust on the bus because they would not fix the [NAME] - about a month ago. Being in a wheelchair, you sat in the back, and you could clearly smell exhaust and the [NAME] was very loud. During an interview on 1/10/23 at 2:14 p.m., Resident #C10 was asked about transportation in the facility van. Resident #C10 stated, There is no G. D . [NAME] or exhaust on there (van). You can smell the gas exhaust. If you have to stay in there and wait for a second, all that exhaust comes up through the floorboards . it has been like that for a year. Either fix it or get it out of here. During an interview on 1/5/23 at 3:47 p.m., the NHA was asked why the exhaust had not been fixed on the facility transportation van. The NHA paused, then stated, Miscommunication with the requirement of prepayment for services rather than fixing and being paid. When asked if the van repair facility had requested pre-payment, due to previous difficulties with receipt of timely payment for work completed, the NHA confirmed that was correct. The NHA said the repair would be performed by a local auto repair company, and stated, They have not been prepaid for the repair of the exhaust, which is going to cost approximately $2,300.00. During an interview on 1/7/23 at 1:34 a.m., when asked about why Staff #C3 had quit transporting residents in the facility van, Staff #C3 stated, It was a struggle to get any gas in the bus. The company (corporate management) would not pay to get things fixed. I brought it to [Auto Repair Company]. (They) agreed to start fixing the van, and then the company (corporate management) never sent them a check. They (corporate management) kept saying it was in the mail. They never did pay for it . Staff #C3 said the exhaust pipe had been broken since they got the bus a year and a half ago, in November of 2021. I had seat belts and wire hangers holding up the exhaust. My stress levels were going through the roof . (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 1/11/23 at 2:37 p.m., the local [Auto Repair Company] Owner DDD was interviewed via telephone. Owner DDD confirmed they had completed an oil change and tire rotation, and there were other maintenance issues that were to be performed on the facility van. Owner DDD stated the work was not continued because It was a billing issue. The company (corporate accounts payable) was supposed to provide a check and they didn't send it. We did not get paid for the oil change and tire rotation. I also did a brake inspection. The check for the whole job was supposed to be $1,166.32, but I don't have a direct contact in the building. The driver took the paper copies of the bill back to the administrator, and I was under the assumption that the check was going to be in the mail. I had done work for them in the past and had a very difficult time receiving payment, so I was not going to accept responsibility for the whole job and not get paid. During an interview on 1/12/22 at 11:40 a.m., Transporter DD when informed facility residents had complained about smelling exhaust in the van cabin while sitting in wheelchairs. Transporter DD stated, They can't be smelling exhaust. That is just not possible. Transporter DD said he had an exhaust repair scheduled for another [Auto Repair Company] for 1/27/23 through 1/30/23, which was the first availability they had for the repair. Transporter DD confirmed they were replacing numerous feet of exhaust pipe underneath the bus. Transporter DDD said he did not know how long the facility van had been in that state of disrepair. TELEVISION During an interview on 1/5/23 at 9:24 a.m., Confidential Resident #C1 stated, The TV was off from a Sunday until a Thursday. That was awful. There was nothing - there wasn't even a sound or nothing in some of these rooms. They owed money is why I heard the TV went off. During an interview on 1/5/23 at 3:47 p.m., when asked who was responsible for paying the television invoices, the NHA said it would be the accounts payable person at the corporate office. The NHA stated, We send it (invoice) to an Accounts Payable email. The NHA confirmed the television was off in the facility for all facility residents 9/5/22 through 9/9/22, due to lack of payment of the previous bill(s). During a telephone interview on 1/10/23 at 4:23 p.m., Family Member (FM) SS said facility residents were without television for a whole week. FM SS stated, During that timeframe she went a whole week without television. The nurses were so upset because they (residents) have their programs they watch each day. Without TV for a whole week she (Resident #C9) was almost in tears for that week . During a telephone interview on 1/12/23 at 10:01 a.m., [Television Company] Accounts Receivable staff EEE confirmed that television service was cut off because the bill had not been paid for the previous three months. Accounts Receivable EEE said an email had been sent to [Corporate Accounts Payable Manager] On September 8th, an overnight partial payment was received, and service was restored on September 9th. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on 1/12/23 at 3:15 p.m., Regional Accounts Payable Manager FFF was asked about the lack of TV services due to non-payment of multiple invoices and informed that the facility NHA and DON were also present in the room, with the interview on speaker phone. Regional Accounts Payable Manager FFF said there should be communication, and it was not the practice that people are paying out of pocket and being reimbursed. Nobody should be reimbursed out of pocket. The NHA sighed heavily, and the DON stated, That is crazy . I think everyone of us has paid for gas for the van and gotten reimbursed. The NHA confirmed [Business Office Manager (BOM)] WW had submitted for reimbursement for the petty cash on 12/2/22. None had been received. The NHA stated, We have $4.00 in petty cash . NURSE STAFFING During interviews on 1/5/23 at approximately 12:20 p.m., and 1/11/23 at 12:37 p.m., the NHA expressed understanding of the staffing deficiency, and stated, Staffing has been a struggle. When asked about the NHA's knowledge regarding the lack of Registered Nurses (RNs), eight hours daily, seven days a week, the NHA stated, I did know that we were out of compliance. When asked about DON coverage during the shifts where no RN was available to be scheduled, the NHA acknowledged that would have been an alternative solution. SUPPLIES During an interview on 1/7/23 at 1:34 a.m., when asked about other supplies/services that were not always certain in the facility, Staff #C3 stated, We (facility) have gotten shut-off notices for gas. We went a week with no TV for the residents. We have run out of depends, and we have run out of incontinence wipes numerous times. People have even ran (sic) to the store to purchase them out of pocket. We did not have a petty cash fund .I have gone to the NHA numerous times and asked if things have been paid, and he said he is taking care of it . During an interview on 1/7/23 at approximately 3:50 p.m., Staff #C6 said the previous week, on a Monday or Tuesday, an electric utility vendor was at the facility door with a sign that said Notice and he said, I have got the shut-off notice. Staff #C6 directed him to the front office. During an interview on 1/11/23 at 3:25 p.m., when asked about purchasing of necessary supplies, Staff #C17 stated, We have been trying to order window blocks (to secure windows and prevent elopements) since July, but corporate is not paying the bills so we can't get things that we need ordered. I can't go to [Hardware Store] because they haven't paid the bill. (continued on next page)

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	235349	A. Building B. Wing	01/18/2023

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

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/13/23 at 10:27 a.m., Staff #C18 confirmed petty cash was requested on 12/2/22 from corporate, with $4.00 currently in the petty cash fund. Staff #C18 confirmed the NHA, DON, HIC A, and CNA H had to personally pay for gas and be reimbursed because there was no petty cash, and the credit card was maxed out. Staff #C18 stated, We have not had the ability to get paper since October 2022, and we didn't get paper without the staff buying paper out of our pockets and getting reimbursed through our payroll system. It is actually very frustrating to buy it here, because there are no paper supply companies here, and you are buying packs (of paper) at a time, and we were having to go out and buy it during work. Everybody is busy and we don't have the time to do that. Staff #C18 there had been disconnect notices from the electric supplier, natural gas supplier, and television. Local vendors no longer able to be utilized because of non-payment issues included: a local hardware store, pharmacy, mechanical repair vendor, plumbing vendor, and plowing company. Staff #C18 stated, We are not getting our stuff paid for, not being able to get supplies, and not getting responses, and asked about if later, when if they (corporate accounts payable) had responded it would have been done. We are all so stressed, and I have been in tears because we can't fix things that are above our control . I get shut-offs and disconnects and we get no response from corporate . Review of the Director of Nursing Position Summary, revised 4/27/2020, revealed the following, in part: The Director of Nursing assumes authority, responsibility, and accountability for the delivery of nursing services in the facility. In collaboration with facility Administration, allocates department resources in an efficient and economic manner to enable each resident to attain or maintain the highest practical physical, mental, and psychosocial well-being .Principal Duties and Responsibilities: Monitors facility incidents and complaints daily to identify those defined as unusual occurrences by State policy and promptly reports such occurrences to Administrator for appropriate action. Monitors complaint reports daily for allegations of potential abuse or neglect, or the loss or misappropriation of resident property, and participates in these investigations . Acts in an administrative capacity in the absence of the Administrator . Expectations of all Employees: Adheres to all [Corporate] Policies and Procedures. Conducts self in a manner consistent with [Corporate] Core Values at all times. Maintains a positive and respectful attitude with all word (sic) related contacts. Consistently reports to work on time and prepared to perform the duties of the position .Must be able to work overtime. Must be available on an on-call basis. May be summoned to the facility in an emergency and is expected to report to the facility in an emergency. Review of the Nursing Home Administrator Position Summary revealed the following, in part: The Nursing Home Administrator (NHA) assumes authority, responsibility, and accountability for their facility. The Administrator manages the facility operations within established guidelines and provides effective supervision of staff for all departments. The NHA develops and implements the annual plans for the facility and provides proper management of the financial and/or business affairs of the facility . Principal Duties and Responsibilities: . Provide for adequate staffing and for regular training of staff in areas appropriate to their needs . Maintain an open door to patients, their families, staff and others to promote communication about likes, dislikes and management of problem situations that may from time-to-time arise . Provide for effective supervision of staff for all departments . Provide support for and supervision to key supervisors and Department Heads in the management of personnel under their direction . Monitor documentation of employee performance and disciplinary actions performed by the Department Heads . Designate the Director of Nursing to fulfill duties in case of absence and inform designee of responsibilities. Provide staff with on-call schedule for evenings, weekends, and holidays . Expectations of all Employees: . Consistently reports to work on time and prepared to perform the duties of the position . The Nursing Home Administrator oversees all staff at all levels of the facility .

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 35103 Based on interview and record review, the facility failed to annually review and update the facility wide assessment to determine the level and competency of staff and the resources necessary to care for all 48 facility residents. This deficient practice resulted in the potential for insufficient staffing and resources to provide for resident care needs. Findings include: This citations pertains to #MI00132379, #MI00132709, #MI00125915, #MI00130432, #MI00131908, and #MI00132303. Findings include: Review of the facility Resident Census and Conditions of Residents form, dated 1/4/23, revealed the number of total residents was 48. Review of the Facility Assessment, updated December 1st, 2022, revealed the following staffing information, in part: Average daily census: (Monthly). 42 Position - Total Number Needed or Average or Range Licensed nurses providing direct care - 2 per shift Nurse Aides - 4 average per shift . Note: Clinical Management team will support as needed. 3.3 Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and assess these staff assignments. Facility incorporates PPD (cost per patient day), census and acuity of care in determining the amount of staff scheduled. Review of the Shift Schedules for nursing staff, including nurses and Certified Nurse Aides (CNAs) received from Scheduler C on 1/4/23 revealed all days were staffed at less than four CNAs average, per shift. Night shift was routinely scheduled with two CNAs, with day and afternoon shifts also staffed with less than the average number of four aides on multiple occasions throughout the month of December 2022. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/12/23 at 12:50 p.m., the NHA was asked to review the Facility Assessment for the level of staffing currently required for the facility. When asked how many aides were required on day shift, the NHA referred to the Facility Assessment and said the information in the facility assessment said four aides per shift. 2 aids on the 100/300 halls, and 2 aides on the 200/300 halls. When asked if the NHA was aware of how many residents currently required two-person assistance, the NHA said he did not know. When the number of residents who required two-person assistance with ADLs of 25 was provided from the list previously received from the NHA, the NHA stated, Oh, my. When asked how the calculation, with the inclusion of resident acuity, was made to determine four aides (one per hall) would be an acceptable number on day shift, the NHA stated, I was trying to put a number that was reasonable, and I did not do any calculation based on any algorithm based on what our actual staffing needs are. When rephrased for clarification, that no calculation was performed, and the number was what he thought reasonable - the NHA agreed. When asked if two nurses with four aides was enough staff to provide for resident needs, the NHA stated, It would be very, very slim. I went off the old 1-15 calculation. One nurse and two aides (per two halls) is (sic) not enough. Review of the Facility Assessment policy, revised 12/2020, revealed the following: The facility assessment will be reviewed and updated whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment or at a minimum annually.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35103 Based on interview and record review, the facility failed to accurately document Skin Sweep assessments in the Electronic Medical Record (EMR) for 24 Residents (#1, #2, #3, #4, #13, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, and #33), of 24 residents reviewed for completion of skin assessments. This deficient practice resulted in the falsification of skin assessments and a potentially inaccurate representation of resident skin conditions in the electronic medical record (EMR). Findings include: This citation pertains to Intakes #MI00132379 and #MI00132709. During an interview on 1/4/23 at 2:30 p.m., the Director of Nursing (DON) was asked how many hours she worked as the DON in the facility. The DON stated, 40 (hours) plus. When asked if she worked from home, the DON said she did not work from home. The DON was asked to provide documentation showing that she worked in the facility 40 hours per week. The DON said she was salaried and was not required to clock in or out when beginning or ending the workday. The DON was asked to provide an EMR report showing the IP (internet portal - a unique address that identifies a device on the internet or a local network) address used to access the EMR during the last 30 days. Review on 1/10/23 at 11:40 a.m., of the DONs IP Audit Report for the previous 30 days beginning 12/5/23, revealed the facility IP address was fixed at 24.xxx.xx.162, with provision of internet services by [Company Name] Business. Review of the internet IP addresses in the report revealed the following information: No EMR logins by the DON were present on the IP Audit Report for 12/10, 12/11, 12/18, 12/23, 12/24, 12/25, 12/26, 12/31/22, 1/1/23, and 1/2/23. EMR logins were provided by a non-business internet provider (not the facility internet provider but the same provider used by the DON), and multiple IP addresses (as possible with an internet gateway that assigns different IP addresses depending upon usage and availability) on the following dates: 12/12, 12/14, 12/15, 12/19, 12/22, 12/27, 1/3, and 1/4. During a telephone interview on 1/10/23 at 11:24 a.m., corporate IT (information technology) (Staff) CCC confirmed the facility IP address was static (did not change) and all computers used in the facility would have the same IP address of 24.XXX.XX.162, with the internet provided by (Company Name) Business. If she [the DON] were to log in at home, they (IP addresses) would show up at (Company Name) if she had that (Company Name) connection at home. The IP addresses used by a personal account could change during the day, and on different days the IP address may be different but would not be the same as the Business internet provided by the facility at IP address 24.XXX.XX.162. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review of the DON's IP Audit Report revealed the following weekly skin sweeps were created on 12/12/22 and 12/27/22, when the DON was not working from the facility Business internet IP address of 24. xxx.xx.162, but rather a personal internet account provided by her home internet provider with an IP address of 131.XXX.XXX.3: December 12/22 IP address 131.XXX.XXX.3 (not facility IP address) 1. 12/12/22 at 13:18 (1:18 p.m.), Resident #3 2. 12/12/22 at 13:19 (1:19 p.m.), Resident #16 3. 12/12/22 at 13:19 (1:19 p.m.), Resident #17 4. 12/12/22 at 13:20 (1:20 p.m.), Resident #18 5. 12/12/22 at 13:20 (1:20 p.m.), Resident #19 6. 12/12/22 at 13:21 (1:21 p.m.), Resident #20 7. 12/12/22 at 13:21 (1:21 p.m.), Resident #21 8. 12/12/22 at 13:22 (1:22 p.m.), Resident #22 9. 12/12/22 at 13:22 (1:22 p.m.), Resident #15 10. 12/12/22 at 13:23 (1:23 p.m.), Resident #23 11. 12/12/22 at 13:23 (1:23 p.m.), Resident #24 12. 12/12/22 at 13:24 (1:24 p.m.), Resident #25 13. 12/12/22 at 13:25 (1:25 p.m.), Resident #26 14. 12/12/22 at 13:25 (1:25 p.m.), Resident #27 15. 12/12/22 at 13:26 (1:26 p.m.), Resident #28 16. 12/12/22 at 13:26 (1:26 p.m.), Resident #1 17. 12/12/22 at 13:27 (1:27 p.m.), Resident #13 18. 12/12/22 at 13:27 (1:27 p.m.), Resident #29 December 27, 2022, IP Address 131.XXX.XXX.75 (not facility IP address) 19. 12/27/22 at 14:03 (2:03 p.m.), Resident #36 20. 12/27/22 at 14:03 (2:03 p.m.), Resident #31 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	21. 12/27/22 at 14:04 (2:04 p.m.), Resident #26 22. 12/27/22 at 14:04 (2:04 p.m.), Resident #4 23. 12/27/22 at 14:05 (2:05 p.m.), Resident #2 24. 12/27/22 at 14:05 (2:05 p.m.), Resident #32 25. 12/27/22 at 14:06 (2:06 p.m.), Resident #33 26. 12/27/22 at 14:07 (2:07 p.m.), Resident #20 During an interview on 1/7/23 at 4:55 p.m., when asked if the DON had ever completed skin sweep assessments with the Resident, Confidential Resident #C1 stated, No, she (DON) has never looked at my skin. LPN Q would come and look at me (my skin). During an interview on 1/7/23 at 4:58 p.m., when asked if the DON had ever completed skin sweep assessments with the Resident, Resident #C11 said the DON had never performed a skin sweep observation on her. Resident #C11 had an EMR documented skin sweep assessment completed by the DON on 12/12/22. During an interview on 1/10/23 at 5:21 p.m., when asked if the DON had performed skin sweeps (assessments) on Resident #C8, (with a documented skin assessment by the DON on 12/27/22) the Resident stated, I never see the DON. She has never come and done (a) skin assessment on me . During an interview on 1/9/23 at 3:25 p.m., when asked when weekly skin sweeps were performed by facility staff, Staff #C7 stated, I know a lot of people are not caught up with their skin sweeps. They are assigned shower days, and we do it the first part of the week (on) Monday, Tuesday, and Wednesday. I know for sure the treatment nurse does skin assessments. During an interview on 1/10/23 at 1:28 p.m., the DON was asked for her personal internet provider, and said it was (Company Name), the same as identified on 12/12/22 and 12/27/22 when the facility EMR was accessed to create skin sweep assessments from outside the facility. Also present during the interview was the Nursing Home Administrator, and Regional Clinical Director HHH. The DON said she was not in the building every day, every week in December, and confirmed she did work from home. The DON said she did not work as a nurse on the floor during the month of December. The DON was asked to review the IP Address Audit Report for the previous 30 days and provide an explanation of how weekly skin sweeps could have been performed on dates and times that she was not in the facility but logged on to the EMR through a personal internet provider. The DON said she may not have observed all the people who were documented with a weekly skin sweep performed on 12/12/22 and 12/27/22 by the DON. Some of those skin assessments I did not do the observations. When asked if completion of a weekly skin sweep (which means you have observed the residents' skin) and documentation of such in the electronic medical record, when you had NOT observed the residents' skin, would be fraudulent, the DON agreed that it would be considered fraudulent. When asked which skin sweep observations she had observed, the DON could not provide an answer. The DON acknowledged she may have been working from home that day. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/10/23 at approximately 1:27 p.m., when asked who should be completing the EMR assessments for weekly skin sweeps, Regional Clinical Director HHH stated, The skin assessment should be completed by the nurse completing (observing) the skin assessment. I would not put my name on a document and say that I observed it. Regional Clinical Director HHH agreed the DON did confirm she (the DON) did not do the resident skin observations and acknowledged that she (the DON) had fraudulently created, and documented observations not performed by completion of the Weekly Skin Sweep documents in the facility EMR while working from home in December. During an interview on 1/10/23 at 3:13 p.m., when asked how often the DON was working in the building, Staff #C9 stated, I would say [the DON] is not in the building for eight hours every day. I have no idea what she does at home. I would absolutely not be able to do a skin assessment at home. During an interview on 1/11/23 at 11:20 a.m., Regional Clinical Director HHH stated, (I) was not aware the DON was working from home so frequently . When you asked me (in the previous interview), I would not falsify documentation. I am not going to put my license in jeopardy to do that . Review of the facility undated Employee Handbook, pages 44-45, revealed the following, in part: .Conduct Guidelines: All companies, including [Corporation Name] set reasonable conduct guidelines. The guidelines allow us to coordinate a variety of activities within our organization and to provide a safe working environment for our employees, residents, and visitors. The following list is not intended to be all-inclusive but illustrates certain types of behavior [Corporation Name] deems unacceptable, and which may result in disciplinary action up to and including termination, with or without any written warnings. Other behaviors not listed may result in similar action . Falsification of timecards or any other documents . Falsifying any reports or records . Review of the DON Position Summary, revised 4/27/20 revealed the following, in part: . Adheres to all [Corporation Name] Policies and Procedures. Conducts self in a manner consistent with [Corporation name] Core Values at all times . Consistently reports to work on time and prepared to perform the duties of the position .

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a Compliance and Ethics Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation pertains to Intakes: #MI00132379, #MI00132709, #MI00125915, #MI00130432, #MI00131908, #MI00132303, #MI00132379, #MI00131701. Based on observation, interview, and record review, the facility failed to fully implement their Compliance and Ethics Program for two Residents (#4 and #14) with the potential to affect all facility residents. This deficient practice resulted in hiring and retaining two staff with criminal backgrounds who committed misappropriation towards Resident #4, lack of a hiring process or policy, and the lack of all staff Compliance and Ethics Training. Findings include: Resident #4 Review of the Minimum Data Set (MDS) assessment, dated 06/26/22, revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including seizure disorder, myoclonus (quick, jerking movements), myopathy (muscle disorder with weakness), chronic pain, depression, and anxiety disorder. Resident #4 required extensive, two-person assistance with bed mobility, transfers, dressing, toileting, and extensive one-person assistance with feeding. Review of the Brief Interview for Mental Status (BIMS) assessment showed Resident #4 scored 15/15, which indicated Resident #4 had intact cognition. Review of the PHQ-9 score [a depression assessment scale] revealed a score of 6/27, which placed Resident #4 in the mild depression score range. Review of Resident #4's Accident and Incident Report, dated 07/21/22 at 16:10 (4:10 p.m.), completed by the Director of Nursing (DON), revealed, Resident [#4] reported incident to nurse [unnamed] and nurse reported it the [Nursing Home Administrator (NHA)] immediately, in regards to a staff member [Nursing Aide (NA) NN] borrowing money from [Resident #4]. [Resident #4] alleged that a staff member [NA NN] borrowed money from [Resident #4] via app on cell phone and has not paid her back . The report showed law enforcement was notified of the occurrence, and [NA NN] was removed from the facility pending investigation. Review of Resident #4's Accident and Incident Report, dated 07/21/22 at 16:25 (4:25 p.m.), completed by the DON, revealed, Staff member [unnamed] reported to the [NHA] that another staff member [CNA OO] had allegedly borrowed money from [Resident #4] in the past. [Resident #4] confirmed that staff member [CNA OO] had borrowed money in the past, and later requested more money but [Resident #4] did not give [CNA OO] the money the 2nd time . The report showed law enforcement was notified of the occurrence, and [CNA OO] was removed from the facility pending investigation. During an observation on 01/10/23 at 2:00 p.m., Resident #4 was observed in their hospital bed. Resident #4 was observed with pronounced tremors of her arms and hands. Resident #4 agreed to be interviewed. (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/10/23 at 2:32 p.m., Resident #4 was asked about any missing property. Resident #4 confirmed she had money taken from her by two former staff members, NA NN, and CNA OO, with a total of $190.00. Resident #4 clarified, [CNA OO] told me someone stole her paycheck . and [asked] if I could loan her $100. I did, and I sent it to her on [social media cite]. And then a couple months later [CNA OOO] said, 'Could I have $58.00?', as she was going to lose the minutes on [CNA OO's] phone. I ignored it. I didn't because I [prior] loaned [NA NN] $90.00, and she said, 'Next week, when I get paid, I'll pay you.' I didn't get paid. [It happened] in July [2022]. So then when [CNA OO] asked, I was like, '[Expletive], no.' .The total amount was $100, then $90.00, $190.00 total . Resident #4 reported she was reimbursed the total amount ($190.00) by the Administrator. Resident #4 explained law enforcement spoke to her the day of the incident, and the two involved staff were terminated. Review of NA NN's investigation file revealed NA NN was suspended from employment on 07/21/22, and terminated on 07/26/22. NA NN's investigation file showed no abuse training since date of hire on 10/22/20. Both were confirmed by the NHA and the Regional Human Resources Manager, Staff MM. Review of CNA OO's investigation file revealed CNA OO was suspended from employment on 07/21/22, and terminated on 07/26/22, which was confirmed by the NHA and Staff MM. Review of NA NN's Personnel file revealed a (State) Criminal Background check dated 10/14/20 which showed NA NN was eligible for employment. Review of a second (State) Criminal Background check, dated 1/17/23 at 5:20 p.m., provided by Staff MM upon request, revealed, Important: Information Contained in this Record .12/08/2008 .Misdemeanor: Check - Non-sufficient funds less than $100 .08/13/2021: Felony Controlled Substance - Possession .[Charged] . It was noted there were no job references, which was confirmed by Staff MM. Review of NA NN's [State] Workforce Background Check Consent and Disclosure, signed by NA NN on 10/12/20, revealed, .I understand that as a condition of continued employment, I am required to report in writing to the health facility/agency .immediately upon being arraigned on a felony charge or convicted of one or more of the criminal offenses as described in .[State law] .or upon being the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property . During an interview on 01/12/23 at approximately 4:30 p.m , the Compliance Officer (NHA) and DON, with Staff MM, present confirmed they were unaware of NA NN's felony charge, which occurred during their employment at the facility, prior to Resident #4's misappropriation of personal funds, and understood NA NN signed the above employment form where they were to self-report an arraignment, charge, or conviction of a felony. The NHA reported this would be a concern for continued employment at the facility, but did not state they would suspend or terminate the employee. Staff MM acknowledged there was no process or policy found related to hiring or retention practices, upon Surveyor request. Review of a (State) licensing letter dated 10/10/22, provided by the NHA and Staff MM, revealed NA NN was charged with one count of misappropriation of Resident #4's property. The NHA confirmed NA NN was prohibited from working in any (Federal/State) nursing facility, per the letter. (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 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of CNA OO's personnel file revealed a (State) Criminal Background check dated 10/07/21, which showed CNA OO was eligible for employment. Further review of the file revealed a second (State) Criminal Background check dated 03/02/22, which showed, Important: Information Contained in this Record . 12/07/2014 .Misdemeanor Retail Fraud - Third Degree .Pled guilty . It was noted there were no job references. During an interview on 01/12/23 at approximately 4:10 p.m , with the Compliance Officer (NHA) and Staff MM, the NHA was asked why the second criminal background check was run for CNA OO on 03/02/22, and by whom. The NHA reported they were unaware of these charges, and were unclear why the criminal background check was run, was present in the employee file, and by whom. Staff MM confirmed they were unable to find this information. Both confirmed there would be a concern employing an individual with a prior criminal charge of retail fraud, given CNA OO perpetrated misappropriation (towards Resident #4), and was subsequently charged and convicted. Review of a (State) licensing letter dated 09/26/22, provided by the NHA and Staff MM, revealed CNA OO was charged with one count of misappropriation of Resident #4's property. The NHA confirmed CNA OO was prohibited from working in any (Federal/State) nursing facility, per the letter. Resident #14 Review of the Minimum Data Set (MDS) assessment, dated 08/19/22, revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including cerebrovascular disease (disease affecting blood supply to brain), atrial fibrillation (irregular heartbeat), encephalopathy (disease of the brain), dementia, dizziness, and repeated falls. The assessment revealed Resident #14 required supervision for walking, transfers, dressing, and toileting. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 14/15, which showed Resident #14 was cognitively intact. The sensory assessment revealed Resident #14 had severely impaired vision. Review of Resident #14's Accident and Incident report, dated 08/20/22 at 14:05 p.m. (2:05 p.m.) revealed, DON contacted at 1405 [2:05 p.m.] that resident [#14] had left the building with a gentleman [Visitor PPP] at approximately 11:40 a.m. and entered a vehicle, leaving the premises. DPOA [Durable Power of Attorney] called immediately and did not answer; [DPOA] did return call to facility stating the [sic] he was not aware of [Resident #14] leaving and the gentlemen who took him is an old friend. Resident [#14's] cellphone called and resident stated he was at home on [road] and safe and that he has been held captive at facility for long enough, and he was just going to stay at home and not return to the facility .Law enforcement called . [Resident #14] has been expressing he would like to leave the facility; Care Conference held with DPOA this past week and [DPOA] did not want him to leave the facility at this time due to cognitive factors and choices . Review of Resident #14's face sheet revealed Resident #14 had an activated DPOA, who was the primary contact for health care and finances. The diagnoses also showed Resident #14 had homonymous bilateral [both eyes] field deficits, right side. [A condition where a person sees only one side [right or left] of the visual world of each eye from brain dysfunction, after a stroke or other neurological brain condition, which requires training in compensatory strategies, vision adaptations, and limits driving safety without intensive retraining.] (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #14's facility Investigation report, dated 08/20/22, revealed, At approximately 11:25 a.m. on 08/20/22, [Resident #14] had [Visitor PPP] enter the facility. [Visitor PPP] spoke with [LPN KK] who stated he was there to see [Resident #14]. [Visitor PPP] stated he knew where [Resident #14's] room was and did not need assistance finding it. Approximately 15 minutes later [Visitor PPP] and [Resident #14] came up to the 100 nurses [hall] [sic] stated with some paperwork and belongings of [Resident #14's]. [Visitor PPP] stated he had the walking papers, referring to discharge. [LPN KK] was under the impression this was a discharge for [Resident #14], as the Medical Director was in the facility at the time. [LPN BBB] the nurse caring for [Resident #14] went to give [Resident #14] his lunch tray when they noticed he was not in his room at approximately 1:30 p.m . [LPN BBB] immediately began looking for [Resident #14] at which time [LPN KK] had explained she thought he had discharged [from the facility]. [LPN BBB] called the DON at approximately 2:05 p.m. to explain the incident .[DON] notified [NHA] of the incident at approximately 2:12 p.m . Review of the investigation report and attached timeline revealed Resident #14 left the faciity on [DATE] at 11:40 a.m. and was discovered missing by their nurse [LPN BBB] at 1330 [1:30 p.m.], nearly two hours later. The DON was not in the building when the incident occurred, and the NHA was notified at 2:12 p.m. The Medical Director was notified at 3:50 p.m. Review of Resident #14's nursing progress note, dated 08/20/22 at 21:09 [9:09 p.m.], signed by the DON, revealed, .This writer asked [DPOA] if he would give verbal consent or sign AMA [Against Medical Advice] paperwork after explaining document, and stated, 'No, I am not signing anything because I don't feel he [Resident #14] was ready to leave and the doctor didn't feel he was ready to leave .He's an old man and is going to do what he wants to do but I will not be signing any further documents from your facility .' [DPOA] asked [if they] would want us to provide anymore discharge plans from facility such as homecare and stated, 'I don't want anything more from [sic] facility .' [Physician GGG] notified of [DPOA] not having police escort back to the facility and asked if [they] felt it was a safe discharge. [Physician GGG] stated [sic] not a safe discharge with resident's vision and driving, no home care, and alcoholism. Police also notified of resident's vision impairment and driving concerns . During an interview on 01/11/23 at 10:55 a.m., LPN KK was asked about Resident #14's elopement on 08/20/22. LPN KK acknowledged they were the staff that allowed Resident #14 to leave the facility with Visitor PPP. LPN KK reported they had been off work a few days when the incident occurred and did not know Resident #14 personally. LPN KK reported a well-dressed man [Visitor PPP] entered the facility and said, I'm here to pick up [Resident #14] . LPN KK reported Visitor PPP returned to the main entrance with Resident #14, and had Resident #14's paperwork, including a medication paper with a name and description of a medication, but did not see discharge paperwork .Resident #14 left with Visitor PPP. LPN KK confirmed they did not call or contact Resident #14's nurse, LPN BBB, or Resident #14's DPOA, either prior to Resident #14 leaving, or after they left the facility. (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During further interview, LPN KK was asked about the typical resident discharge process. LPN KK stated they would need a doctor's order, and run a list of medications, and there would typically be a paper with each department's discharge recommendations, and any follow-up appointments would be listed. LPN KK reported a resident being discharged is discharged to the guardian, stating, The guardian has to be here. When asked if any of this occurred, LPN KK stated, I didn't have [Resident #14] as a patient. LPN KK continued, A couple hours later [LPN BBB] came down the hall with a CNA [unnamed] and said, 'I can't find [Resident #14].' LPN KK reported what had occurred and then asked, 'Is he his own person [responsible party]?' (And learned he was not) and called his DPOA. LPN KK reached the Resident #14's DPOA, and then called the DON and NHA. LPN KK reported they understood the discharge process and had received a reeducation from the DON, however received no disciplinary action. LPN KK stated, I will never do this again [allow a resident to leave the facility without medical authorization and following facility processes] .I am upset with myself. I knew better . During an interview on 01/13/23 at 11:21 a.m., the Compliance Officer (NHA), with the DON present, was asked about Resident #14's elopement, and LPN KK allowing Resident #14 to leave the facility without checking paperwork for physician discharge, not following the facility process for discharge, not contacting the DPOA, and not following the facility process for representative notification with change in status. Reviewed concern regarding LPN KK essentially allowing [Resident #14] to walk out of the facility with no medical clearance, no management clearance, leaving with a non-family member or representative, and lack of supervision in the facility without assigned staff being aware of Resident #14's absence for nearly two hours. It was also noted LPN KK received no disciplinary action, which the DON confirmed. The NHA and DON reported they understood the concerns. Review of faciliy's Compliance and Ethics training for employees revealed the facility did not ensure all staff completed the required training annually. Review of the policy, Compliance and Ethics Program, revised 08/15/2022, revealed, This facility is committed to compliance and has designed, implemented, and enforced a compliance and ethics program for promoting quality of care and preventing and detecting criminal, civil, and administrative violations. Policy Explanation and Compliance Guidelines: 1. As part of the facility's culture of compliance, establihsed standards of conduct apply to everyone involved in the company .3. All staff, including individuals providing services under a contract and as a volunteer, committing violations of the compliance and ethics program will be subject to disciplinary actions, up to and including termination .

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 40330 This citation pertains to Intakes: MI00132379, MI00132709, MI00125915, MI00130432, MI00131908, MI00132303. Based on interview and record review, the facility failed to ensure the provision of effective communication training for five staff of five reviewed for communication training. This deficient practice had the potential to result in ineffective communication to residents and representatives including clear dialogue, respectful communication, active listening, understanding resident communication, understanding body language, provision of adaptive communication methods, and provision of an alternate means of communication as indicated, with the potential to affect all facility residents. Findings include: Review of (Vendor) computer training logs on 01/12/23 revealed the following staff had no effective communication health care training, per the recently updated regulatory requirements: - Social Services Designee, Staff RR, date of hire 09/06/2022. - Licensed Practical Nurse (LPN) P, date of hire 05/19/2020. - LPN UU, date of hire 12/03/2022. - Certified Nurse Aide (CNA) H, date of hire 01/19/2015. - CNA K, date of hire 04/28/2009. During an interview on 01/12/23 at 3:39 p.m., the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Regional Human Resources Manager, Staff MM, were asked about the missing effective communication trainings. The NHA acknowledged they had not begun the specific effective communications health care training, per the Phase 3 recently implemented regulatory requirements. The NHA reported they understood the concern, and had no policy for this training requirement. Review of the facility assessment, titled, Facility Wide Assessment, dated 12/01/2022 - Updated, received from the NHA, revealed, .Consider the following training topics (this is not an inclusive list): Communication - effective communications for direct care staff .Cultural competency (ability of organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of residents .).

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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. 40330 This citation pertains to Intakes: MI00132379, MI00132709, MI00125915, MI00130432, MI00131908, MI00132303 and MI00126137. Based on interview and record review, the facility failed to ensure compliance with annual abuse and/or dementia training requirements for three employees [Nursing Aide (NA) NN, Certified Nurse Aide (CNA) OO, and the Social Services Designee, Staff RR] of seven employees reviewed for abuse and dementia training. This deficient practice resulted in misappropriation for Resident #4, the potential for new and ongoing abuse, and the potential for lack of understanding of residents cognitive and behavioral challenges, with the potential to affect all facility residents. Findings include: Review of NA NN's employee file and [Vendor name] computer training program showed NA NN received abuse training upon their date of hire, 10/22/20. There was no annual abuse training in 2021 or 2022. Further review revealed they had not received any dementia training. NA NN was suspended from employment on 07/21/22 and terminated from employment at the facility on 07/26/22 for misappropriation. Review NA NN's (State) Criminal background check, dated 12/06/22, revealed they were not eligible ot work in long term care, or similar health care settings and had a Permanent Exclusion . During an interview on 01/12/23 at 4:10 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) were asked about NA NN's missing abuse and dementia training. Both reviewed the employee file and [Vendor] computer training and confirmed none was found in the past year, but they would have the Regional Human Resources manager check, Staff MM, who was present during the interview. Surveyor showed them NA NN's employee file, which showed no abuse and dementia training. During an interview on 01/12/23 on 01/12/23 at 4:50 p.m., Staff MM was asked if they were able to find any evidence of the abuse and dementia training being completed for NA NN. Staff MM acknowledged they were unable to locate any evidence of these trainings for NA NN, and the abuse and dementia training should have been completed annually. Staff MM reported they assumed the file had not been completed by Human Resources, and there had been some turnover in the department. Review of CNA OO's employee file and [Vendor] computer training revealed they were hired on 10/08/21, and had not received any dementia training, or similar cognitive or behavioral management training. CNA OO was suspended from employment on 07/21/22 and terminated from employment at the facility on 07/26/22 for misappropriation. During an interview on 01/12/23 at 3:39 p.m., the NHA, DON and Staff MM were asked about CNA OO's missing dementia training. All confirmed the dementia training could not be found, and understood the concern, given CNA OO was doing direct care with cognitively impaired residents with dementia. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Staff RRs employee file revealed they had not completed any dementia training since their date of hire, 09/06/22. Further review of their [Vendor] computer training revealed no dementia training, or similar training for residents with cognitive impairment or behavior concerns. During an interview on 01/12/23 at 3:45 p.m., the NHA, DON, and Staff MM were asked about CNA OO's missing dementia, cognitive, and behavioral management training. All reviewed Staff RRs file and [Vendor] training, and understood the concern with the missing trainings. All agreed the Social Service designee would need this type of training to adequately perform their job duties related to providing Social Services to residents with dementia and cognitive impairment. During an interview on 01/12/23 at 1:49 p.m. Staff RR reviewed their [Vendor name] computer training with the survey team and confirmed they did not have dementia training. When asked about why dementia training was important for their job, Staff RR reported they understood the concern. Review of the policy, Abuse, Neglect, and Exploitation, revised 06/2022, revealed, It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written polices and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .II. Employee training .Training topics will include: 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation .5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect .

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 40330 This citation pertains to Intakes: MI00132379, MI00132709, MI00125915, MI00130432, MI00131908, MI00132303. Based on interview and record review, the facility failed to ensure two of three staff reviewed completed required Quality Assurance and Performance Improvement (QAPI) training, per updated regulatory requirements. This deficient practice had the potential for staff to lack knowledge of the elements and goals of the facility's QAPI program, and their role and potential input, with the potential to affect all residents. Findings include: Review of (Vendor) computer training logs on 01/12/23 revealed the following staff had no QAPI training, per the recent regulatory updated requirements: - Social Services Designee, Staff RR, date of hire 09/06/2022. - Certified Nurse Aide (CNA) K, date of hire 04/28/2009. During an interview on 01/12/23 at 3:39 p.m., the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Regional Human Resources Manager, Staff MM, were asked about the missing QAPI training. The NHA acknowledged and understood the concern. Review of the policy, Quality Assurance and Performance Improvement, revised 10/(20)22, received from the NHA, revealed no reference to the updated Phase 3 regulatory requirements implemented 10/24/22, for staff QAPI training requirements, and the necessary training components outlined in the regulation. Review of the facility assessment, titled, Facility Wide Assessment, dated 12/01/2022 - Updated, received from the NHA, revealed the QAPI training was not referenced in the facility training topics as required training for facility staff.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. 40330 This citation pertains to Intakes: MI00132379, MI00132709, MI00125915, MI00130432, MI00131908, MI00132303. Based on interview and record review, the facility failed to ensure the provision of training for compliance and ethics requirements for two of five staff reviewed for compliance training. This deficient practice had the potential to result in unethical and unprofessional staff conduct, with the potential to affect all facility residents. Findings include: Review of (Vendor) computer training logs on 01/12/23 revealed the following staff had no compliance training, per the recent regulatory updated requirements: - Licensed Practical Nurse (LPN) P, date of hire 05/19/2020. - LPN UU, date of hire 10/27/2014. During an interview on 01/12/23 at 3:39 p.m., the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Regional Human Resources Manager, Staff MM, were asked about the missing compliance trainings. The NHA understood the concern. Review of the policy, Compliance and Ethics Program, revised 08/15/2022, revealed, This facility is committed to compliance and has designed, implemented, and enforced a compliance and ethics program for promoting quality of care and preventing and detecting criminal, civil, and administrative violations. 1. As part of the facility's culture of compliance, established standards of conduct apply to everyone involved in the company. 2. The facility maintains a designated compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution. 3. All staff .committing violations of the compliance and ethics program will be subject to disciplinary actions, up to and including terminations. 4. Components of the facility's compliance and ethics program include: a. Written compliance and ethics standards, policies, and procedures .As part of an operating organization with five or more facilities, additional components of the facility's compliance and ethics program include: a. Mandatory annual program on the facility's compliance and ethics program. B. A designated compliance officer in which the program is their main responsibility. C. Designated compliance liaisons located at each of the organization's facilities .6. The facility reviews the compliance and ethics program annually, revising as needed to: a. Reflect changes in the applicable laws or regulations within the organization. b. Improve performance in deterring, reducing, and detecting violations. c. Promoting quality care. Review of the facility assessment, titled, Facility Wide Assessment, dated 12/01/2022 - Updated, received from the NHA, revealed the compliance and ethics training was not referenced in the facility training topics as required training for facility staff.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 40330 This citation pertains to Intakes: MI00132379, MI00132709, MI00125915, MI00130432, MI00131908, MI00132303. Based on interview and record review, the facility failed to ensure 12 hours of annual certified nurse aide (CNA) training were completed for two CNA's of three reviewed for annual training requirements. This deficient practice resulted in the potential for unmet care needs, and adverse outcomes, including accidents, injuries, functional decline, abuse and neglect, with the potential to affect all facility residents. Finding include: Review of (Vendor) computer training logs on 01/12/23 revealed the following staff lacked the 12-hour training annual requirements: - CNA K, date of hire 04/28/2009. 1.0 hours (completed one course). - CNA OO, date of hire 10/08/2021. 0.0 hours (completed no courses). During an interview on 01/12/23 at 3:39 p.m., the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Regional Human Resources Manager, Staff MM, were asked about the missing 12 hours of CNA trainings. The NHA understood the concern. Review of the policy, Online Training System - [Vendor] Learning, revised 09/26/2017, revealed, [Facility Name] is committed to the structured and systemized training and development of all it's employees on an ongoing basis to enable them to perform their duties effectively and efficiently, as well as meet regulatory compliance standards. Definition: Mandatory in-service training: training on a topic or variety of topics that is required for all employees to complete to ensure continued employment .Procedure: [Facility] has entered into a contract with [Vendor] Learning to utilize and access their online course library. [Vendor] offers a broad range of in-services and Continuing Education Courses for licenses and certified staff .[Facility] assigns a course package to employees in [Vendor] monthly, as well as additional courses that are rotated throughout the year. All courses assigned by [Facility] are mandatory in-services .Certified Nurse Aides: Certified Nurse Aides (CNA's) are required to complete 12 hours of in-servicing annually. Failure to complete this requirement could result in the loss of certification. Review of the facility assessment, titled, Facility Wide Assessment, dated 12/01/2022 - Updated, received from the NHA, revealed, .Consider the following training topics (this is not an inclusive list): .Required in-service training for nurse aides. Inservice training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Include dementia management training and resident abuse presentation training. Address areas of weakness as determine in nurse aide's performance reviews .For nurse aides providing services to individuals with cognitive impairment, also address the care of the cognitively impaired. Identification of resident changes in condition .

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	01/18/2023

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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 40330 This citation pertains to Intakes: MI00132379, MI00132709, MI00125915, MI00130432, MI00131908, MI00132303. Based on interview and record review, the facility failed to ensure the provision of training for behavioral health care needs for five staff of five staff reviewed for behavioral health care training. This deficient practice had the potential to result in unmet behavioral health care needs for residents, with the potential to affect all facility residents. Findings include: Review of (Vendor) computer training logs on 01/12/23 revealed the following staff had no updated behavioral health care training, per the recent regulatory updated requirements: - Social Services Designee, Staff RR, date of hire 09/06/2022. - Licensed Practical Nurse (LPN) P, date of hire 05/19/2020. - LPN UU, date of hire 12/03/2022. - Certified Nurse Aide (CNA) H, date of hire 01/19/2015. - CNA K, date of hire 04/28/2009. During an interview on 01/12/23 at 3:39 p.m., the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Regional Human Resources Manager, Staff MM, were asked about the missing behavioral health care trainings. The NHA acknowledged they had not begun the specific, updated behavioral health care training, per the Phase 3 recently implemented regulatory requirements. The NHA reported they additionally had no policy for this training requirement. Review of the policy, Behavior Management Program, revised 12/2020, received from the NHA, revealed no reference to the updated Phase 3 regulatory requirements implemented 10/24/22, for the behavioral health care training requirements, and the necessary training components outlined in the regulation. Review of the facility assessment, titled, Facility Wide Assessment, dated 12/01/2022 - Updated, received from the NHA, revealed the behavioral management training was not referenced in the facility training topics as required training for facility staff.