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	01/25/2022

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview and record review, the facility failed to ensure continued evaluation for self-administration of medications for one Resident (#31) of one resident reviewed for medication self-administration. This deficient practice resulted in the potential for late administration of medications and the potential for inaccurate dosing of medications. Findings include: According to a facility admission record (no date noted), Resident #31 was admitted to the facility on [DATE] with the diagnoses of major depressive disorder and chronic pain syndrome. On 01/13/22 at approximately 7:43 AM, LPN T was observed entering Resident #31's room and then coming out a few minutes later. On 01/13/22 at approximately 7:45 AM, Resident # 31 was observed asleep in her room, wearing a continuous positive air way pressure mask (a breathing mask to support breathing) in her bed. Resident #31 awoke and was interviewed. Resident #31 was asked if she was aware the nurse was in her room delivering medications and responded, No. Three medication cups were observed left on her bedside table stacked on top of one another in a plastic cup with a lid on it. Review of interdisciplinary team (IDT) Review Note dated 05/26/21, read in part; Note: Wound and Weight Meeting: Resident (#31) refused weekly weight. Will continue to attempt monitor weekly at this time. IDT did not document regarding Resident #31's safe self-administration of medication in this quarterly note. Review of IDT Review Note dated 08/24/21, read in part; Note: Wound and Weight Meeting - Resident on weekly weights r/t (related to) readmission. Resident refused to be weighed. Skin is intact. The IDT note did not document Resident #31's safe self-administration of medication in this quarterly note. No further IDT Review Notes were found in Resident #31's medical records dated after 08/24/21 through 01/19/22. Review of Resident #31's medication orders were reviewed and compared to the medications written on the Evaluation for Self-Administering of Medications, dated 10/21/16 and signed by the former Director of Nursing (DON) and Assistant DON on 10/21/18 and found to have at least eight medication changes since the signed evaluation. Medications added included: quetiapine fumarate, butalbital-acetaminophen, metoclopramide, levothyroxine, lactose enzyme, losartan potassium, ondansetron, and atorvastatin calcium. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #31's medication administration record (MAR) and the progress notes in the electronic medical record (eMAR) revealed no indication of self-administration of medications by the Resident #31 and the nurses were marking them as given and or signed out without any indication of Resident #31's self-administering of her own medications. Review of Resident #31's Minimal Data Set Assessment (MDS), dated [DATE] revealed a Brief Interview for Mental Status (BIMS) which is used to assist with identifying a resident's current cognition and indicates that Resident #31 has a BIMS score of 15, indication intact cognition. Review of a facility policy titled Resident Self-Administration of Medication date reviewed 12/20, read in part; It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team (IDT) has determined which medications may be self-administered safety. Under the section Policy Explanation and Compliance Guidelines read in part .3.) No medication shall be left unattended without the resident's knowledge that it has been left there for them. 4.) Resident administering their own therapy shall be reviewed quarterly or sooner upon the discretion of the IDT . 5.) Upon notification of the use of bedside medication by the resident, the medication nurse records the self-administration on the MAR/TAR (Treatment Administration Record).

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 35103 Based on interview, and record review, the facility failed to provide written notice prior to a room change for two Residents (#3 & #19) of three residents reviewed for room changes. This deficient practice resulted in the potential for increased anxiety, misunderstanding of the reasons for the room change, and the lack of opportunity for resident questions or concerns. Findings include: Review of Resident #3's and Resident #19's complete electronic medical record (EMR), including progress notes, and Room Change Forms failed to find written documentation to provide notification to Resident #3 and Resident #19 when they were moved to the 200 hall. During a telephone interview on 1/19/22 at 9:48 a.m., Social Services Director (Staff) I, confirmed Resident #3 stayed out on the floor for 4-5 days after testing positive for COVID-19. Staff I stated, I was [upset] about that. I don't know why they didn't move her. I kept inquiring and they kept saying they would do it, and there was only one person that could do it, and then they had to wait . During a telephone interview on 1/19/22 at 12:52 p.m., Infection Preventionist (IP) J was asked when Resident #3 and Resident #19 were moved to the COVID unit. IP J said that information should be documented in the chart. IP J reviewed Resident #3 and Resident #19's EMRs and found no documentation showing when either COVID-19 positive resident was moved to the COVID unit. IP J confirmed there was no charting for when either resident was moved to isolation, and no room change form was found. On 1/20/22 at approximately 11:30 a.m., Change of Room or Roommate forms for Resident #3 and Resident #19 were requested from the Nursing Home Administrator (NHA), via email. A response from the NHA, received on 1/20/22 at 11:58 a.m., revealed the following information, in part: The room change forms were not filled out for [Resident #19] or [Resident #3]. Review of the Change of Room or Roommate policy, revised 12/20, revealed the following, in part: Policy: It is the policy of this facility to conduct room changes or roommate assignments when considered necessary by the facility and/or when requested by the resident or resident representative .2. Reasons for a change in room or roommate could include but are not limited to: .b. Medical conditions which prohibit certain room sharing (e.g., infection control for isolation) .3. Requests for changes in room or roommate should be communicated to the Social Service Designee. 4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. 5. The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understand, and will include the reason(s) why the move or change is required . During a telephone interview on 1/25/22 at 2:47 p.m., Social Service Director (Staff) I was asked about Resident #3 and Resident #19's Change of Room or Roommate form. Staff I stated, I know they (IP J and NHA) could not find the room change forms. I said, Well it is on me. What can I do? Social Service Designee acknowledged that she may not have completed the room change forms and may have failed to have them signed by the Residents and/or Resident representatives. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/25/22 at approximately 9:30 a.m., the NHA was asked if the Change of Room or Roommate form was an optional form. The NHA stated, No, it is not acceptable to not complete the room change documentation. The NHA confirmed it was not an optional form but was required to be completed by facility staff.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to update the advance directive and pursue competency and guardianship for one Resident (#14) of four residents reviewed for Advanced Directives. This deficient practice resulted in Resident #14 lacking legal representation to clarify their advance directive to represent a decline in their health care decision-making capacity. Findings include: Review of Resident #14's Minimum Data Set assessment, dated 10/25/21, revealed Resident #14 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including dementia, transient ischemic attack (mini-stroke), depression, and schizophrenia (a serious mental health illness which may cause altered perception and psychosis). Resident #14 required total two-person assistance for transfers, eating, and toileting. The Brief Interview for Mental Status showed Resident #14 scored 5/15, which indicated Resident #14 was severely cognitively impaired. Review of Review of Resident #14's Electronic Medical Record (EMR) revealed they were designated with full code status (full resuscitation and life-saving measures) on 6/12/20, when Resident #14 signed their code status, after three other attempts to sign were noted. There was no documentation in the EMR regarding annual review of their advanced directive status. During interviews on 1/11/22 at approximatley 11:00 a.m., 2:30 p.m., and 3:10 p.m., Resident #14 was observed in their room. Resident #14 answered some yes/no questions, however the accuracy could not be determined. Resident #14 could not use their call light upon request to communicate their needs. During other observations during the survey, Resident #14 was often found sleeping. During an interview on 1/11/22 at 2:45 p.m., the Director of Social Services, Staff I, was asked about the lack of a recent review of Resident #14's advanced directive. Staff I reported ever since Resident #14 had been readmitted to the facility (in 2018), they had let the Nursing Home Administrator (NHA) know the probate court judge had asked for Resident #14 to have facility legal representation for guardianship. Staff I reported the NHA had approached the corporate staff on more than one occasion, and a facility corporate attorney was never appointed. They confirmed Resident #14 was still their own representative, but they believed Resident #14 needed a guardian appointed, as the family was estranged and had declined to be involved in Resident #14's care decisions as a POA (Power of Attorney). Staff I reported they had been doing three jobs at the facility, and had not completed any documentation pertaining to review of Resident #14's advance directive status since 6/12/20. Staff I reported they would put an updated note in the medical record today (on 1/11/22), and stated, I apologize, and it bothers me. Staff I acknowledged Resident #14's physician had affirmed it was time for guardianship to be pursued, which they noted on 1/20/21 in their progress note, and no guardian had yet been appointed. Staff I stated Resident #14 at times refused to answer questions on the BIMS (cognitive) assessment, thus their competency could not be fully determined. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Social Services progress note by Staff I, dated 1/12/22 at 12:47 p.m., revealed: [Resident #14] is his own person. [Staff I] Reached out to the probate court for guardianship. Judge [name redacted] wishes for the facility to have an attorney represent the facility and apply for guardianship. Administrator reached out about this concern via phone. We have not heard back from [facility] corporation . Review of a Social Services progress note by Staff I dated 1/12/21 at 12:37 p.m., revealed a late entry progress note, dated 10/28/21, titled, Interdisciplinary Care Conference, (entered after the survey started), which revealed Resident #14 agreed they would like to remain full code with yes/no responses. Surveyor was unable to verify the meeting occurred other than verbal affirmation by Staff I, as there was no other documentation related to this meeting in the EMR prior to survey entry on 1/11/21. Review of Resident #14's dietary progress notes dated 1/12/22, 1/04/22, and 12/27/21 revealed Resident #14 was unable to participate in conversations. On 12/27/21, the dietary note showed .he seemed too out of it to talk to me . Prior progress notes during 11/2021 revealed Resident #14 was able to answer basic questions about his needs. Review of Resident #14's occupational therapy discharge summary (most recent), dated 1/29/21, revealed, Goals not met 2 [secondary to] limited participation/carryover from therapy services Gains limited 2 [secondary to] inconsistent therapy participation, limited carryover from therapy sessions and d/t [due to] combative behaviors and confusion . Review of Resident #14's face sheet revealed they were designated as their own responsible person, as their family declined to be involved in Resident #14's care decisions per Staff I. Resident #14's emergency contact, Family Member (FM) MM, was called during the survey on 1/11/22 at 4:27 p.m., and on 1/12/22 at 10:07 a.m., with no return call or response received. Staff I reported their calls were not returned when they tried to reach Resident #14's family. Review of Resident #14's Social Services notes since 2018 confirmed the same; there were no returned calls from any family regarding his advance directive or guardianship. Review of Resident #14's progress note, dated 5/08/18, revealed the facility Social Services had begun pursuing guardianship at that time. Further EMR review confirmed they did not pursue guardianship again until 1/20/21. Review of Resident #14's progress note dated 5/28/18 indicated Resident #14's BIMS assessment score was 3/15, which was indicative of severe cognitive impairment. During a phone interview on 1/18/22 at 12:02 p.m., Staff I reported they had secured guardianship for Resident #14, so the advance directive would soon be updated, and the facility physician would be evaluating Resident #14's competency. Staff I' did not provide any additional documentation as requested to show any other facility efforts to clarify the advance directive, pursue guardianship, competencies, or legal representation during the survey. During an interview on 1/19/22 at 9:19 a.m., the Nursing Home Administrator (NHA) was asked about Resident #14's lacking an advance directive update and concerns regarding lack of pursuit of competency and guardianship, related to lack of facility legal representation. The NHA acknowledged the concern, and reported they understood the deficient practice. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, Advance Directives, revised 12/2020, revealed, It is a policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advanced directive .5. The facility will periodically assess the resident for decision-making abilities, and approach the health care proxy or legal representative if the resident is determined not to have decision-making capabilities .8. Decisions regarding advance directives and treatment be periodically reviewed .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to provide a timely and homelike dining environment for five Residents (#4, #10, #18, #23, and #40) of 18 residents reviewed for dining. This deficient practice resulted in feelings of frustration, boredom, and restlessness. Findings include: Review of Resident #23's most recent Minimum Data Set (MDS) assessment, dated 11/07/21, revealed Resident #23 was independent with set-up for eating, and had no communication impairment. Resident #23 scored 9/15 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment. An observation on 1/11/22 at 12:04 p.m. of the main facility dining room revealed 9 residents in the dining room, with no beverages including water or a lunch meal, each at their own table at least 6' apart. Resident #23 arrived to the dining room in their wheelchair during this observation. An observation on 1/11/22 at 12:36 p.m. revealed 10 residents, including Resident #23, had no beverages or lunch meal. Resident #23 attempted to exit the dining room, and stated to Activity Staff Q she was tired of waiting and wanted to come back. During an interview on 1/11/22 at 12:40 p.m., Activity Staff Q was asked why residents did not have any beverages including water or soup while they were waiting. Activity Staff Q reported prior to COVID (the facility outbreaks) they did serve drinks and water before the meals from a drink cart, but they could not do this now due to staff shortages. During an interview on 1/11/22 at 12:44 p.m., Resident #23 was asked how they felt about waiting for their lunch meal. Resident #23 said, I'm tired; and I've been waiting about an hour . An observation on 1/11/22 revealed residents began receiving their lunch meal on trays with beverages on the trays in the main dining room at 12:45 p.m. Review of Resident #4's most recent MDS assessment, dated 10/11/21, revealed they were independent with set-up for eating, and had no communication impairment. The BIMS assessment revealed a score of 12/15, which indicated moderate cognitive impairment. An observation on 1/11/22 at 1:02 p.m. revealed Resident #4 had not received their lunch tray, on their hall, as they were planning to eat in their room. During an interview on 1/11/22 at 1:13 p.m., Resident #4 was observed eating their lunch meal in their room, seated upright on the edge of their bed. Resident #4 reported they received their lunch meal at 1:00 p.m. They reported they usually received it much earlier, around 12:15 to 12:30 p.m., and hoped this was an isolated incident. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility document, Meal Times, received from the dietary department, showed meal times per hall, and revealed Resident #4's (number) hall was not listed on the schedule for when residents received their meal trays. The other hall lunch mealtimes were 12:00 p.m., 12:10 p.m., and 12:20 p.m., and the Dining Room lunch time was noted as 12:30 p.m An observation of the main dining room on 1/12/22, beginning at 12:10 p.m. revealed 10 residents in the dining room, seated at their own tables at least 6' apart. One of the residents had a soda can which they brought down to the dining room. The remaining residents had no beverages or lunch meal. These same residents had no beverages or meals at 12:25 p.m. By 12:39 p.m., 13 residents were present, and had no beverages or lunch meal. There were still no beverages or meals on the dining room tables at 12:54 p.m. Beverages and the lunch meal were received by the first Resident (#40) at 12:56 p.m Review of Resident #18's MDS assessment, dated 10/29/21, revealed they were independent with set-up for eating, and had no communication impairment. The BIMS assessment revealed a score of 14/15, which indicated normal cognition. During an interview on 1/12/22 at 12:51 p.m., Resident #18 was observed seated in the dining room at their own table, without a beverage or lunch meal. Resident #18 was asked about the timing of their lunch meal, and responded, I got there at '20 til '12 (11:40 a.m.), and now it's '10 til '1 (12:50 p.m.). It makes me feel pretty [NAME] [not having a lunch meal tray or a beverage]. Review of Resident #40's MDS assessment, dated 12/15/21, revealed they were independent with set-up for eating, and had no communication impairment. The BIMS assessment revealed a score of 15/15, which indicated normal cognition. During an interview on 1/12/22 at 12:53 p.m., Resident #40 was also seated in the dining room at the adjacent table without a beverage or lunch meal. Resident #40 was also asked about the timing of the lunch meal, and responded, It's late, and I've been down here since 12 [12:00 p.m.]. If I knew it was this late, I would have been doing something else [another task]. An observation of the main dining room on 1/12/22 at 1:11 p.m. revealed all residents had received their beverages and lunch meals on trays. Review of Resident #10's MDS assessment, dated 10/09/21, revealed they required extensive one-person assistance for eating, and they were rarely able to understand others or be understood. The BIMS assessment revealed a score of 99, which indicated Resident #10 was unable to complete the cognitive assessment. During an interview on 1/12/22 at 1:15 p.m. with Resident #10's Family Member (FM), FM V was asked about the lunch timing today. FM V responded, The wait [time] was long today, which is not unusual, but it was too long . FM V reported they transported Resident #10 to the dining room (in their wheelchair) at 12:05 p.m. to assist them with their lunch meal, and Resident #10 did not receive their tray until 1:00 p.m. FM V noticed Resident #10 sometimes became agitated and restless when they waited too long, and FM V could tell it was a long time for Resident #10 to wait, and reported this concerned them. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 1/13/22 at approximately 5:30 p.m., with the Nursing Home Administrator (NHA) and the Director of Nursing (DON), both acknowledged the resident and family concerns related to late meals, and understood the deficient practice. Review of the policy, Dining Service, revised 1/05/21, received via email from the NHA on 1/18/22 at 4:48 p. m., revealed, It is the policy of this facility to provide a positive dining experience. 1. Meal will be served at regularly scheduled times .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to ensure the provisios of care necessary to avoid potential physical harm and emotional distress resulting in neglect for one Resident (#46) of 18 residents reviewed for abuse. This deficient practice resulted in Resident #46 being left in a soiled brief (with feces) for an extended time, the potential for a urinary tract infection (UTI), and feelings embarrassment, hopelessness, and helplessness when facility staff were unresponsive to physical care needs. Findings include: Review of Resident #46's Minimum Data Set (MDS) assessment, dated 12/27/21, revealed Resident #46 was admitted to the facility on [DATE], with active diagnoses including paraplegia, fusion of thoracic region spine, muscle weakness, need for assistance with personal care, and history of urinary (tract) infections. Resident #46 required extensive two-person assistance with bed mobility and toilet us,e and was totally dependent upon staff for transfers. Resident #46 scored 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition and was able to make her needs known. Resident #46 was documented as always incontinent of bowel, with no toileting program implemented to manage the Resident's bowel incontinence. Review of Resident #46's Physician Order Summary, dated 1/25/22, revealed the following: one suppository daily at 0730 (7:30 a.m.) for constipation . Start Date: 12/28/21. During a telephone interview on 1/25/22 at 12:04 a.m., the County 911 Dispatch was contacted by telephone regarding a complaint allegation received 1/25/22 involving Resident #46. The complainant was unavailable and unable to be contacted. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/25/22 at 12:07 p.m., Resident #46 was contacted via telephone in the facility. Resident #46 confirmed she had called the Sheriff's department on Saturday 1/22/22, who had advised her to call 911 with a non-emergency situation. Resident #46 called 911 at 3:55 p.m. and called adult protective services at 9:12 p.m., after being left in a soiled (feces) brief with insufficient staff to provide care that day. Resident #46 stated, I had my bowel movement by 8:30 a.m. by 10:00 a.m. I needed to straight cath (catheterize for removal of urine) and by then I had a pile (of feces) in there (the brief) . At 10:40 (a.m.) they came in and changed me. I was still in bed, and I ate my lunch in bed. I called the administrator in the building, but he has no voicemail . On Saturday there were two aides for the whole building (on day shift) . The same thing happened today (Tuesday, 1/25/22), there was one (aide) on each side (covering two halls each) . I am a two-person [mechanical] lift to get out of bed. One aide did do the [mechanical] lift alone because she could not find anybody (to assist her). I finally got out of bed at 1:45 p.m. This is very typical of what has occurred during my stay . I have had to sit in stool probably half of the time. It gets old in a hurry . When asked how many times she had to sit in stool for an extended period, Resident #46 stated, It has been more than 10 for sure. It depends if they can find someone to clean me up and get the [mechanical lift] so I could get out of here (bed). Resident #46 stated, On the 20th (of December) they brought me here (to the facility) and they fed me dinner, and then the next day they didn't feed me at all. When asked how she felt about the provision of incontinence care by the facility, Resident #46 stated, What really made me feel demeaned - they turned me on my side, took off the [incontinence brief], and then I was left on my side for two hours before anybody came back. I s*** all over the bed. I had a pile (of feces) on the bed. People are not taken very good care of here. It is mainly because of being short-staffed . Resident #46 said she had kept written notes and would provide them to this Surveyor via email and/or text message. Approximately 40 photographs were received via email on 1/25/22 at approximately 1:00 p.m., and via text message on 1/25/22 at 1:14 p.m., taken by Resident #46 of her written documentation detailing care during her time in the facility. Review of the photographic documentation written by Resident #46 on 1/22/22 through 1/25/22 included the following, in part: Saturday 1/22/22: Very short on aides, 2 for whole building . 7:45 (a.m.) suppository (received) . 10 (10:00) AM, Will probably get a UTI from cathing today had lots of poop and it could have affected it. Still in bed! 10:40 (a.m.) Came in and changed me . 12:30 (p.m.) Lunch came. 1:45 (p.m.) Finally out of bed. [Telephone number] to call Nursing Home Administrator (NHA) . 3:55 (p.m.) Called 911 to report non-emergency . 9:12 (p.m.) I called [Adult Protective Services] Abuse and Neglect 24-hour hot-line to report my abuse as an advocate for the residents here. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sunday 1/23/22: Two aides for the whole building . 7:50 (a.m.) Rang to see if I could be put on the toilet. [CNA LL] here. Couldn't put me on toilet. Only aide on this side . 8:40 (a.m.) Nurse came in to clean me up . [CNA LL] came in and both helped clean me up (which wouldn't have been necessary if I could have gotten to toilet). Asked when I'd be getting out of bed, said when another aide gets here probably around 10:30 (a.m.) . Monday 1/24/22: Only one aide again today for the whole building! Tuesday, 1/25/22: Two aides in building today! . 8:56 (a.m.) Lady looking for help to get me to toilet. 9:25 (a.m.) .PT was in after seeing my light on for some time. She is going to look for someone to get me on toilet . 9:35 (a.m.) [PT] found [Staff Name] to help get me on toilet . (39 minutes after initial request) Review of Resident #46's Bowel Incontinence, ADL (Activities of Daily Living), and Fall care plans, revealed the following interventions: - Check with me every 2 hours and as needed for episodes of bowel incontinence. I require extensive staff assistance with incontinent cares. - I am non-ambulatory. - TOILETING - I require extensive staff assistance with toileting needs. Date Initiated: 12/20/2021. - TRANSFERRING - I am dependent on staff assistance of 2 for transfers using a full body mechanical lift. Date Initiated: 12/20/2021. - Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance. Date Initiated: 12/20/2021. Review of Resident #46's POC (point of care) Response History for Bowel Movements look back of 14 days, revealed the CNAs documented Large bowel movements on 1/22/22, 1/23/22, and 1/24/22. During interviews on 1/11/22 at 9:44 a.m., 10:14 a.m., 9:58 a.m., with Resident #20, #37, and #40, respectively, and all agreed there were not enough staff to provide for timely provision of resident care needs. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 1/12/22, at 10:19 a.m., 1/18/22 at 9:45 p.m., and 4:05 a.m., and 1/19/22 at 5:48 p.m., CNA F, CNA FF, CNA GG, CNA KK, respectively, all reported they had worked alone as the only nurse aide either on a two-hall assignment, or in the whole facility, had used the mechanical lift alone for resident transfers, and said there were not enough CNAs to provide timely provision of resident care. Review of the Rights of Residents in [state] Nursing Facilities, dated 11/28/16, revealed the following, in part: .You have the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living .You are entitled to receive adequate and appropriate care . During a telephone interview on 1/25/22 at 1:41 p.m., the NHA confirmed staffing on Saturday 1/22/22 was challenging. The NHA said he had not received any reports from staff that a resident had been left in feces for an extended period of time, and/or telephoned 911. When asked about the number of aides on Sunday, 1/23/22, day shift, the NHA stated, I believe they only had one aide on Sunday. When asked how long a resident should be left sitting in feces, waiting to be cleaned up by facility staff, the NHA stated not longer than 10-15 minutes. The NHA agreed having to sit in feces for 30-45 minutes or longer was unacceptable. Review of the facility Abuse, Neglect and Exploitation policy, revised 12/20, revealed the following, in part: Policy: It is the policy of this facility to provide protections for the health, welfare and right 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 the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Possible indicators of abuse, include but are not limited to: 1. Resident, staff, or family report of abuse .8. Failure to provide care needs .

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 Based on interview and record review, the facility failed to ensure facility nursing staff were properly trained and certified in CPR (Cardiopulmonary Resuscitation) to ensure the provision of emergency care prior to the arrival of emergency medical personnel when one nurse of five nurses reviewed for CPR had evidence of CPR certification. This deficient practice resulted in the potential for an inadequate number of facility staff available to effectively provide CPR due to lack of current education and training. Findings include: On [DATE] at 11:26 a.m., Registered Nurse (RN), Licensed Practical Nurse (LPN), Charge Nurse, and any other nursing position job descriptions were requested from the NHA via email to determine facility requirements for CPR certification. On [DATE] at 11:58 a.m., the NHA provided Position Summaries for Charge Nurse LPN and Charge Nurse RN. One CPR certification card, showing current certification, was provided for one Charge Nurse RN of five requested from current nursing staff including the Director of Nursing, RN/Infection Preventionist, LPN/MDS Coordinator, and two Charge Nurse LPNs. Review of the facility Cardiopulmonary Resuscitation (CPR) - Adult policy, revised ,d+[DATE], revealed the following, in part: .1. In the event a resident is identified unresponsive and upon thorough assessment determines that there is no pulse or respiratory activity, and the resident has declared a full-code status, a BLS certified staff member will . Continue to administer chest compressions and rescue respirations per the [CPR Training Provider] recommendations. Review of the Charge Nurse LPN (Licensed Practical Nurse) Position Summary, revised [DATE], revealed the following, in part: .Education, Training, and Experience: Must possess a current [state] license as a licensed practical nurse. CPR certification required . Review of the Charge Nurse RN (Registered Nurse) Position Summary, revised [DATE], revealed the following, in part: .Education, Training, and Experience: Must possess a current [state] License as a Registered Nurse. CPR certification required . During a telephone interview on [DATE] beginning at 9:25 a.m., the NHA confirmed that only one nurse valid CPR certification, of five nurse's CPR certification requested, was found. The NHA said he was not aware of how many facility nurses were currently CPR certified and acknowledged only one of the five nurses reviewed had evidence of current CPR certification. Upon further review, the NHA was able to provide evidence of valid CPR certification for four full-time and one part-time nurse of 21 nurses on the Staff Contact List provided by the facility. The NHA expressed understanding of the deficiency related to CPR training and certification.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on observation, interview, and record review, the facility failed to ensure meaningful activities were provided for six Residents (#3, #10, #14, #35, #36, #38) out of 14 residents reviewed for activities. This deficient practice resulted in feelings of boredom. Findings include: On 1/11/22 at 9:23 a.m., an interview was conducted with Social Worker (SW) I who reported she was assisting in the role of activities director. SW I stated, We are trying to hire an activities director. SW I reported that she was in charge of the social services department and was also covering as the admission director and the activities director. On 1/12/22 at 3:25 p.m. it was observed that the activities whiteboard in the hall near the dining room, which had previously contained the evening activities, had been erased after the 2:00 p.m. Karaoke activity. On 1/13/22 at 7:30 a.m., Activities Aide/Staff Q was observed in the hallway writing the day of activities on the whiteboard. When asked about the previous evening's activities being cancelled, Staff Q reported that the afternoon activities aide had not been feeling well, so the activities were not held. Resident #10 A review of Resident #10's medical record revealed she admitted to the facility on [DATE] with diagnoses including dementia, major depression, and history of stroke. A review of her 10/9/21 MDS assessment revealed she assessed by staff to be Severely Cognitively impaired. A review of Resident #10's care plan for activities developed 4/8/21 revealed, I am here for a long term stay and will be offered therapeutic activities that support my rehab goals. I will participate (in) 1:1 activities 1x per week of my leisure choice such as discuss and recall . This care plan contained only one intervention dated 4/30/21 of For 1:1 visits, I would enjoy: Strolls around the building, conversation, watching t.v., listening to music. This care plan had no updated interventions since April of 2021. On 1/12/22 at 3:23 p.m., Resident #10 was observed self-propelling in her wheelchair down the hallway, not engaging in any meaningful activities. On 1/13/22 at 10:11 a.m., Resident #10 was observed sitting in her wheelchair staring at the 100 hall nurses station desk. Resident #10 was not engaging in any meaniful activities. A review of the facility policy titled, Activities revised 1/21 revealed, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as, encourage both independence and interaction within the community . (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36 A review of Resident #36's medical record revealed she admitted to the facility on [DATE] with diagnoses including dementia and schizophrenia. A review of her 12/2/21 MDS revealed she was assessed by staff to be Severely Impaired for cognition and required the use of a wheelchair for mobility. A review of Resident #36's care plan for activities dated 2/21/17 revealed, I demonstrate strong leisure activities of choice as evidence(d) by engaging in leisure activities of my interests . Encourage my favorite independent activities of choice such as watching tv, westerns, cartoons, making up my bed, folding cloths/towels, sorting objects, walking in hallways, pet visits, going outside when the weather permits . Invite me to a wide variety of group offering such as table games, crafts, and group activities . Provide me with hand towels as I like to fold laundry . Provide me with a baby doll . Further review of the care plan revealed it had not been updated since 2020 and had not been updated the change in ambulation status when Resident #36 transition to requiring a wheelchair for locomotion. On 1/12/22 at 10:21 a.m., Resident #36 was observed up in her wheelchair self-propelling throughout the facility. On 1/12/22 at 11:54 a.m., Resident #36 was observed sitting in her wheelchair in the activities room. Resident #36 was just sitting in her wheelchair with no meaningful activities occurring. On 1/12/22 at 3:22 p.m., Resident #36 was observed self-propelling in her wheelchair out of the dining room and was not being engaged in any meaniful activities. On 1/13/22 at 8:38 a.m., Resident #36 was observed self-propelling down the hallway and not engaging in any activities. Resident #38 A review of Resident #38's medical record revealed he admitted to the facility on [DATE] with diagnoses including Down Syndrome, Diabetes type 1, and aphasia. A review of his Minimum Data Set (MDS) assessment dated [DATE] revealed he was assessed by staff to be Severely Impaired for cognition. A review of Resident #38's care plan for Activities dated 5/27/18 revealed, I demonstrate strong leisure activities as evidence by engaging in regular activity participation . Encourage favorite independent activities such as balloon volleyball, coloring, listening to music . meals in the dining room, watching movies . Invite me to a wide variety of group offering such as table games, crafts, and cooking . Leisure interests include balloon volleyball, entertainment, coloring, arts and crafts, going outside when the weather permits, listening to music . On 1/11/22 at 12:37 p.m., an interview was conducted with Family Member S, the mother of Resident #38. When asked about whether she felt there were enough activities, Family Member S reported that Resident #38 used to love going to balloon volleyball but that it was no longer being done or Resident #38 wasn't going anymore. Family Member S also reported that she was informed Resident #38 was getting apple juice throughout the day from the kitchen window and felt he was doing this because he was just bored. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/12/22 at 10:20 a.m., Resident #38 was observed up in his wheelchair at the 100 hall nurses station near the exit door. Resident #38 was not engaging in any meaningful activities. On 1/12/22 at 11:53 a.m., Resident #38 was observed sitting in the activities room. Resident #38 was not engaging in any meaningful activities. On 1/12/22 at 12:15 p.m., Resident #38 was observed sitting in his wheelchair near the 100 hall nurses station staring at the desk. Resident #38 was not engaging in any meaningful behaviors. On 1/12/22 at 3:34 p.m., Resident #38 was observed sitting in his wheelchair in the 100 hall, not engaging in any meaningful activities. On 1/13/22 at 10:10 a.m., Resident #38 was observed in his room sitting on his bed. When asked if he had been invited to play balloon volleyball, Resident #38 shook his head no. When asked if wanted to play balloon volleyball, Resident #38 started to grin widely and started to transfer himself into his wheelchair to head down to the activities room. On 1/13/21 at 10:11 a.m., Staff Q was observed in the dining room preparing the balloon volleyball activity. When asked if she had asked residents about playing balloon volleyball, she reported that the residents had calendars in their rooms to let them know the activities. When asked about Residents who were cognitively impaired and couldn't read the calendar, Staff Q reported that they had already went around and invited those Residents to come down. On 1/13/22 at 8:45 a.m., Resident #38 was observed sitting in his wheelchair at the 100 hall nurses station staring at the wall. Resident #38 was not being in engaged in any meaningful activities. 40330 Resident #3 During an interview on 1/12/22 at 2:26 p.m., the Infection Preventionist Nurse, Registered Nurse (RN) J, confirmed Resident #3 resided on the facility COVID unit due to a COVID-19 positive diagnosis. They explained Resident #3 was a long term care resident at the facility prior to their transfer to the COVID unit. During an observation with Licensed Practical Nurse (LPN) G on 1/12/22, at approximately 4:00 p.m., Resident #3 was observed in a private room on the COVID unit hall. Surveyor and LPN G wore full PPE, and greeted Resident #3 at their door. Resident #3 asked Surveyor when they could leave the unit, and explained they were bored. Resident #3 stated they used to participate in several activities in their room and on the unit where they formerly resided. When asked if activity staff or nursing staff had addressed their activity needs, Resident #3 reported they had not seen anyone, and they were down there on their own, and were bored and lonely. They acknowledged only seeing staff for brief nursing interactions, and were not aware when they could leave the unit. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/13/22 at 10:21 a.m., Activity Staff Q was asked if they had provided any activities to Resident #3 or their nursing staff. Activity Staff Q confirmed they only had the time to do one to two activities a day in the absence of an activity director or more activity staff, and the afternoon activity director was petrified of going on the COVID unit. Staff Q confirmed the activity staff had not been doing any activities or providing any activities for Resident #3 or any residents formerly on this unit including magazines, puzzle books, etc., which nursing staff could have brought to residents who temporarily resided there. Staff Q confirmed Resident #3 was an active participant in many individualized and group activities prior to her transfer to the COVID unit, and they would not be surprised if Resident #3 was bored on the unit, since the activity staff had been no directives for any activity participation on the unit, and thus not provided any individualized or one-to-one activities. Review of Resident #3's current Care Plan, accessed 1/19/22 at 10:20 a.m., revealed Resident #3 enjoyed working puzzles, BINGO, walking with staff, bowling, movies, reading, puzzle books, and phone games. Resident #14 Review of Resident #14's Minimum Data Set assessment, dated 10/25/21, revealed Resident #14 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including dementia, transient ischemic attack (mini-stroke), depression, and schizophrenia (a serious mental health illness which may cause altered perception and psychosis). Resident #14 required total two-person assistance for transfers, eating, and toileting. The Brief Interview for Mental Status showed Resident #14 scored 5/15, which indicated Resident #14 was severely cognitively impaired. Observations of Resident #14 on 1/11/22 (at 10:56 a.m., 2:30 p.m., 3:10 p.m. and 3:46 p.m.) and on 1/12/22 (at 9:35 a.m., 9:53 a.m., 10:21 a.m., 10:47 a.m., 11:16 a.m., 11:35 a.m., 12:16 p.m., 1:22 p.m., 2:00 p.m. 2:48 p.m. and 3:58 p.m.) revealed Resident #14 in their room, either in their bed or in their Geri-chair (a positional lounge recline chair). During this time, there was no activity participation observed or staff conversing with them. Resident #14 was heard to make loud vocalizations at times and demonstrated some moaning. Resident #14 denied pain or discomfort when asked via yes/no questions, and could not give a reason for his vocalizations. Resident #14 may have benefitted from positive distraction such as one to one conversation but this was not observed. Surveyor attempted to ask Resident #14 about their activity preferences, however they were unable to clearly respond. Review of Resident #14's current Care Plan, accessed 1/18/22 at 10:23 a.m., revealed activity preferences including one-to-one activities including conversation, listening to music, watching television, following sports, country western, and food related activities. Observations of the activities staff on 1/12/22 from approximately 11:45 a.m. to 1:30 p.m. revealed Activity Staff Q and R were observed in charge of resident dining tasks including washing residents' hands, pushing resident wheelchairs, supervising residents, passing dining trays, assisting with clean up, and helping residents exit the dining room. This showed they spent extended periods of their day in the dining room. After lunch, both Activity Staff Q and R were observed in the Activity room seated at their desk and were not engaging residents in activities. Activity Staff Q reported they were training Staff R who was new to their position this week. Both acknowledged they were also in charge of residents' smoking supervision, which also took up some of their daily time in the facility. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/13/22 at 9:14 a.m., Activity Staff Q was asked about any activities completed with residents on 1/12/22. Staff Q reported they were training Staff R, who was new in their position as an activity aide, and because of this they had only completed one group activities with residents, and no one-to-one activities. They stated they only have Monday mornings for one-to-one activities. Staff Q reported during their day shift they spent most of their time on clerical tasks, getting calendars together, taking bulletin boards up and down, and this week sanitizing Christmas ornaments, and training Staff R. Staff Q was asked if they were recently completing one-to-one activities with residents' who required individual activities. Staff Q reported since the facility activity director had walked off their job a few week ago, they had only been able to complete group activities, and were unable to make individualized room visits for those residents who required the visits during their day shift. They reported there was an evening activity aide who did some evening one-to-one activities but said they had called off work the rest of this week due to illness. When Staff Q was asked if operating without an Activities Director affected the residents' activity participation, Staff Q acknowledged this affected the activities program as now they spent less time with the residents, and nodded yes, this concerned them. Review of the January (2022) activity calendar with Staff Q, who was the only staff who had worked in activities recently, reported when they passed snacks and helped at lunch they charted this as an activity. They saw no concerns there when asked. Resident #35 During an interview on 1/18/22 at 2:28 p.m., Resident #35 was in their bed, and reported feeling bored with nothing to do. Resident #35 was asked what they liked to do for activities, and they reported they liked to look at magazines, and have someone to talk to, and clarified they meant they would enjoy some conversation. During the survey on 1/11/22 and 1/12/22, Resident #35 was observed in their bed in their room, and not engaged in any activities. Observation of Resident #35's room showed no bedside activities such as puzzle books, magazines, etc. During an interview on 1/13/22 at 10:30 a.m., Activity Staff Q was asked about Resident #35's activity participation. They confirmed they had been unable to do one-to-one visits, as Resident #35 enjoyed activities in their room, and they would take Resident #35 some magazines to read, as they were unaware there were none in their room. Review of Resident #35's current Care Plan, accessed 1/12/22 at 11:37 a.m., revealed Resident #35 enjoyed reading magazines, and preferred one-to-one activities including conversing with staff. Review of the January, 2022, activity calendar with Staff Q revealed the activities the activities not done after karaoke, on 1/12/22, were: 3:30 (p.m.) Snack cart, 4:30 (p.m.) dinner time trivia, and 7:00 (p.m).- (One :[to] Ones). (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy, Activities, revised 1/2021, revealed, .Activities refer to any endeavor, other than routine ADLs, in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health. Policy Explanations and Compliance Guidelines: . Activities will be designed with the intent to. a. enhance the resident's sense of well-being, belonging, and usefulness, b. promote or enhance physical activities. c. promote or enhance cognition. d. promote or enhance emotional health. e. promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence. f. reflect resident's interests. g. reflect cultural and religious interests of the residents. h. reflect choices of the residents Activities may be conducted in different ways: a. One-to One programs [individual]. b. person appropriate [individualized] .c. program of activities [variety of activity categories] .

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 34276 Based on observation, interview, and record review, the facility failed to ensure that a qualified activities director was employed at the facility to provide a meaningful activity plan with the potential to effect all 47 residents residing in the building. This deficient practice resulted in boredom and the a lack of meaningful activities. Findings include: On 1/11/22 at 9:23 a.m., an interview was conducted with Social Worker (SW) I who reported she was assisting in the role of activities director. SW I stated, We are trying to hire an activities director. SW I reported that she was in charge of the social services department and was also covering as the admission director and the activities director. On 1/12/22 at 12:10 p.m., Activities Aide/Staff Q was observed in the dining room. When asked about the lack of Activities Director, Staff Q stated, I didn't want it (the position of activities director). Staff R was standing beside Staff Q and reported that he was training in the role of activities aide and would potentially step in as the activity director. On 1/12/22 at 3:25 p.m. it was observed that the activities whiteboard in the hall near the dining room, which had previously contained the evening activities, had been erased after the 2:00 p.m. Karaoke activity. On 1/13/22 at 7:30 a.m., Staff Q and Staff R were observed in the hallway writing the day of activities on the whiteboard. When asked about the previous evening's activities being cancelled, Staff Q reported that the afternoon activities aide had not been feeling well, so the activities were not held. On 1/18/22 3:32 p.m., an interview was conducted with the Administrator. When asked about the hiring of an activity director, the Administrator reported that he had interviewed a few people. The Administrator reported that he had liked one of the candidates, but she was asking for too much money, and therefore had not been hired. The Administrator reported that he understood that the facility did not have a qualified activities director and was not aware that the activities on 1/12/21 in the evening had been cancelled.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to provide adequate quality of care for one Resident (#14) of 14 residents reviewed for quality of care. This deficient practice caused Resident #14 to not reach their highest practicable level of physical, mental, and psychosocial well-being, with the potential for physical, mental and psychosocial decline. Findings include: Review of Resident #14's Minimum Data Set (MDS) assessment, dated 10/25/21, revealed admission to the facility on [DATE], and readmission on 2/18/18, with diagnoses including dementia, transient ischemic attack (mini-stroke), depression, and schizophrenia (mental health illness which may cause altered perception and psychosis). Resident #14 required total two-person assistance for transfers, eating, and toileting. The Brief Interview for Mental Status showed Resident #14 scored 5/15, which indicated severe cognitive impairment. This MDS assessment revealed Resident #14 had adequate vision and wore eyeglasses. Observations of Resident #14 on 1/11/22 (at 10:56 a.m., 2:30 p.m., 3:10 p.m. and 3:46 p.m.) and on 1/12/22 (at 9:35 a.m., 9:53 a.m., 10:21 a.m., 10:47 a.m., 11:16 a.m., 11:35 a.m., 12:16 p.m., 1:22 p.m., 2:00 p.m. 2:48 p.m. and 3:58 p.m.) revealed Resident #14 in their room, either in their bed or in their Geri-chair (a positional lounge recline chair). Resident #14 was heard to make loud vocalizations at times, and demonstrated some moaning. Resident #14 denied pain or discomfort when asked via yes/no questions, and could not give a reason for his vocalizations. Resident #14 was not repositioned off their back during these observations, which placed Resident #14, a vulnerable resident who was dependent on staff for positioning, at risk for skin breakdown. Resident #14 reported they were struggling to sleep, and did not sleep at all on 1/12/22. During these observations, Resident #14 demonstrated eye twitches and significant lateral jaw and tongue movements when they were awake. The movements subsided when they were sleeping. Resident #14 was unable to stop the movements when asked, and they were not related to chewing or eating. Resident #14 also presented with their fists clenched and their elbows flexed with their hands closed on their chest. Resident #14 could partially open their hands and straighten their hands upon request but then resumed the same posture which placed him at risk for contractures. Resident #14 was unable to use their call light upon request, despite being available in various positions. They reported they were unable to see their call light, and were unable to visually track surveyor, and presented with their right eye was closed. They were observed rubbing their right eye at times, and were unable to find the call light, or identify fingers held up in front of them accurately. Resident #14 was not observed wearing eyeglasses during any of these observations. Review of Resident #14's physician orders on 1/12/22 revealed Resident #14 was receiving Haldol, an antipsychotic medication, since 5/19/21, which may over time produce the effects of Tardive dyskinesia (a neurological disorder characterized by involuntary movements of the face and jaw caused by long-term use of neuroleptic [anti-psychotic] drugs, which are used to treat psychiatric conditions). This condition can be preventable with close observation and symptom assessment and monitoring for the symptoms. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident #14 (standardized) assessment for involuntary movements revealed a score of 0, which was indicative of no abnormal movements, on 10/21/21 and 7/21/21. During an interview on 1/13/22 at approximately 8:00 a.m., Resident #14's Certified Nurse Aide. (CNA) H, was asked if they had observed any abnormal movements. Resident #14 affirmed they had seen Resident #14 demonstrate abnormal facial movements and some tightness in their extremities. They were asked if they reported the movements to anyone, and denied doing so as they had been occurring for an extended period, likely several months. CNA H reported they believed Resident #14 had very poor vision as they were unable to reach for any items held in front of them during feeding, needing total assistance including to even drink from a cup. Further review of the Electronic Medical Record (EMR) revealed no evidence of a Gradual Dose Reduction (GDR), or documentation of such, since 2/11/21. Review of Resident #14's most recent occupational therapy episode, with discharge on 1/20/21, received by the Rehab Director on 1/12/22, revealed Resident #14 was shaky/Jitter, or had tremors, which limited their therapy progress and ability to participate. During a phone interview on 1/18/22 at 12:03 p.m., the Director of Social Services, Staff I, confirmed there had been no GDR attempted since 2/11/21 per their documentation, and the last behavioral care referral was completed on 6/18/20. Staff I reported Resident #14 refused another but this was not found in any documentation, or provided upon request of Staff I by the end of the survey. During a phone interview on 1/18/22 at 12:20 p.m. with the Director of Nursing (DON), they reported a GDR was done on 5/19/21, when Resident #14's Haldol was reduced from .5 mg at night to .25 mg at night. They reported the only documentation they had for this GDR was the physician order which showed the reduction. They reported they were unaware of Resident #14's facial movements and muscle tightness and clenching his fists. They would have an abnormal movement scale assessment done, to assess if there were any changes. They stated their assessments were done quarterly. Review of Resident #14's (standardized) abnormal movement scale in the EMR, dated 1/18/22, revealed a score of 5, which included 2 for mild jaw movements, and score of 3 for moderate tongue movements. The DON confirmed the score was 5 for this assessment. Item 8 was scored separately as a summary, and showed a score of 3 which indicated moderate abnormal movements. The DON shared these results with Surveyor immediately after completion of the abnormal movement scale, and noted it was a concern the scores had increased, and staff had not made them aware of the changes. They reported they would have the physician complete a visit with Resident #14 on 1/19/22, to address the change. Review of Resident #14's EMR revealed there was no recent ophthalmology or optometry consult for vision decline, such as new glasses, which Social Services Director I confirmed . Review of Resident #14's current care plan, accessed 1/18/21 at 10:43 a.m., revealed Resident #14 wore eyeglasses since 10/23/20. Physician orders (current) revealed an order to scrub right eyelid with baby shampoo BID [twice daily] to manage drainage. During an interview with 1/12/22 at 10:13 a.m., Registered Nurse (RN) K was asked about Resident #14's vision. RN K stated, I believe [Resident #14] is blind in both eyes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/12/22 at approximately 2:35 p.m., Licensed Practical Nurse (LPN) G was asked about Resdient #14's eyes. LPN G reported Resident #14 kept their right eye closed as they had blepharitis (eye inflammation). During an interview on 1/13/22 at approximately 8:30 a.m. with CNA H, they were asked if Resident #14 wore eyeglasses. CNA H reported they wore them until this summer when they disappeared, and reported the nursing staff knew and nothing was done about it. CNA H stated one day this summer Resident #14 reported everything was dark, and they couldn't see. They reported they were frustrated Resident #14 did not receive a vision referral, as they had told nursing staff of this concern. They also noted Resident #14 was constantly rubbing his right eye and kept it closed. CNA H checked in Resident #14's room for eyeglasses during this interview, and reported they had not seen the glasses for a long time. During a phone interview on 1/18/22 at 5:45 p.m. with the NHA and DON, they were asked about Resident #14's reported vision decline, and not wearing any eyeglasses. Surveyor shared during multiple staff interviews with Resident #14's care staff revealed nursing staff believed he was blind or had very poor vision, and their right eye drainage and discomfort for several months. They reported Resident #14 did see an ophthalmologist in 8/2019 which showed significant cataracts and acknowledged there was no follow-up since then about this condition or the need to wear eyeglasses. Review of physician and nursing progress notes for 6/11/21, 6/12/21, 6/13/21, 8/09/21, 8/10/21, 8/11/21, 9/16/21, 10/13/21 revealed Resident #14 struggled with symptoms of blepharitis (eyelid inflammation, rubbing of righ eye, closing right eye), with no outside referral made. The NHA and DON acknowledged this as a concern, and they would follow up there too, and would work to locate Resident #14's eyeglasses. During an interview on 1/12/22 at 10:13 a.m., with Resident #14's unit manager, Registered Nurse (RN) K, they were informed Resident #14 reported they were struggling with sleep, and did not sleep at all on 1/12/22. RN K reported this had been an ongoing concern for Resident #14, and did not express any plan to follow-up on these occasions. On 1/13/22 RN K reported they did not address the sleep concern further, and confirmed they did not do any follow up. During this same interview with the DON and NHA, they were asked about Resident #14 reporting not sleeping, and nursing staff not following up re this concern. The NHA acknowledged the concern, and reported they would do a sleep study and have facility physician see the resident to follow up on this concern. NHA reported they understood the significance of a resident not sleeping the entire night, and would be following up with RN K with an education. During an interview on 1/12/22 at 10:33 a.m., the Rehabilitation Director, Certified Occupational Therapy Assistant, COTA W was asked about Resident #14's decreased range of motion, muscle tightness, and risk for contractures in hands, and if they were receiving therapy or restorative therapy. They reported there had not been a restorative program since 3/2020, and there was no one designated in charge of a restorative program. COTA W reported the facility tried to have nursing assist with range of motion, but they did not believe Resident #14 was in therapy recently, and screenings did not show a change in their functional status. They reported they may have provided the resident with a splint long ago, but they would not have placed it in orders, and only instructed staff upon discharge. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/12/22 at 10:54 a.m., CNA F was asked if they provided range of motion to Resident #14. They reported they were never instructed to do range of motion with any resident, and did not do any range of motion with Resident #14. They were not aware of a splint(s) for Resident #14. During an interview on 1/12/22 at 12:19 p.m., with CNA H, they were instructed to do range of motion with dressing, but explained they were not able to get in the counts as designated, and did not consider this doing range of motion, such as lifting a resident's arm into their shirt sleeve one time. They confirmed there was no restorative program. They were not aware of a splint(s) for Resident #14. Review of Resident #14's physician orders and care plan, accessed 1/12/22 and 1/18/22, respectively, revealed no order or care plan intervention for a splint(s). Review of Resident #14's most recent occupational therapy episode, with discharge on 1/20/21, received by the Rehab Director on 1/12/22, revelaed there was no mention of a program or instructions for continued range of motion or splints upon discharge from therapy. During a phone interview with the NHA and DON on 1/18/22, Surveyor explained their observations of Resident #14 on his back during observations on 1/11/22 and 1/12/22, whether they were in bed or in their wheelchair, with no offloading observed, and concerns were expressed about range of motion and therapy not provided recently, given Resident #14's risk for skin breakdown and contractures, decreased range of motion, and increased muscle tightness. There was no comment regarding these concerns. A policy was requested during the survey from the NHA and DON pertaining to Quality of Care, or Best Standards of practice. Both reported they were unable to locate these policies, and none were provided by the end of the survey.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation and record review the facility failed to provide service in accordance with standards of practice for catheter care for two Residents (#16 and #21) out of four resident's reviewed for appropriate catheter care. This deficient practice has the potential for the development of urinary infections and displacement of the urinary catheter. Findings include: On 01/11/22 at approximately 10:00 AM, Resident #16 was observed in his room with was a sheet covering his midsection with his left leg sticking out and a leg strap on his upper left thigh with the urinary catheter tubing not secured to the leg strap. On 01/11/22 at approximately 10:30 AM, Resident #21 was observed in his room lying in his bed with his catheter bag resting on the floor. The floor had some trash on it including a used alcohol swab, a used gauze and a tissue. On 01/12/22 at approximately 9:20 AM, Resident #16 was observed in his room lying in bed with his catheter drainage bag touching the floor. The floor had some trash on it including a used tissue and a napkin. Review of a facility reference book titled Fundamentals of Nursing by [NAME] and [NAME], ninth edition, copywrite 2017, Urinary Elimination, pages 1119-1122 read in part; .The bag should never touch the floor to prevent accidental contamination .Prevent the urinary drainage bag from touching or dragging on the floor . Secure indwelling catheters to prevent movement and pulling on the catheter.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on observation, interview, and record review, the facility failed to ensure nutritional interventions were implemented for three Residents (#10, #36, #38) out of four Residents reviewed for nutrition. This deficient practice resulted in significant and insidious weight loss and hyerglycemia with the potential for further health decline. Findings include: Resident #10 A review of Resident #10's medical record revealed she admitted to the facility on [DATE] with diagnoses including dementia, major depression, and history of stroke. A review of her 10/9/21 MDS assessment revealed she assessed by staff to be Severely Cognitively impaired. This MDS also revealed Resident #10 was assessed to have a loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. A review of Resident #10's weight log revealed the following: 4/7/21 190.4 pounds (admission weight) 7/13/21 160.8 pounds 10/14/21 137.2 pounds 12/2/21 137.1 pounds 1/6/22 130.6 pounds Resident #10 lost 30.2 pounds or -18.7% in 6 months. Resident #10 lost 59.8 pounds or -31% of her body weight since admission 10 months prior. A review of Resident #10's most recent 10/14/21 Nutrition Summary Note revealed, . weight history is Continued weight decline. Approx. 53.2lbs/28% x last 6 months, 9.2lbs/6.3% x last month. Current BMI: 22.8 . Will discuss with med(ical) team and recommend to liberalize diet as well as focus on finger foods as resident prefers to eat with her hands and if utensils are suggested, gets frustrated and stops eating. RD to relay this information to dietary manager and update tray card to reflect. Additionally, noted resident does enjoy milk, will change to whole to help increase caloric intake in light of weight decline . A review of Resident #10's lunch meal ticket card revealed, Diet Order: 7-Regular, Consistent Carbohydrate, No Added Salt, ~Thin Liquids Standing Orders: 8 fl oz (fluid ounces) Milk 2%. 8 fl oz Water. On 1/12/22 at approximately 1:00 p.m., Resident #10 was observed in the dining room with a family member assisting her for the lunch meal. A review of her tray revealed 2% milk and no finger foods. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/18/22 at 1:04 p.m., a phone interview was conducted with Registered Dietitan (RD) C. When asked about Resident #10's weight decline she reported she was aware and that the son wanted only non-aggressive nutrition interventions. When asked why her recommendations from the 10/14/21 Nutrition Summary Note (finger foods, liberalized diet, and whole milk) had not been followed, the RD expressed concern as she thought the recommendations had been carried over to the meal ticket to be followed. RD C reported she did not know the formal process for how to relay her recommendations to other facility staff. Resident #36 A review of Resident #36's medical record revealed admission to the facility on [DATE] with diagnoses including dementia and schizophrenia. A review of the 12/2/21 MDS revealed she was assessed by staff to be Severely Impaired for cognition and had a loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a physician-prescribed weight-loss regimen. A review of Resident #36's weight log revealed the following: 1/6/21 132.6 pounds 6/2/21 121.9 pounds 12/22/21 116.4 pounds 1/6/22 114.8 pounds 1/19/22 109.7 pounds Resident #36 had a weight loss of -17.8 pounds in one year, or -13.4% of her body weight, and triggers for -5% loss since 12/22/21. A review of Resident #36's 12/28/21 Nutrition Summary Note revealed, .weight history is Stable x last 3 months, current BMI: 25.2. I have difficulty chewing/swallowing. My appetite/intake has been Good, averaging 75%. I need: Set-up and cueing PRN (as needed) . I am at nutritional risk Plans/recs: Continue with current recs: Addition of finger foods (sandwiches) offered when resident refusing meals. MedPass (supplement), offered TID (three times per day (720kcal/30gm protein/day) to help augment est. kcal/protein needs. Will continue to monitor weights weekly .: On 1/13/22 at approximately 7:45 a.m., Resident# 36's meal tray was observed in the dining room. The meal contained a carton of 2% milk, pancakes cut up into tiny pieces, oatmeal, and an empty juice glass. There were no finger foods on the tray and review of her meal ticket did not include any notes about finger foods. There was less than 25% eaten of the meal. Resident #36 was then observed out in the hallway self-propelling. On 1/18/22 at 1:10 a.m., an interview was conducted with RD C. When asked about Resident #36's weight loss, RD C reported the Resident needed cueing and did best with finger foods or things she could carry, as she was constantly self-propelling in the facility. RD C reported she thought that her recommendations for finger foods had carried over to the meal ticket so that staff were aware. (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #38 A review of Resident #38's medical record revealed he admitted to the facility on [DATE] with diagnoses including Down Syndrome, Diabetes type 1, and aphasia. A review of his Minimum Data Set (MDS) assessment dated [DATE] revealed he was assessed by staff to be Severely Impaired for cognition. A review of Resident #38's weight log revealed the following: 6/11/21 133.4 pounds No July weight was documented 8/4/21 136.2 pounds 10/14/21 145.0 pounds 12/2/21 145.9 pounds 1/6/22 149.9 pounds (+10% weight gain x 5 and 12% gain x 7 months) A review of Resident #38's progress notes revealed the following: 12/17/21 Resident's blood sugar: 451. On call provider notified as sliding scale goes only to 400. Order received to give 8 units Humolog (insulin) . 12/7/21 Per wing nurse res RBS 494 . 12/4/21 Resident's RBS at 1630 read HI on glucometer. Dr. [NAME] contacted by this writer and instructed to give 2 more units of humalog . 12/2/21 .Blood sugars high today 452 covered with 7 units of insulin. res was [NAME] to wake up BS 589 . A review of Resident #38's 12/12/21 Nutrition Assessment revealed he was on a CCD (Carbohydrate Controlled Diet) due to his diabetes. On 1/11/22 at 12:37 p.m., an interview was conducted with Family Member S, the mother of Resident #38. Family Member (FM) S reported that she was informed by staff that Resident #38 was getting regular apple juice throughout the day from the kitchen window and felt he was doing this because he was just bored. FM S reported she was concerned that he was getting juice with so much sugar as it was contributing to his elevated blood sugars and asked why the facility couldn't provide a sugar-free alternative drink. On 1/13/22 at 10:40 a.m., an interview was conducted with Dietary Aide/Staff O. When asked if Resident #38 received juice from the kitchen window, Staff O reported that Resident #38 had a friendship with Dietary Aide/Staff E who gave him whatever he wanted. On 1/18/22 at 1:15 p.m., a phone interview was conducted with RD C. When asked about Resident #38 receiving regular apple juice from the kitchen, RD C reported she had not been aware this was happening and reported she was frustrated. RD C reported she felt that the staff should be aware of what types of liquids and foods are allowed on the different therapeutic diets. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy title, Nutrition at Risk and Review revised 2/21 revealed, Policy: It is the practice of this facility to identify residents at nutritional risk and intervene to minimize decline in nutritional status. Residents shall maintain an acceptable nutritional status unless clinical condition demonstrates that this is not medically possible .

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45123 Based on observation, interview, and record review, the facility failed to provide oxygen services per standards of practice for two Residents (#15 and #45) out of two residents reviewed for oxygen services. This deficient practice resulted in the potential for the development of respiratory infections. Findings include: Resident #15 On 01/11/22 at 10:07 AM, Resident #15 was observed in his room with an oxygen concentrator that was in use, delivering oxygen at three liters via nasal cannula (a device used to deliver oxygen into the nose). No date present on the oxygen tubing, a bag on the back of the concentrator was dated 08/31/21, and part of the oxygen tubing lying on the floor. Resident #15 also had a nebulizer that had tubing and medication cup connected together, appeared to be dirty with residue inside the area where medication was added on the top of his nightstand and was not dated. Review of Resident #15's Medication Administration Record (MAR) for the months of November 2021 through January 2022 revealed that his oxygen tubing was not changed on November 14th, 2021, December 19th and 26th, 2021. Resident #15 did not receive oxygen tubing changes for 3 of 11 scheduled changes reviewed. Resident #45 On 01/11/22 at 10:17 AM, Resident #45 was observed in her room with an oxygen concentrator in use delivering oxygen at three liters via nasal cannula. There was no date present on the oxygen tubing, no bag was present to store the tubing, part of the tubing was on the floor and no sign on the outside of the door alerting oxygen in use. Review of Resident #45's MAR for the current month of January 2022 revealed that her tubing was scheduled to be changed on January 15th, 2022 which was not marked off as completed on the MAR. On 01/19/22 at 10:28 AM, an interview was conducted with the Director of Nursing (DON) regarding the oxygen delivery for Resident #15 and Resident #45. The DON was asked who changed the oxygen tubing and how is it was signed out that it was completed and responded, It is done on Sunday night and the nurses sign it out in the MAR. The DON was then asked how the facility ensures that there is not any bacterial growth in the environment and responded, We have the tubing changed weekly and there are orders in the medical record and filters are rinsed on the back of the oxygen concentrators. The DON was asked how she knew this task was being done weekly and responded, The nurses sign it out on the MAR, and she runs a 24-hour summary shift report to view that everything was done and assumes that if it was signed out, then it was done. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Oxygen Administration and Concentrator Policy, date reviewed 12/20, read in part; Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences .Policy Explanation and Compliance Guidelines: .4.) Infection control measures include: .b.) Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated and document in the electronic health record. Review of a facility policy titled Nebulizer Therapy, date reviewed 07/21, read in part; Policy: It is the policy of this facility for nebulizer treatments, once ordered, to be administered as directed using proper technique and standards of practice .Care of the Resident: .12.) Disassemble and rinse the nebulizer and allow to air dry . Care of the Equipment: 1.) Disassemble parts after every treatment.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to complete bedrail assessments, physician orders, and include bedrails in the comprehensive care plan for five (#6, #20, #35, #37, and #40) of five Residents reviewed for bedrails. This deficient practice resulted in the lack of individualized assessment and care planning for bedrails, and the potential for an accident, injury and/or death. Findings include: Resident #35 Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was admitted to the facility on [DATE] and had diagnoses including heart and respiratory failure, end stage kidney disease, neuropathy (disease of nervous system which may cause decreased sensation), anxiety, and depression. Resident #35 required extensive two-person assistance for bed mobility and transfers, and extensive one-person assistance for dressing and toileting. The Brief Interview for Mental Status (BIMS) assessment revealed a score of a 13/15, which indicated Resident #35 had normal cognition. An observation on 1/11/22 at 3:44 p.m. revealed Resident #35 in their bed with bilateral enabler (mobility) bedrails on each side of their bed. During an interview on 1/11/22 at 3:50 p.m., Resident #35 affirmed they used their bedrails for bed mobility and transfers. Record review on 1/12/22 revealed no bedrail assessment respective to Resident #35's individual ability to safely utilize bedrails, no assessment for zones (areas) of entrapment (which would ensure no gaps were between the mattress and the bedrails), no physician orders for the bedrails, and no mention of bedrails in Resident #35's current Care Plan. A consent was found for bedrails signed by Resident #35 on 5/24/21. Review of Resident #35's medical record did not reveal any falls or accidents involving the bedrails, nor did the Resident report any such incidents. On 1/18/22 the Nursing Home Administrator (NHA) and the DON were asked about the missing bedrail documentation for Resident #35, at 12:55 p.m. and 1:35 p.m., respectively. In an email received on 1/18/22 at 2:46 p.m., the NHA acknowledged they did not have the requested documents for Resident #35, and had started the bedrail assessment today, with an attached copy. There was no explanation of why the assessments, orders, and care plan were not present for the enabler bedrails. Review of Resident #35's (new) bedrail assessment, dated 1/18/22 @ 13:47 (1:47 p.m.), titled Physical Device Assessment, was checked for Assist/Enabler Bar(s). This document showed the bedrail consent was obtained on 5/24/21, and was signed by the Director of Nursing (DON). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/18/22 at 2:59 p.m., the DON confirmed they had begun doing bedrail assessments. They reported it had gotten missed somehow and stated, Yes, we do know what [documentation] is required. The DON confirmed Resident #35 liked having the enabler bedrails for mobility, and did not feel trapped by them. 35103 Review of Resident #6's, #20's, #37's, and #40's complete medical record revealed no Physical Device Assessment had been completed for their individual bed rails until 1/18/22 after the facility was notified of the bed rail concern. The electronic Physical Device Assessment for each Resident was completed by Licensed Practical Nurse/MDS Coordinator AA on 1/18/22. Review of Resident 20's, #37's, and #40's physician order summary revealed no physician orders were present for bed rails for each respective Resident until 1/18/22. Resident #20, #37, and #40 all had a new verbal physician order, dated 1/18/22, for Bilateral assist/enabler bars to aide in bed mobility and promote independence. Review of the Bedrails policy, revised 12/2020, received via email from the NHA on 1/18/22 at 2:46 p.m., revealed, Policy: Full and half bed rails will be safely used only as needed to treat a resident's medical symptoms .1. The IDT [Interdisciplinary Team] to complete the following items prior to initiating side rail usage: a. Complete the resident bedrail consent form. b. Complete the bedrails clinical guidance assessment. c. Obtain a Physician Order that contains statements and determinations regarding medical symptoms and is specific to the circumstances under which bed rails are to be used and time limit for use. d. Initiate a Care Plan. e. Complete the [facility name] Side Rail Measurement Monitoring UDA at the time of instillation and every day for 4 days (to total 5 days of measurement). f. Document corrective action taken if measurements do not meet Michigan guidelines for gaps. g. Complete the [facility name] Side Rail measurement monitoring UDA every quarter .2. Complete the [facility name] Clinical Guidance Assessment quarterly . Review of the policy, Bedrails, revised 12/2020, received via email from the NHA on 1/18/22 at 2:46 p.m., revealed, Policy: Full and half bed rails will be safely used only as needed to treat a resident's medical symptoms .1. The IDT [Interdisciplinary Team] to complete the following items prior to initiating side rail usage: a. Complete the resident bedrail consent form. b. Complete the bedrails clinical guidance assessment. c. Obtain a Physician Order that contains statements and determinations regarding medical symptoms and is specific to the circumstances under which bed rails are to be used and time limit for use. d. Initiate a Care Plan. e. Complete the [facility name] Side Rail Measurement Monitoring UDA (User Defined Assessment) at the time of instillation and every day for 4 days (to total 5 days of measurement). f. Document corrective action taken if measurements do not meet [state] guidelines for gaps. g. Complete the [facility name] Side Rail measurement monitoring UDA every quarter .2. Complete the [facility name] Clinical Guidance Assessment quarterly .

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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 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 provide sufficient nursing staff to ensure resident safety and to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with the facility assessment for five Residents (#20, #31, #37, #40, & #46) of 18 residents reviewed for sufficient staffing. This deficient practice resulted in resident dissatisfaction with provision of cares, unsafe mechanical lift transfers, and delay in provision of personal cares. This deficient practice has the potential to affect all 47 facility residents. Findings include: Resident #40 During initial tour of the facility, on 1/11/22 at 9:58 a.m., Resident #40 was observed sitting in his room in his wheelchair. When asked if there were enough facility staff to provide resident care, Resident #40 stated, It takes two people to handle the lift (two-person mechanical lift for resident transfers) but last night there was only one aide, and you can't handle that lift with only one person . she did it by herself and there was nobody to hold it. Resident #40 said that he had not received his shower that week, on Monday, because there was nobody to do it .I normally get them (showers) on Monday and Thursday . Resident #40 said he had last received a shower Thursday, five days previous. Review of Resident #40's Minimum Data Set (MDS) assessment, dated 12/15/21, revealed Resident #40 had depression as the only active neurological or mood disorder diagnosis, and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, reflective of intact cognition. Resident #40 had clear speech and was able to be understood and to understand others. Resident #40 required extensive two-person assistance with transfers, bed mobility, dressing, and toilet use. Resident #40 was recorded as 72 inches in height, and 214 pounds in weight and used a wheelchair for locomotion. During an interview on 1/11/22 at 12:15 p.m., Registered Nurse (RN) K said she had overheard Resident #40 complain about one CNA (certified nurse aide) using the mechanical lift the previous night shift. RN K confirmed the identity of the CNA as CNA FF and confirmed she had worked alone as an CNA on the 200/300 hall the previous night. Review of Resident #40's POC (Point of Care) Response History, Task: Shower/Bathing/Bed Bath Scheduled - Monday and Thursday Afternoon Shift revealed no shower was documented on Monday, 1/10/22, but the shower was documented as Resident Refused. Resident #40's previous shower was checked as completed on Thursday 1/6/22 as reported by the Resident. Review of the mechanical lift Operating Instructions, dated 2016, received from the Nursing Home Administrator (NHA) via email on 1/19/22, revealed the following Caution: Have someone assist you when attempting to transfer a patient. Review of the second [Name Brand] mechanical lift User Manual, dated 2018, revealed the following recommendation: Warning . [Name Brand] recommends that two assistants be used for all lifting preparation, transferring from, and transferring to procedures . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #40's Activities of Daily Living (ADL) care plan, revealed the following, in part: - TRANSFERRING - I need staff assistance of 2 with all transfers using the sit-to-stand lift. Date Initiated: 09/28/2020. - Showering/Bathing/Bed Bath Scheduled - Monday and Thursday Afternoon Shift. Date Initiated 09/28/2020, Revision on 08/24/2021. Resident #37 During an interview on 1/11/22 at 10:14 a.m., when asked if there were sufficient nursing staff to meet resident needs, Resident #37 stated, Oh my God, no! There is (sic) not enough people (staff). They are calling in all the time, only one person [Certified Nurse Aide (CNA)] is working. Resident #37 confirmed there was only one CNA providing care the previous night - on night shift. Resident #37 said the CNA working today on the 300 hall was working by herself, and that had been happening almost every day. Resident #37 stated, Some of the CNAs just break down and cry. When asked about staff assistance with transfers, Resident #37 said she did not use a mechanical lift, but stated, staff hold the back of my pants up and I swivel over to the chair. When asked about the use of a gait belt during transfers, Resident #37 stated, No, they do not put a gait belt around my waist. Review of Resident #37's MDS assessment, dated 12/3/21, revealed Resident #37 required extensive two-person assistance with transfers, and had depression as the only active neurological or psychiatric/mood disorder. Resident #37 scored 15 of 15 on the BIMS, reflective of intact cognition, and was able to make her needs known. Review of Resident #37's ADL care plan revealed the following, in part: TRANSFERRING - I require staff assistance of 2, May use full body lift when fatigued, Date Initiated: 09/28/20 . Revision on: 10/02/2020. Resident #20 During an interview on 1/11/22 at 9:44 a.m., Resident #20 was asked about the facility nurse staffing levels. Resident #20 stated, I have been here over four years . I have had girls (CNAs) come in her and cry, and I tell them not to cry, and they say they cannot do it (work without enough staff). When they (facility administration) give(s) one aide 28 people by herself - that is not right. Just about anyone of them out there would tell you about it - but they are afraid . I tell them they have to speak up or nothing will get changed . This place is a sh#t hole, and all of us need to be moved somewhere else and this place needs to be stayed shut . When asked if administrative staff are assisting on the floor when staff are short, Resident #20 stated, The only time the high administration people come out on the floor to help (is) when the State (State Agency) is here. As soon as you leave, they go back into their offices, and they don't come back (out to assist when short staffed) until you come back (to the facility). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #20's MDS assessment, dated 11/2/21, revealed Resident #20 required extensive to dependent two-person assistance with bed mobility, dressing, toilet use, and transfers. Resident #20 scored 15 of 15 on the BIMS, reflective of intact cognition and was able to understand, be understood, and speak clearly to make her needs known. Resident #20 was documented as 65 inches in height, and 270 pounds in weight. Review of Resident #20's ADL care plan revealed the following, in part: TRANSFERRING - I require two people and a [mechanical] lift for any transfers. Date Initiated: 12/01/2020 .Revision on: 04/20/2021. BED MOBILITY - I require staff assistance of 2 with bed mobility .Date Initiated: 12/01/2020 .Revision on 01/18/2022. During an interview on 1/12/22 at 10:19 a.m., CNA F confirmed she has worked as the only CNA on a two-hall assignment, either 200/300 hall, or 100/400 hall on night shift, afternoon shift, and day shift. CNA F stated, The 100/400 hall(s) are awful, and you need to have two people down there no matter what. When asked about use of the mechanical lifts with only one CNA staffing the two-hall assignment, CNA F said she had done mechanical lifts alone, mostly on nights, but also on afternoon and day shifts. During a telephone Interview on 1/18/22 at 9:45 p.m., CNA FF confirmed she had used the mechanical lift alone because there was nobody else to help. CNA FF said she did not feel that there was enough help (staff) to provide care for the residents, and stated, At times there are only two people putting people to bed. It makes it hard . When I used to stay over on day shift, I never saw the administration come out of their office, unless the State (surveyor) was here . CNA FF said showers were hard to get completed when working short staffed, and stated, .I have the nurse watch the wing while I am doing the showers. Resident #46 Review of Resident #46's MDS assessment, dated 12/27/21, revealed Resident #46 was admitted to the facility on [DATE], from an acute care hospital, with active diagnoses including paraplegia, fusion of thoracic region spine, muscle weakness, need for assistance with personal care, and history of urinary (tract) infections. Resident #46 required extensive two-person assistance with bed mobility and toilet use and was totally dependent upon staff for transfers. Resident #46 scored 15 of 15 on the BIMS reflective of intact cognition and was able to make her needs known. Resident #46 was documented as always incontinent of bowel, with no toileting program in place to manage the Resident's bowel incontinence. During a telephone interview on 1/25/22 at 12:07 p.m., Resident #46 was contacted via telephone in the facility. Resident #46 confirmed she had called the Sheriff's department on Saturday 1/22/22, who had advised her to call 911 with a non-emergency situation. Resident #46 called 911 at 3:55 p.m. and called adult protective services at 9:12 p.m., after being left in a soiled brief with insufficient staff to provide care that day. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on 1/18/22 at 4:05 a.m., when asked about facility staffing, CNA GG stated, . We definitely don't have enough CNAs. When we are short workers, we do not have help from administration . CNA GG confirmed she was working alone on the 200/300 halls, and confirmed that aides were using the mechanical lifts alone (with only one staff person). CNA GG stated, It is not that we want to do that, but we don't have the staff to do it properly. It is sad when the patient cares are being neglected because of the (short staffing) situation. CNA GG said she had worked the 100/400 halls alone and it was very difficult because they were the busiest hallways. During a telephone interview on 1/19/22 at 5:48 p.m., CNA KK confirmed CNAs are working alone and when asked about use of the mechanical lift by only one staff person, CNA KK stated, We all use the [mechanical] lift alone. We have to . Nursing staff are sitting at the desk eating when call lights are going off right and left. That happens all the time. I will tell people things and they will say - shut up [CNA KK], you are not my boss. Review of the Rights of Residents in [state] Nursing Facilites, dated 11/28/16, revealed the following, in part: . You have the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living .You are entitled to receive adequate and appropriate care . Review of the Facility Wide Assessment, updated November 22th (sic), 2021, revealed the following, in part: Staffing Plan . Position: Licensed nurses providing direct care, Total Number Needed or Average or Range: 2 per shift . Position: Nurse aides, Total Number Needed or Average or Range: 4 avg. (average) per shift . Facility incorporates PPD, census and acuity of care in determining the amount of staff scheduled. The . Average daily census: (monthly) was documented as 55 in this updated Facility Wide Assessment. During a telephone interview on 1/25/22 at 9:30 a.m., the Nursing Home Administrator (NHA) acknowledged he was aware staffing levels had been below the Facility Wide Assessment levels in the past several months. The NHA also confirmed the facility Human Resources Director had left her position in the end of November, and the Regional Human Resources Director had left her position in December. Currently the facility Human Resource department was being directed by the corporate Human Resources Director, located approximately 400 miles away, who had been inside the facility one time. 45123 On 01/13/22 at approximately 7:45 AM, an interview was conducted with Resident #31 regarding the care she was receiving at the facility. Resident #31 was asked if she was receiving her scheduled showers. Resident #31 responded, There was a time last month when I did not get a shower for two weeks in a row and I know that at times there is only one care assistant (CNA) on the night shift and that is not safe for people who are a lift assist because there needs to be two, they are transferring with one staff when there should be two, and the nurses do not help with this .and I don't refuse showers, I need them. Resident #31 was very upset about the lack of staffing in the facility. Resident #31 picked up her water pitcher to take and drink and it was empty. Resident #31 was asked if she had seen any staff today and responded, No. Resident # 31 continued to voice her concerns stating, The pad underneath me has been the same pad for three days and has not been changed and it should be done (changed) daily. (continued on next page)

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	235349	A. Building B. Wing	01/25/2022

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	Review of Resident #31's Task for Showering viewed from the electronic medical record for the month of December 2021 a thirty-day look back, shows that Resident #31 is scheduled to have the task completed on Sunday and Wednesday's during evening shift. The task was documented on 12/22/21 and 12/29/21 as Resident Refused. Review of Resident #31's MDS assessment, dated 11/24/21, revealed a BIMS score of 15, indicative of intact cognition.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45123 Based on observation, interview, and record review, the facility failed to ensure expired medications were removed from the active medication room supply storage in two of two medication storage room areas reviewed. This deficient practice resulted in the potential for lessened drug effectiveness with potential to affect all forty-seven facility residents. Findings include: On 01/12/22 at approximately 9:30 AM, an observation of the medication storage room on 100 Hallway was conducted. The medication room door was ajar, open and not locked. A return to pharmacy bag was found under the sink, with five different medications inside the return to pharmacy bag. The inside of the bag was wet with approximately an inch of an unidentified liquid at the bottom of the bag. On 01/12/22 at approximately 10:00 AM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA was asked why the door was ajar and responded, It should be closed and locked at all times, and I will get the maintenance man to look at it right away. The NHA was asked to verify the pharmacy return bag items and condition of the bag and responded, The bag should not be under the sink, (the return medications) should not be in a wet return bag and should have been returned to pharmacy as they come (to the facility) every day. On 01/12/22 at approximately 10:30 AM, an observation of the medication storage room on the 300 Hallway was conducted. A plastic grocery bag had three mini candy bars in it was found in a lower cupboard not labeled for a specific resident. Several expired over the counter medications were found in the active medication storage room as follows: A. Vitamin A, 10,000 international units (IU), 100 soft gels, one bottle with lot #20704WN expired on 12/21, B. Allergy Relief 180 milligram (mg), 100 tabs, one bottle with lot #357816 expired on 06/21, C. Multi Vitamin with iron, 100 tabs, one bottle with lot #521R04 expired on 03/21, D. Vitamin E, 100 soft gels, one bottle with lot #751R07 expired on 07/21, E. Name brand probiotic, 50 caps, four bottles with lot #356517 expired on 07/21, F. Glycerin suppositories, 24 count, with lot #1911519 expired on 11/21, G. Pro biotic acidophilus, 100 wafers, with lot # 21304NFN expired on 04/21, H. Iron supplement liquid, 16 fluid ounces, with lot #M328 expired on 06/21. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/12/22 at 11:35 AM, an interview was conducted with Licensed Practical Nurse (LPN) U. LPN U was asked to verify the expired medications found in the medication storage room on the 300 Hallway and responded, These expired medications should not be in the active medication storage room. LPN U was asked who was responsible for checking for expired medication in the medication storage rooms and responded, The infection control nurse and/or the night shift nurse. LPN U was asked if there was any kind of check off sheet that was signed that the medication storage room was checked for any expired medication and responded, Not that I am aware of, it is just something that is done during night shift randomly. LPN U was then asked if the food found in the medication storage room was to be in the medication storage room and responded, Absolutely not. Review of the facility policy, Medication Storage in the Facility, date June 2019, read in part; Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to nurses, pharmacists, and pharmacy technicians .Procedures: G.) Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from the medication supply, disposed of according to procedures for medication disposal, and recorded from . pharmacy. H.) Medication storage areas are kept clean .I.) medication storage areas are monitored periodically by facility staff or pharmacy designee, and corrective action is taken if problems are identified . Expiring Dating: All expired medications will be removed from the active supply and destroyed .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation, interview and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service potentially resulting in sanitation measures and food service needs not being met for all 48 residents in the facility. Findings include: On 1/11/22 at 10:30 AM, an interview was conducted with Dietary Manager (DM) B related to the chemical sanitizer and the testing of the chemical in the sanitizing compartment of the three compartment sink. DM B stated she did not know what the sanitizer being used to sanitize food contact surfaces, did not know the required concentration of the chemical and did not know how to test the concentration of the sanitizing solution. At this same time the condition of the ice machine was brought to the attention of DM B, and was instructed to prohibit the use of any ice from the machine due to observed mold like growth in the bin of the machine. At 11:08 AM a plastic bussing bin was observed in the walk in cooler with half pint milk cartons covered with ice cubes . An interview with Dietary [NAME] E was conducted at this time who stated he had not been informed the ice from the ice machine was not to be used. At 11:20 AM, an interview was conducted with DM B and asked if she had communicated the condition of the ice from the machine to her staff. DM B stated she had not shared this with them. The interview continued concerning the cleaning of the ice machine following the observations of the mold like substance. DM B stated she did not know when the ice machine had last been cleaned, was not aware of the cleaning schedule nor the procedure to clean it. DM B stated, I'll have to go online and look that up. On 1/12/22 at 7:40 AM, an interview was conducted with DM B concerning the three compartment sink and testing procedure. During the interview, conducted at the three compartment sink, a packet of self adhesive Thermolabels were on the ledge above the sink. DM B was asked what the Thermolabels were for, as they had not been observed the day before. DM B stated I don't know. I just grabbed a bunch of things when I went to the store. When asked is she knew what they were used for, DB B stated Not really. It was explained to her that they were to be used with a high temperature dish machine, not for testing the chemical sanitizer in the sink, and, that the facility used a low temperature dish machine and therefore rendered the use of the Thermolabels in that kitchen useless. On 1/12/22 at 7:39 AM, observations of the kitchen were made during the morning meal. The three compartment sink was observed to have had all three compartments filled, including the sanitizing compartment solution. Utensils were observed draining and drying on the drainboards to the left of the sanitizing compartment. The temperature of the sanitizing solution was measured with a metal stem thermapen and found to be 61 F. Using the facility's QT 40 test strips, the solution was determined to have between 100 and 150 PPM quaternary ammonium compound. An interview with DM B was conducted at this time and shown the test strip results, then asked if she had anyone address the low concentration of the sanitizer being dispensed from the dispenser, as it had been identified the previous day. DM B stated she had not contacted anyone to fix the dispensing system of the sanitizer into the sink. On many occasions DM B was observed walking through the kitchen with more than 50% of her hair extending below her hair net. These observations were made during food preparation and service at the following times: (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1/11/22 at 9:30 AM; 10:25AM; 12:18PM 1/12/22 at 7:25 AM; 8:05 AM; 11:47AM On 1/11/22 at 2:45 PM an interview was conducted with DM B about her qualifications as a dietary manager. She acknowledged she had not begun the certification process of becoming a certified dietary manager (CDM) and had also allowed her Serve-Safe certification to expire.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 34276 Based on observation, interview, and record review, the facility failed to ensure that the meals were served according to the posted menu with the potential to affect all 47 residents residing in the facility. This deficient practice resulted in the potential for dissatisfaction with meals and the potential for weight loss. Findings include: On 1/11/22 at approximately 12:15 p.m., an interview was conducted with Resident #46. Resident #46 reported that often she doesn't not receive on her tray what the printed menu said the meal was going to be. Resident #46 also reported that she felt like peas were being served too often and more than was planned. On 1/12/22 a review of the menu printed and placed on the wall outside of the dining room revealed: Porkchops with mushrooms, Gravy, Roasted Potato Medley, Dilled Carrots, Turtle Squares. Alternate: Turkey slices with Gravy. On 1/12/22 at 12:30 p.m. Resident #46's meal was observed on a cart in the hallway and revealed: Porkchop with gravy, steamed vegetables, potato medley, and peaches. There were no dill potatoes or turtle square. A review of the comparison between the Planned Menus provided and the production sheets revealed the following discrepancies: 1/2/22 Dinner was supposed to be Seasoned Greens, but peas were served. 1/5 Dinner was supposed to be coleslaw but was Brussel sprouts (which were made again for the next day's lunch). 1/6 Dinner was supposed to be asparagus, but carrots and peas were served instead. 1/9/22 Breakfast meal was supposed to be the Western Omelet Bake but Scrambled Eggs were served. 1/10/22 breakfast was supposed to be cheesy omelets, yet just scrambled eggs were served. 1/11/22 Dinner was supposed to be Brussel sprouts, but peas and carrots were served. Further review of the production sheets revealed that green peas were served 8 times between 1/2/22 and 1/11/22. On 1/18/22 at 1:30 p.m., a phone interview was conducted with Registered Dietitian (RD) C. When asked about the discrepancies between what was being served versus what the menu stated RD C reported that she thought that the facility was getting better about serving the right foods. RD C reported she felt it was an issue of the cooks not wanting to make certain things and due to the facility changing the company that they get their food from. RD C reported that it was nutritionally important for the Residents to get the planned menus.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to provide food to accommodate resident preferences for three Residents (#6, #37, & #46) of 18 sampled residents. This deficient practice resulted in distribution of meal trays with resident expressed food dislikes, lack of fruit and vegetables to maintain digestive regularity, and decreased meal satisfaction. Findings include: During an interview on 1/11/22 at 10:14 a.m., Resident #37 was asked about the food provided by the facility. Resident #37 stated, Food? They give me everything I don't want. I write it down and tell them what I don't want, and I still get it - like green beans, and there is (sic) only two kinds of soup that I want - no other soup, but they give that (other kinds of soup) to me anyway. During an observation and interview on 1/11/22 at 12:50 p.m., Resident #6 was observed eating a piece of cake from his meal tray. The tan crumbled mound of what had been identified by facility staff as carrot cake, was topped with a wrinkled, white frosting. The cake did not hold together and dropped onto the plate with each attempted fork-full of cake. Resident #6 said it did not taste like carrot cake. When asked about the food, Resident #6 stated, The cooks are changing all the time, so the food is not that great. Resident #6 lifted the insulated cover off the lunch meal plate to reveal a piece of fish with a crumb coating, a portion of collard greens (a vegetable), mashed potatoes and gravy. Review of Resident #6's meal tray card revealed, Dislikes: Mushrooms, Vegetables (cooked), Other (shellfish). During an observation and interview on 1/11/22 at 12:52 p.m., Resident #37 was observed eating her yogurt. When asked about the lunch provided, Resident #37 lifted the insulated lid off the lunch plate to reveal a piece of fish with crumb coating, a portion of collard greens, mashed potatoes, and gravy. The soup on her meal tray was noted to be vegetable soup. When asked about her satisfaction with the meal she pushed her fork into the fish and stated, Not good - it's fish. Resident #37 also commented that once again she had received vegetable soup - contrary to her preference. Review of Resident #37's meal tray card revealed the following, in part: Notes: only chicken noodle or tomato soup .Dislikes: Green Beans, Brussel Sprouts, Fish. On 1/12/22 at 12:48 p.m., Resident #6's lunch meal tray was observed with a pork chop topped with mushroom gravy, and approximately 1/2 of the plate filled with cooked, mixed vegetables (cauliflower, broccoli, carrot). Meal tray card dislikes continued to include mushrooms and cooked vegetables. On 1/12/22 at 12:56 p.m., Resident #37's lunch meal tray was observed with the same pork chop and mixed vegetables with an insulated bowl of vegetable soup. The meal tray card Note continued to specify only chicken noodle or tomato soup. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Food Preferences policy, revised 1/5/21, revealed the following, in part: Policy: Nutritional assessment will include an evaluation of individual food preferences. Purpose: To maintain quality of life and help residents maintain nutritional status. Procedure . 6. Every effort will be made to accommodate resident's individual preferences. During telephone interviews on 1/19/22 at 7:38 a.m. and 8:46 a.m., when asked about the process to ensure residents were receiving their food preferences and not receiving foods they disliked, Dietary Manager (DM) B said the meal tray cards were read out loud while on the tray line. We have one of the (dietary) aides place the cards on the tray and they read the tray cards out loud to the cook. When asked how residents would then receive food they specifically disliked, DM B stated, I cannot answer that, because I am not the one reading the cards. During the second interview at 8:46 a.m., DM B said she had read the tray cards for breakfast, and both she and the Cook found things the residents didn't want (on the tray cards) and they (the residents) didn't get those food items. DM B stated, I am going to have to do some real educating. I didn't realize they (dietary aides) were as slack as they have been. DM B confirmed the dietary tray card reader had not been reading the tray cards well enough and making mistakes. 34276 Resident #46 On 1/11/22 at approximately 12:15 p.m., an interview was conducted with Resident #46. Resident #46 reported that the food at the facility was terrible. Resident #46 reported she had suffered with constipation and knew she needed to be eating more fruits and vegetables to help with regularity, yet she reported her preferences were not followed. Resident #46 reported she had been complaining about the food since she arrived on 12/20/21. On 1/11/22 at 12:30 p.m. Resident #46's tray was observed sitting in the hallway. The meal included fish, collard greens (cooked), mashed potatoes and gravy, and carrot cake. There was no bottle of water, salad, or any fresh fruit. A Review of Resident #46's face sheet revealed she was admitted to the facility on [DATE] with diagnoses including spinal fusion, paraplegia, and acid reflux. A review of her BIMS conducted on the 12/27/21 Minimum Data Set (MDS) assessment revealed she scored 15/15 indicating fully intact cognition.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety as evidenced by: A. Failing to provide qualified and knowledgeable dietary manager. B. Failing to ensure the sanitizing compartment of the three compartment sink was operated in a manner to properly sanitize food contact surfaces. C. Failing to maintain the ice making machine in a sanitary condition. D. Failing to discard expired food in the walk in refrigerator. E. Failing to ensure staff in the kitchen during food preparation had their hair properly restrained. F. Failing to maintain floors in a sanitary, clean and cleanable condition. G. Failing to maintain food contact surfaces in a sanitary manner (ice scoop holder; utensil bins) H. Failing to maintain non-food contact surfaces in a clean manner. I. Failing to maintain an upright freezer in working condition and provide adequate freezer space for the storage of frozen food. This deficient practice has the potential to result in food borne illness among any or all of the 48 residents in the facility. Findings include: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A. On [DATE] at 10:30 AM, an interview was conducted with Dietary Manager (DM) B related to the chemical sanitizer and the testing of the chemical in the sanitizing compartment of the three compartment sink. DM B stated she did not know what the sanitizer being used to sanitize food contact surfaces, did not know the required concentration of the chemical and did not know how to test the concentration of the sanitizing solution. At this same time the condition of the ice machine was brought to the attention of DM B, (See paragraph C below for details) and was instructed to prohibit the use or distribution of any ice from the machine due to observed mold like growth in the bin of the machine. At 11:26 AM a plastic bussing bin was observed in the walk in cooler containing half pint cartons of milk and covered with ice cubes. An interview was conducted with Dietary Aide E who confirmed the ice had been sourced from the ice machine and stated he had not been informed the ice from the ice machine was not to be used. At 11:20 AM, an interview was conducted with DM B and asked if she had communicated to her staff that ice from the machine was not to be used. DM B stated she had not shared this with them. The interview continued concerning the cleaning of the ice machine following the observations of the mold like substance. DM B stated she did not know when the ice machine had last been cleaned, was not aware of the cleaning schedule nor the procedure to clean it. DM B stated, I'll have to go online and look that up. On [DATE] at 7:40 AM, an interview was conducted with DM B concerning the three compartment sink and testing procedure. During the interview, conducted at the three compartment sink, a packet of self adhesive Thermolabels were on the ledge above the sink. DM B was asked what the Thermolabels were for, as they had not been observed the day before. DM B stated I don't know. I just grabbed a bunch of things when I went to the store. When asked is she knew what they were used for, DM B stated Not really. It was explained to her that they were to be used with a high temperature dish machine, not for testing the chemical sanitizer in the sink, and, that the facility used a low temperature dish machine and therefore rendered the use of the Thermolabels in that kitchen useless. On [DATE] at 2:45 PM an interview was conducted with DM B about her qualifications as a dietary manager. She acknowledged she had not begun the certification process of becoming a certified dietary manager (CDM) and had also allowed her Serve-Safe certification to expire. The FDA Food Code 2013 states: ,d+[DATE].11 Demonstration. Based on the RISKS inherent to the FOOD operation, during inspections and upon request the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, application of the HAZARD Analysis and CRITICAL CONTROL POINT principles, and the requirements of this Code. The PERSON IN CHARGE shall demonstrate this knowledge by: (C) Responding correctly to the inspector's questions as they relate to the specific FOOD operation. The areas of knowledge include: (11) Explaining correct procedures for cleaning and SANITIZING UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT also ,d+[DATE].11 Person in Charge. The PERSON IN CHARGE shall ensure that: (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(J) EMPLOYEES are properly SANITIZING cleaned multiuse EQUIPMENT and UTENSILS before they are reused, through routine monitoring of solution temperature and exposure time for hot water SANITIZING, and chemical concentration, pH, temperature, and exposure time for chemical SANITIZING; B. On [DATE] at 9:15 AM, during the initial tour of the kitchen, cooking utensils were observed draining on the drain boards of the three compartment sink, with the sanitizing solution compartment of the sink filled. An interview with Dietary Cook D was conducted at this time, and it was learned dishes and utensils were currently being cleaned in the three compartment sink having been used for the preparation of the morning meal. Cook D confirmed the sink was being used to wash, rinse and sanitize these food contact surfaces, with the left sink being used as the sanitizing solution. Cook D was then requested to demonstrate the process used to test and confirm the concentration of the sanitizing compound in the sink. Cook D stated he takes the water temperature (which was not done), then extracted a three inch section from the QT 40 test strips dispenser. Cook D then imersed the strip in the sanitizing solution for two seconds, removed it and held it up. Cook D was not able to tell this surveyor what the chemical or the concentration of the sanitizing chemical was following the test. Cook D was directed to the packaging of the QT 40 strips dispenser and the directions written on them. Cook D then stated Oh, ten seconds. He then removed another three inch section, submerged the test strip in the solution, moving the strip through the solution for 6 seconds, then removed it. Cook D then compared the color of the strip to that on the package and with some hesitation stated it was about 150 ppm (parts per million). When asked what the concentration of the chemical was supposed to be, he stated Oh, I think above 150. A review of the label on the Quat concentrate gallon container showed the minimum concentration for food service and food contact equipment sanitizing was to be 200 ppm. Additionally, the temperature of the sanitizing solution was measured using a metal stem Thermopen thermometer and determined to be 61 F. A review of the QT 40 test strip directions was conducted which directed the user: Solution temperature is to be between 65 F and 75 F, and to hold the strip still in the solution for 10 seconds without shown to Cook D. On [DATE] at 7:39 AM, observations of the kitchen were made during the morning meal. The three compartment sink was observed to have had all three compartments filled, including the sanitizing compartment solution. Utensils were observed draining and drying on the drainboards to the left of the sanitizing compartment. The temperature of the sanitizing solution was measured with a metal stem thermapen and found to be 61 F. Using the facility's QT 40 test strips, the solution was determined to have between 100 and 150 PPM quaternary ammonium compound. An interview with DM B was conducted at this time and shown the test strip results, then asked if she had anyone address the low concentration of the sanitizer being dispensed from the dispenser, as it had been identified the previous day. DM B stated she had not contacted anyone to fix the dispensing system of the sanitizer into the sink. The interview continued and focused on the testing procedure for the sanitizing chemical in the sink. When asked if she was aware of the minimum temperature required by the food code for a sanitizing solution of Quaterany ammonium chemicals, DM B stated No. DM B was informed the food code requires a minimum temperature of 75 F in the solution containing the manufacturer's required concentration of the chemical. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 7:50 AM, a bucket containing water and wiping cloths was observed under the food preparation table. DM B was asked what the bucket contained, to which she replied I'm not sure. DM B then asked Cook D what the bucket was for and how it was filled. Cook D explained the bucket was filled by the same dispensing apparatus as the sanitizing compartment of the three compartment sink. Using the facility's QT 40 test strips, the solution in the bucket was tested for the concentration of quaterany sanitizer and determined to be between 100 and 150 ppm. DM B acknowledged the concentration was below the accepted limit after observing the test strip and comparing it to the color coded key on the test strip dispenser. The FDA Food Code 2013 states: ,d+[DATE].114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under ,d+[DATE].11(C) shall meet the criteria specified under S,d+[DATE].11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows: (C) A quaternary ammonium compound solution shall: (1) Have a minimum temperature of 24 C (75 F), (2) Have a concentration as specified under S ,d+[DATE].11 and as indicated by the manufacturer's use directions included in the labeling and ,d+[DATE].14 Wiping Cloths, Use Limitation. (A) Cloths in-use for wiping FOOD spills from TABLEWARE and carry-out containers that occur as FOOD is being served shall be: (1) Maintained dry; and (2) Used for no other purpose. (B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S ,d+[DATE].114 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. On [DATE] at 9:30 AM the Manitowoc ice machine, located in the kitchen, was observed to have mold like substance on the plastic deflector shield. An interview with DM B was conducted at this time and requested information regarding the cleaning schedule of the machine. DM B stated she had been in the position as dietary manager for approximately 90 days and she was not aware it had been cleaned in that time frame. When asked who was responsible for cleaning the machine, she stated she was not sure and then It's probably me. When asked if she had the user's manual for the machine which delineated the cleaning procedure, she stated No. On [DATE] at 10:25 AM, an iterview was conducted with Maintenance Director (MD) A concerning the cleaning of the ice machine. MD A stated he had not cleaned the machine since he had begun his position as the MD in early [DATE]. When asked if he knew where the manual or cleaning schedule for the machine was, he stated he did not know. On [DATE] at 11:26AM, a plastic bussing bin was observed in the walk in cooler with half pint cartons of milk covered with ice cubes. An interview was conducted with DA E about the use of ice covering the milk cartons. DA E confirmed he had placed the ice on the milk cartons and had not been informed by DM B the ice was not to be used. On [DATE] at 12:18 PM, DM B was observed removing the ice from the ice machine. When asked if she had located at cleaning procedure, she stated No. Not yet. I have to go online to find one. At 2:43 PM, DM B was observed in the kitchen with two containers of Manitowoc ice machine cleaners. When asked if she knew how to use the chemicals and how to flush and sanitize the bin following the use of the chemicals, she stated No. I haven't gone online to find out yet. On [DATE] at 1:30 PM, an interview with the NHA was conducted and instructed the facility to ensure there was a written procedure to follow which defined the use of the chemicals and the subsequent disinfection of the machine prior to putting the ice machine back on line for use. The FDA Food Code 2013 states: ,d+[DATE].11 Safe, Unadulterated, and Honestly Presented. FOOD shall be safe, unADULTERATED, and, as specified under S ,d+[DATE].12, honestly presented. and ,d+[DATE].11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts ,d+[DATE] and ,d+[DATE]. ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. and ,d+[DATE].11 Equipment Food-Contact Surfaces and Utensils. (A)EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: (E) Except when dry cleaning methods are used as specified under S ,d+[DATE].11, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cleaned: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(1) At any time when contamination may have occurred; (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. and ,d+[DATE].12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. D. On [DATE] at 8:27 AM the walk in cooler was observed to have the following items on the shelves which were expired: one 7# container of sour cream exp [DATE] four 5# containers of cottage cheese. exp [DATE] At 9:08 AM, an interview with DM B was conducted, and the expired food in the walk in cooler brought to her attention. DM B stated she normally does that each morning and had not gotten into the cooler yet that day. It was noted that the products had expired 4 and 5 days prior. Also observed was a cardboard case container with 8 plastic shells containing fresh strawberries. One of the containers contained many mold covered berries. The FDA Food Code 2013 states: ,d+[DATE].11 Discarding or Reconditioning Unsafe, Adulterated, or Contaminated Food. (A) A FOOD that is unsafe, ADULTERATED, or not honestly presented as specified under S ,d+[DATE].11 shall be discarded or reconditioned according to an APPROVED procedure E. On many occasions DM B was observed walking through the kitchen with more than 50% of her hair extending below her hair net. These observations were made during food preparation and service at the following times: [DATE] at 9:30 AM; 10:25AM; 12:18PM [DATE] at 7:25 AM; 8:05 AM; 11:47AM The FDA Food Code 2013 states: ,d+[DATE].11 Effectiveness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES F. On all days of the on-site survey (,d+[DATE]-,d+[DATE]) during all observation opportunities, the kitchen floor was observed to be in a state of disrepair, unclean and uncleanable. The following locations were observed to have floor tiles which were broken, curled or separated resulting in an uncleanable surface: a. under the entire two compartment sink to the left of the stove b. Under the cook stove and oven c. Under the hand sink and three compartment sink d. Under the steam table e. Under the ice machine and coffee maker table The following areas of the floor were observed to be unclean with long term dirt and grime build up: a. The entire perimeter of the kitchen with vinyl tile. b. Under the metal rack shelving unit to the left of the two compartment sink c. In front of and under the non-working 3 door freezer. d. Area around the entrance to the walk in cooler. e. Under the hand sink adjacent to the left of the dish machine The FDA Food Code 2013 states: ,d+[DATE].11 Floors, Walls, and Ceilings. Except as specified under S ,d+[DATE].14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are SMOOTH and EASILY CLEANABLE. and ,d+[DATE].11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair. ,d+[DATE].12 Cleaning, Frequency and Restrictions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. G. On [DATE] at 10:15 AM, the scoop holder, for the ice machine, mounted on the wall to the left of the ice machine, was observed to be absent of any drainage holes. The holder was further observed to have foreign deposits of lime and other unidentified contamination in the bottom and sides of the holder where the tip of the scoop sits confirming there is standing and pooling water at times. Additionally, plastic bins containing food preparation utensils, located on the wire shelves to the left of the two compartment sink, were observed to be broken and the tops soiled with a greasy and dusty residue. The FDA Food Code 2013 states: ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Pf (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. H. On [DATE] at 10:15 AM, the following non-food contact surfaces were observed to be coated in dust and dirt: Plumbing water supply pipes under the three compartment sink; electrical and other utility hook up connectors behind the stove and cooking equipment; electrical conduit connected to the wall under the two compartment sink. The FDA Food Code 2013 states: ,d+[DATE].13 Nonfood-Contact Surfaces. NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. I. On [DATE] at 9:15 AM during the initial tour of the kitchen, the three door [NAME] freezer was observed to have a temperature of 52 F registering on the external digital thermometer. When the doors were opened, it was observed the unit was not cold and not being used for refrigeration, rather, the interior space was being used to store shelf stable supplements and other food products. An interview with DM B was conducted at this time and was learned the freezer had not worked in months and was being used for storage space. The two door upright freezer, located near the three compartment sink was opened and observed to be full of frozen food in boxes and plastic bags. The space was fully packed and did not allow for the proper circulation of air within the unit. DM B stated that staff had to remove food from boxes and place in bags because there was not enough room to store the frozen food being delivered by vendors. DM B continued explaining this two door unit and a top loading non-commercial freezer in the maintenance office was the only equipment available to keep frozen food, and was inadequate to maintain the full complement of food required for the menus. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The FDA Food Code 2013 states: ,d+[DATE].11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts ,d+[DATE] and ,d+[DATE].

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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. 40330 Based on interview and record review, the facility failed to accurately update the facility assessment to determine what resources were necessary to care for their residents competently. This deficient practice resulted in the omission of a facility department (activities) and the erroneous identification of community resources, which has the potential to affect all 47 facility residents. Findings include: Review of the facility assessment, last updated 11/22/21, provided by the Nursing Home Administrator (NHA) on 1/24/22 at 12:47 p.m. via email, revealed on Page 7: [in bold] Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies . This section listed all the facility departments and showed the type of staff involved to support and care for the facility residents. This list of departments referenced omitted the activities department, which is a crucial component of residents' quality of care, which supports residents achieving their highest practicable level of physical, mental, and psychosocial well-being. Page 8 revealed no mention of any activity staff in the facility staff numbers was planned to ensure enough staff from each department were available to meet the residents' needs. Further review of the facility assessment revealed on Page 10 the physician team contracted by the facility was erroneously affiliated with a hospital out of the proximity of the facility. The facility assessment further revealed, on Page 13, Attachment 1 .Facility Assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually .The facility must address or include .2. The facilities resources, including but not limited to .services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies .v. Contracts, memorandums of understanding, and other agreements with other third parties to provide services or equipment to the facility during both normal operations and emergencies . During a phone interview on 1/25/22 at 9:17 a.m., the Nursing Home Administrator (NHA) acknowledged the concern, and forwarded a corrected copy of the facility assessment, which added the activities department to the document resources. They planned to further clarify their community resources and contracts when they were made aware of the discrepancy.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 This deficient practice has two parts: A. and B. A. Based on observation, interview, and record review, the facility failed to maintain a complete infection control program to prevent continuation of a facility outbreak of COVID-19 (a highly transmissible virus) during high County COVID-19 transmission rate with a % (percent) positivity rate of 34.2%. This deficient practice resulted in the transmission of COVID-19, and the potential to affect all 47 facility residents. The facility failed to: 1. Ensure staff used Personal Protective Equipment (PPE) appropriately during a COVID-19 outbreak to prevent transmission of COVID-19 within the facility 2. Provide effective education and monitoring of staff related to COVID-19 updates and donning and doffing of PPE. 3. Maintain transmission-based precautions (TBP) while exiting the COVID-19 isolation unit. 4. Communicate timely with the local public health department related to newly identified COVID-19 positive staff and/or residents. 5. Ensure distancing of residents with communal dining and masking during participation with unvaccinated facility residents. 6. Ensure staff perform appropriate hand hygiene. 7. Ensure staff clean and disinfect reusable medical equipment. 8. Post correct signage and educate staff related to COVID-19 isolation and donning and doffing of PPE. 9. Ensure housekeeping staff were educated and cleaning supplies were appropriate and used effectively to kill the COVID-19 virus. The Immediate Jeopardy began on 1/12/22 at 1:45 p.m., when Staff NN tested positive for COVID-19 after passing meal trays throughout the facility during a COVID-19 outbreak, with only a surgical mask for PPE, prior to being tested for COVID-19 at the facility on 1/12/22. The facility had identified two positive Residents (#3 & #19) and six staff tested positive on rapid antigen testing between 12/30/21 and 1/1/22. The Community Transmission rate was high, and the % (percent) positivity of the County was 34.2% as of 1/13/22. The Nursing Home Administrator (NHA), and Registered Nurse (RN)/Infection Preventionist (IP) J were informed of the Immediate Jeopardy concern on 1/12/22 at 4:43 p.m. The Immediate Jeopardy was removed on 1/13/22 at approximately 11:00 a.m., with the initial implementation of the accepted Abatement Plan. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Non-compliance remained at the lower scope and severity of widespread potential for more than minimal harm that is not immediate jeopardy, pending on-site verification of the Plan of Correction. Findings include: Upon entrance to the facility on [DATE] at 8:30 a.m., a sign was posted on the door of the facility that advised visitors the last COVID-19 positive was identified on 1/10/22. Other signs posted included NOTICE Face Mask Required. During the entrance conference on 1/11/22 at 9:08 a.m., the NHA acknowledged there were two Residents (#3 and #19) in isolation for COVID-19 on the 200 Hall COVID-19 isolation unit. During an observation on 1/11/22 at 12:32 p.m., Staff Y was observed as she prepared to clean room [ROOM NUMBER] (former room of COVID-19 positive resident now on isolation hall). During an interview at this same time, Staff Y acknowledged she did not know if the room had been cleaned previously. The room door was left open while Staff Y did a deep clean of the room. On 1/11/22 at 12:41 a.m., Staff NN was observed sitting in a very small office, directly behind the nurses' station between the 200/300 Hall. The office door was open, and Staff NN was observed with her facemask down on her chin, mouth and nose uncovered. (Staff NN tested positive for COVID-19 in the facility the following day, 1/12/22.) Two de-identified nurses (for COVID-19 status privacy) both wore surgical masks without eye protection while working at the 200/300 Hall nurse's desk positioned very close to Staff NN's office door and were observed in close proximity to Staff NN (failed to maintain 6 foot social distancing). The two de-identified nurses tested positive for COVID-19 on 1/19/22. On 1/12/22 at 9:16 a.m., a brown, cardboard box was observed on the floor outside of the 200 Hall COVID-19 isolation unit. The box was located directly across the hall from Resident #22's room outside of the 200 Hall COVID-19 isolation unit. The box contained what appeared to be used (dirty) PPE, including booties (used to cover shoes worn on isolation unit), face masks, gloves, and paper products. There was no cover on the box. During an interview on 1/12/22 at 9:20 a.m., LPN G and Certified Nurse Aide (CNA) H were asked to observe the box of dirty PPE outside, and across from Resident #22's open room door. Both LPN G and CNA H acknowledged the contents of the cardboard box included used booties, used face masks, and dirty gloves. Both also agreed the presence of the used PPE, especially the booties used on the COVID-19 isolation hall, appeared to be dirty PPE disposed of when staff exited the COVID-19 isolation unit. During an interview on 1/12/22 at 10:19 a.m., CNA F was asked to describe the process of donning and doffing to provide care in the COVID-19 isolation unit. CNA F stated, We (facility CNAs) don't know what is going on. There are no signs telling me what to do . I don't know where I am supposed to be taking my gown off. We take off the dirty PPE off outside of [Resident #3's] room, and I de-gown there . I take my gloves off and then I come out (off the isolation unit) without hand sanitizing my hands in there (on the COVID-19 isolation unit) . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility Novel Coronavirus Prevention and Response policy, Revised 12/21, revealed the following, in part: .6. Interventions to prevent the spread of respiratory germs within the facility: a. Keep residents, employees, and visitors informed by answering questions and explaining what they can do to protect themselves and their fell ow residents (i.e. handwashing, spatial separation, respiratory hygiene/cough etiquette) .Notify the health department promptly about any of the following: a) ? 1 residents or healthcare personnel (HCP) with suspected or confirmed SARS-CoV-2 infection . f. Education staff on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye protection. g. Promote easy and correct use of personal protective equipment (PPE) by i. Posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE. ii. Make PPE, including facemask, eye protection, gowns, and gloves, available immediately outside of the resident's room. iii. Position a trash can near the exit inside any resident room to make it easy to discard PPE . k. Staff will wear a well-fitting facemask and practice physical distancing at all times while in the facility . 7. Procedure when COVID-19 is suspected or confirmed: .b. Place resident in a private room (containing a private bathroom) with the door closed .Environmental infection control: e. Once a resident is discharged or transferred, staff will refrain from entering the vacated room (if a single occupied room) until sufficient time has elapsed for enough air changes to remove potentially infectious particles. One the time has elapsed; the room will undergo appropriate terminal cleaning and surface disinfection before returning to routine use . During the infection control interview on 1/12/22 at 3:13 p.m., IP J said the first positive COVID-19 cases were identified on 12/30/21 with two facility staff including one administrative staff, and one nurse. Resident #19 tested positive for COVID-19 on 12/30/21 and was put on the 200 hall COVID-19 unit immediately (that same day), while Resident #3, who had shared a bathroom with Resident #19 tested positive for COVID-19 on 1/3/22. IP J stated, (Initially) We isolated [Resident #3] on the 300 hall, required full PPE, N95, goggles, mask, and gloves to go into [Resident #3's] room . When asked about the PPE that was worn by facility staff at the beginning of the facility outbreak, IP J stated, I feel in our county the rates (% positivity) are very high. My understanding, in the county that is high you should be wearing goggles, and KN95 or N95 (face masks). That is what we started off with, and our corporation came in and told us that we didn't need to do that. I had to go with what the corporate (staff) said . IP J said all staff were instructed to wear surgical masks, and only don full PPE while providing care on the COVID-19 isolation unit or during aerosolization procedures, such as nebulizer treatments. Review of the Center for Disease Control and Prevention (CDC's) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19 Pandemic, Updated Sept. 10, 2021, revealed the following, in part: .Implement Source Control Measures: Source control refers to use of respirators or well-fitting facemasks .to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control options for HCP include: -A NIOSH-approved N95 or equivalent or higher-level respirator OR -A respirator approved under standards in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (note: these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) OR -A well-fitting facemask . (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

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Eye protection (i.e., goggles or face shield that covers the front and sides of the face) should be worn during all patient care encounters .Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles . After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use .Cloth Mask: They are not personal protective equipment (PPE) for use by healthcare personnel . Unvaccinated residents and HCP: Unvaccinated residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities. Review of the LTC Respiratory Surveillance Line Lists for facility residents and staff revealed two Residents were listed as positive for COVID-19: Resident #19 on 12/30/21, and Resident #3 on 1/3/22. Six positive staff members were identified through rapid antigen testing between 12/30/21 and 1/12/22. Five of those six were confirmed positive through PCR testing. Staff NN, the last staff member documented on the Line List tested positive that same day but had not been identified as positive to the Survey Team. The Line List revealed Staff NN had reported COVID-19 symptom of fever and myalgia (body aches) to IP J. When asked when Staff NN was tested and determined to be positive for COVID-19, IP J stated, [Staff C] tested at 1:45 p.m., and was positive (for COVID-19) with symptoms of fever, myalgia, and headache . When asked why the Survey Team was not notified of the new positive, IP J stated, I thought you knew. When asked when the facility COVID-19 outbreak began IP J said the facility was not in an outbreak status. When asked to confirm the definition of a COVID-19 outbreak as one or more facility acquired COVID-19 infections in a resident, IP J stated, Per the definition we are in a COVID outbreak . IP J said they had immediately begun to test facility residents for more potential positives. When asked if all facility staff would also be tested for COVID-19, IP J said they were going to wait until tomorrow (1/14/22), the normal testing day for facility staff. When asked what the facility policy was regarding testing of facility staff following newly identified COVID-19 positive staff or residents, IP J acknowledged facility staff were to be tested immediately. Review of the facility Coronavirus Testing policy, revised 9/21, revealed the following, in part: . Outbreak is a new COVID-19 infection in any healthcare personnel or any nursing-home onset COVID-19 infection in a resident. Testing of Staff and Residents in Response to an Outbreak, 1. A new COVID-19 infection in any staff or any nursing home onset COVID-19 infection in a resident will trigger an outbreak investigation . 2. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing will begin immediately . On 1/13/22 at 7:32 a.m., LPN T was observed at the nurses' medication cart near the front nurses' station 100/400 halls. LPN's surgical mask was down beneath her nose, and she wore no goggles or face shield. She used her bare right hand to pull up her mask to attempt to cover her nose by touching the front of her mask. No hand hygiene was performed between touching the front of her mask and continuing to prepare unidentified resident medications. (continued on next page)

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 1/13/22 at 9:07 a.m., LPN AA was observed in the resident dayroom, where the surveyors were placed, with only a surgical mask on her face. The mask had visible gaps on the right and left sides of her face. When asked about the gaps that allowed inhalation and exhalation of breath by/from LPN AA, LPN AA acted unaware of the gaps and stated, Oh, there is (gaps)? LPN AA stated, I am wearing a surgical mask. That is all we wear. During an interview on 1/13/22 at 9:11 a.m., with Regional Director of Operations (Staff) BB, and Regional Clinical Director (Staff) CC, in the presence of another surveyor, both staff members were observed with air gaps on both sides of their faces, and a small gap at the top of the nose while wearing only a surgical mask. Staff BB confirmed the facility had no shortages of any PPE at that time. Staff CC confirmed she had instructed IP J to discontinue the use of KN95/N95 face masks and eye protection (face shield or goggles) for care of non-COVID positive residents. Staff CC stated, I told [IP J] it (donning of a well-fitting mask and eye protection) was not necessary. When asked why she instructed the facility change to surgical masks rather than the KN95/N95 masks and eye protection the facility infection preventionist had implemented, Staff CC stated, Because it is not in our policy. It is not a practice we utilize in other facilities. Staff BB said their policy was based on CDC (Centers for Disease Control and Prevention) guidelines. Both Staff BB and CC confirmed the local public health department should be notified of any identified COVID-19 positive residents or staff the same day. Review of the CDC Types of Masks and Respirators, updated Jan. 14, 2022, revealed the following, in part: . To protect yourself and others from COVID-19, CDC continues to recommend that you wear the most protective mask that fits well and that you will wear consistently . while all masks and respirators provide some level of protection, properly fitted respirators provide the highest level of protection . Whatever product you choose, it should provide a good fit (i.e., fitting closely on the face without any gaps along the edges or around the nose) and be comfortable enough when worn properly (covering your nose and mouth) so that you can keep it on when you need to . Gaps can let air with respiratory droplets leak in and out around the edges of the mask . Disposable procedure masks are widely available. They are sometimes referred to as surgical masks or medical procedure masks . Do NOT wear procedure masks with gaps around the sides of the face or nose . Telephone interviews were conducted on 1/13/22 at 9:14 a.m., and 1/14/22 at 12:13 p.m., with Public Health Staff Z, a confidential local public health department employee. When asked about timely reporting of all positive COVID-19 residents and staff by the facility, Public Health Staff Z stated, We have been alerted of two positive (COVID-19) residents and three positive staff. Those five cases are the only cases they (the facility) have alerted us about. Public Health Staff Z said the facility had not called them in regarding any other COVID-19 positives as of that time/date. Public Health Staff Z stated they were not made aware of staff positives on the 10th and the 12th (of January 2022). When asked about the use of well-fitting masks (KN95 or N95 masks) for care of non-COVID positive residents in the nursing home facility, Public Health Staff Z stated, If the PPE is available, and they have them available, especially if you are in the midst of increasing cases it seems appropriate to use the highest level PPE available to you in an attempt to staunch the spread (of COVID-19). Public Health Staff Z said they had not had good communication with the facility, which had been an ongoing issue. Public Health Staff Z stated, I don't have confidence in the facilities ability to handle a COVID-19 outbreak . [Facility Name] typically does not reach out to us for guidance and they are not consistent (with) reporting. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, Updated Sept. 10, 2021, revealed the following, in part: Key Points: -Older adults living in congregate settings are at high risk of being affected by respiratory and other pathogens, such as SARS-CoV-2. -A strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP). -Even as nursing homes resume normal practices, they must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalization s, and death. - .Education and train HCP about recommended practices to prevent spread of SARS-CoV-2, including reminding them not to report to work when ill .Including consultants is important since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of SARS-CoV-2. -Notify the health department promptly about any of the following: o(one or more) resident or HCP with suspected or confirmed SARS-CoV-2 infection. -Personal Protective Equipment: Ensure Proper Use, Handling, and Implementation of Personal Protective Equipment. Review of the facility COVID-19 Timeline, received from IP J on 1/13/22 at 10:45 a.m., revealed the following, in part: First contact with health Department left messages stating that we had Positive employee and 1 positive Resident. 12/30/21 Message stated off for Holiday. [Health Department Employee] from Health Department called, she asked how many we had in house with COVID-19, explained that we had 2 staff antigen and PCR tested positive and 2 residents Antigen and PCR tested Positive .She asked that I fax info, which I tried on 1/4/22 our fax was down, 1/5/22 fax with updates went through. Contacted [Health Department Employee] . she was unavailable. Left message for her call as we had another Positive Employee and had questions. No date was noted on the last entry and no times on any of the entries. No other documentation was present to show evidence of any additional COVID-19 positive residents on 1/6/22 and 1/10/22. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 1/13/22 at 9:56 a.m., when asked what PPE should be used in the facility during an outbreak, and a county % positivity rate of approximately 34%, IP J stated, I believe staff should be wearing the N95 or KN95 masks. I agree 200 percent that you should wear the N95 masks . I consider my unvaccinated residents a higher risk to spread the virus. For care of the other residents everybody would be wearing N95 (face masks) and goggles or face shields . that is not my decision (it is a corporate decision). When asked about staff working with a known close contact exposure, IP J stated, If you knew how many people (staff) have been exposed - I wouldn't have any staff left (if they quarantined). IP J, when asked about the status of COVID-19 booster doses for facility Residents, said the facility was behind on boosting everyone. During a telephone interview on 1/18/22 at 12:18 p.m., LPN DD was asked about PPE usage by facility staff. LPN DD said Staff EE sometimes wore a cloth mask while working in the facility. When asked when she had last seen Staff EE in a cloth mask, LPN DD said she had talked to Staff EE last weekend or this weekend (during the COVID-19 outbreak). LPN DD stated, Everybody eats at the nurses' desk (and) they all wear their masks under their nose. The 100 hall has a charting room and when you [State Agency] aren't there, there are snacks and candy and open bags of chips . During a telephone interview on 1/18/22 at 12:57 p.m., Staff EE was asked about PPE use in the facility. Staff EE stated, On the main floor (non-COVID) they are kind of going back and forth. First, we got told to wear N95s the whole time, and then we got told surgical masks. We got told something different every other day. Staff EE confirmed she had a doctor's note for using a cloth mask while providing direct care to facility residents, due to the presence of hives if a surgical mask was worn too long. Staff EE said she had gotten the note from a physician on 1/3/22 and had provided a copy of the note to the facility. During a telephone interview on 1/18/22 at 1:44 p.m., when asked why a close family contact of Staff NN had not been asked to leave the facility following identification of COVID-19 infection of Staff NN, the NHA with IP J present stated, I don't think he is the only one that had been exposed. We (administrative staff) just didn't go there. The NHA also confirmed that Resident #14 was unvaccinated and ate meals in the dining room. The NHA stated, We encourage all of our residents to wear masks, but we don't enforce that. This is their home. The NHA said he could not segregate Resident #14, and he could not tell him no (to communal dining). The NHA stated, Anywhere they go (in the facility) at this point would be the same. It would be no different than a birthday party. Our outbreak is done. When asked about the cardboard box filled with dirty PPE across the hall from Resident #22's open room door on 1/12/22, IP J stated, I would not expect to see used booties outside the door in a garbage box. I was told that was the weekend staff, and I have not had an opportunity to go over that (taking dirty COVID-19 exposed PPE off outside the COVID-19 isolation unit) with the weekend staff .I don't know what happened. IP J confirmed five residents had received COVID-19 boosters of the 47 residents currently in the facility. IP J stated, We have been unable to get a hold of a [Name] pharmacist or [Contractual Pharmacy] and have a vaccination clinic . We have not gotten a hold of the pharmacist because we keep missing each other. Review of the Vaccination Status lists of facility residents and staff provided by IP J revealed the following, in part: 19 of 72 facility staff were unvaccinated, and 10 of 42 listed residents were unvaccinated. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 1/18/22 at 9:45 a.m., CNA FF confirmed she had worked on the 200 hall COVID-19 isolation unit. CNA FF stated, I come out (of the COVID-19 isolation unit) without a face mask on. My new face masks go on up at the nurse's station (200/300 Hall). You are supposed to put the new face mask on just when you get out of the COVID enclosure. There is PPE right outside the zippered area, but I have taken off all my PPE before I get through the zipper, and I put my new surgical mask on at the nurse's desk (outside the COVID-19 isolation unit). I don't know if I am doing it right or doing it wrong. I don't really know. CNA FF confirmed the Director of Nursing (DON), or IP J had never watched her to make sure she was donning and doffing correctly. CNA FF said education related to COVID-19 PPE donning and doffing consisted of reading the paper instructions, signing it, and then you are done. CNA FF said it took Resident #3 longer to move to the COVID-19 isolation unit. Resident #3 was supposed to move to the COVID-19 unit on Monday (1/3/22 when identified as COVID-19 positive) and CNA FF said Resident #3 was moved on Friday, January 7th. During a telephone interview on 1/19/22 at 4:05 a.m., CNA GG was asked about COVID-19 testing on the night shift. CNA GG stated, I was here over the weekend, and we had no solution to even test ourselves for COVID-19. All of administration was gone on Monday. They were off for a holiday, and we didn't have solution for COVID-19 testing. CNA GG confirmed normal twice weekly testing was performed on Mondays and Thursdays. CNA GG did not test on Monday, and said she would test tomorrow (1/20/22), resulting in once-a-week testing. Regarding PPE doffing after provision of care on the COVID unit, CNA GG stated, When you (first) go through the zipper part - there is no PPE there. The clean PPE is outside of the double doors. CNA GG also confirmed no administrative staff had watched her don or doff PPE to ensure it was being performed correctly. When asked about communal dining, and the facility's encouragement for residents to don masks with unvaccinated residents in the dining room, CNA GG stated, [Resident #14 (unvaccinated)] was in the dining room and [Resident #22] yesterday, 1/18/22. No residents are masked in the dining room. I am not aware of them being asked to wear a mask - only when the State is here. During a telephone interview on 1/19/22 at 9:48 a.m., Staff OO, confirmed Resident #3 stayed out on the floor for 4-5 days after testing positive for COVID-19. Staff OO stated, I was [upset] about that. I don't know why they didn't move her (to the COVID-19 isolation unit). I kept inquiring and they kept saying they would do it, and there was only one person that could do it, and then they had to wait . Staff OO said she was not feeling well yesterday and stayed in her office with a little cough and a little headache. Staff OO did test for COVID-19. Staff OO said she would be going to the facility for a repeat test that day. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 1/19/22 at 9:54 a.m., when asked about relocation of the COVID-19 positive residents off the 300 hall, to the 200 hall COVID-19 isolation unit, Maintenance Director (Staff) A said Resident #19 was moved the same day she tested positive for COVID, 12/30/31. Staff A said Resident #3 was quarantined in her room, and Resident #3's 300 hall room was set up as an isolation unit. Staff A said Resident #19's room was deep cleaned the same day after she was moved to the COVID unit. Resident #19 and Resident #3 share a bathroom, staff entered Resident #19's room and went through the bathroom into Resident #3's room for the provision of care for Resident #3 after Resident #19 was moved to the COVID-19 isolation unit. A visqueen barrier was applied to the outside of Resident #3's room door. All access was through Resident #19's COVID-19 exposed room and bathroom. When asked why Resident #3 was not moved to the COVID-19 unit earlier, Staff A stated, Infection control was the reason she didn't move to the unit right away. [IP J} would be responsible for that - for when she moves her. I do what I am asked to do. When asked about Staff A's knowledge of CDC recommendations for the timeframe for entering a COVID-19 positive room for deep cleaning, Staff A stated, I do not know of any CDC guidance for entering and cleaning a COVID positive room. Staff A said staff had their clean PPE in Resident #19's room the same day she was moved out to the COVID unit. Review of Resident #3's and Resident #19's complete electronic medical record (EMR), including progress notes, and Room Change Forms failed to find documentation of when Resident #3 and Resident #19 were moved to the COVID-19 unit. During a telephone interview on 1/19/22 at 12:52 p.m., IP J was asked when Resident #3 and Resident #19 were moved to the COVID unit. IP J said that information should be documented in the chart. IP J reviewed Resident #3 and Resident #19's EMRs and found no documentation showing when either COVID-19 positive resident was moved to the COVID unit. IP J confirmed there was no charting for when either resident was moved to isolation. When asked about when cleaning of a COVID-19 positive room should be completed, IP J stated, If the room was cleaned the same day - I am not sure. I am not sure if they were allowed. If IP, I would want to wait at least 24 hours with the door shut - and signs were still up and go from there. When asked if any new COVID-19 positives were identified with facility testing that day, 1/19/22, IP J reported Resident #22 tested positive for COVID-19 along with, four staff members When asked about Resident #22, IP J stated, She was (her room was located) right next to the door of the COVID-19 isolation unit. During a telephone interview on 1/24/22 at 8:06 a.m., IP J confirmed continuation of the facility COVID-19 outbreak with positive COVID-19 test results obtained for Staff that included eight additional staff members. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the CDC Scientific Brief: SARS-CoV-2 Transmission, updated May 7, 2021, revealed the following: SARS-CoV-2 is transmitted by exposure to infectious respiratory fluids. The principal mode by which people are infected with SARS-CoV-2 (the virus that causes COVID-19) is through exposure to respiratory fluids carrying infectious virus. Exposure occurs in three principal ways: (1) inhalation of very fine respiratory droplets and aerosol particles, (2) deposition of respiratory droplets and particles on exposed mucous membranes in the mouth, nose, or eye by direct splashes and sprays, and (3) touching mucous membranes with hands that have been soiled either directly by virus-containing respiratory fluids or indirectly by touching surfaces with virus on them. People release respiratory fluids during exhalation (e.g., quiet breathing, speaking, singing, exercise, coughing, sneezing) in the form of droplets across a spectrum of sizes. These droplets carry virus and transmit infection. The largest droplets settle out of the air rapidly, within seconds to minutes. The smallest very fine droplets, and aerosol particles formed when these fine droplets rapidly dry, are small enough that they can remain suspended in the air for minutes to hours. During a telephone interview on 1/25/22 at 12:04 p.m., Resident #46 (unvaccinated) was asked about donning of face masks during communal dining. Resident #46 stated, You never have to wear a mask when you go out of the room. Residents never have masks on. No staff have ever encouraged me to wear a mask when outside of my room. Review of the LTC Respiratory Surveillance Line Lists dated 12/30/21 - 1/31/22, and received via email from the NHA on 1/25/22, revealed the following, in part: 1. 15 staff members positive: Two on 12/30/21 One on 1/6/22 One on 1/12/22 Five on 1/19/22 Six additional staff listed with no date of COVID-19 positivity 2. Three residents positive: One on 12/30/21 One on 1/3/22 One on 1/19/22 (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The employee Line Listing (received 1/12/22 from IP J) contained two COVID-19 positive staff identified on 1/10/22. One of these staff was completely removed from the employee COVID-19 Line List received via email 1/25/22, and the other staff member noted initially as positive on 1/10/22 was added to the 1/25/22 Line Listing as positive on 1/19/22. The presence of COVID-19 symptoms for staff and residents were also changed between the COVID-19 Line Listings received on 1/12/22 and 1/25/22. Both staff and resident Line Lists changed from the original 1/12/22 forms received from IP J. Staff OO, during a telephone interview on 1/19/22 at 9:4 [TRUNCATED]

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation and interview, the facilty failed to maintain two critical pieces of equipment (kitchen freezer and ice machine) in a safe and sanitary operating condition. This deficient practice has the potential to result in the lack of storage of frozen food and ice for resident consumption, potentially affecting all 47 residents in the facility. Findings include: On 1/11/22 at 9:15 AM during the initial tour of the kitchen, the three door [NAME] freezer was observed to have a temperature of 52 F registering on the digital thermometer. When the doors were opened, it was observed the unit was not cold and not being used for refrigeration, rather, the interior space was being used to store shelf stable supplements and other food products. An interview with Dietary Manager (DM) B was conducted at this time and was learned the freezer had not worked in months and was being used for storage space. The two door upright freezer, located near the three compartment sink was opened and observed to be full of frozen food. The space was fully packed and did not allow for the proper circulation of air within the unit. DM B stated that this two door unit and a top loading non-commercial freezer in the maintenance office were the only equipment available to keep frozen food, and was inadequate to maintain the full complement of food required for the menus. On 1/11/22 at 9:30 AM the Manitowoc ice machine, located in the kitchen, was observed to have mold like substance on the plastic deflector shield. An interview with DM B was conducted at this time and requested information regarding the cleaning schedule of the machine. DM B stated she had been in the position as dietary manager for approximately 90 days and she was not aware it had been cleaned in that time frame. When asked who was responsible for cleaning the machine, she stated she was not sure and then It's probably me. When asked if she had the user's manual for the machine which delineated the cleaning procedure, she stated No. On 1/11/22 at 10:25 AM, an iterview was conducted with Maintenance Director (MD) A concerning the cleaning of the ice machine. MD A stated he had not cleaned the machine since he had begun his position as the MD in early October 2021. When asked if he knew where the manual or cleaning schedule for the machine was, he stated he did not know. On 1/11/22 at 11:26AM, a plastic bussing bin was observed in the walk in cooler with half pint cartons of milk covered with ice cubes. An interview was conducted with DA E about the use of ice covering the milk cartons. DA E confirmed he had placed the ice on the milk cartons and had not been informed by DM B the ice was not to be used. On 1/11/22 at 12:18 PM, DM B was observed removing the ice from the ice machine. When asked if she had located at cleaning procedure, she stated No. Not yet. I have to go online to find one. At 2:43 PM, DM B was observed in the kitchen with two containers of Manitowoc ice machine cleaners. When asked if she knew how to use the chemicals and how to flush and sanitize the bin following the use of the chemicals, she stated No. I haven't gone online to find out yet. On 1/12/22 at 1:30 PM, an interview with the NHA was conducted and instructed the facility to ensure there was a written procedure to follow which defined the use of the chemicals and the subsequent disinfection of the machine prior to putting the ice machine back on line for use.