STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235664	A. Building B. Wing	06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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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 - Some	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** 30675 Based on interview and record review, the facility failed to ensure adequate documentation that residents and/or their legal representatives were given the opportunity to formulate an advance directive (legal documents that allow a person to identify decisions about end-of-life care ahead of time) for four (R26, R28, R33, and R58) of five residents reviewed for advance directives, resulting in the potential for a resident's preferences for medical care to not be followed by the facility, or other healthcare providers. Findings include: Resident #26: Review of the clinical record revealed R26's physician order for their code status was FULL CODE. According to the initial social service assessment on 1/11/21, there was no documentation about the resident's code status or whether that had been discussed/reviewed with the resident and/or legal representative. Further review of the clinical record revealed R26 was admitted into the facility on [DATE] with diagnoses that included: unspecified combined systolic and diastolic heart failure, degenerative disease of nervous system, immunodeficiency due to conditions classified elsewhere, anxiety disorder due to known physiological condition, and type 2 diabetes mellitus. According to MDS quarterly dated 4/12/21, R26 had severely impaired cognition. Resident #28: On 6/15/21 at 3:29 PM, an interview was conducted with R28 to discuss if anyone had ever discussed their end of life wishes such as choices for resuscitation in the event of an emergency and R28 stated No one has ever talked about that to me here. I would not want to be resuscitated! Review of the clinical record revealed R28's code status was FULL CODE. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the resident's initial social service assessment dated [DATE], there was no documentation about the resident's code status or whether that had been discussed/reviewed with the resident. A care conference note on 4/12/21 documented, .Care Conference held at bedside with resident .Advanced Directives Reviewed/Revisions: Deferred social worker to f/u (follow up) after care conference today resident will remain full code status at this time . A social service progress note on 4/15/21 documented, .Resident is a new admission from the hospital. Resident is alert with ability to participate in her daily routine .She is Full Code status . Further review of the clinical record revealed R28 was admitted into the facility on [DATE] with diagnoses that included: heart failure, acute respiratory failure with hypoxia, type 2 diabetes mellitus with unspecified complications, peripheral vascular disease, chronic kidney disease stage 5, long term use of insulin, and legal blindness. According to the admission MDS assessment dated [DATE], R28 had intact cognition. Resident #33: Review of the clinical record revealed R33 was admitted into the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary disease, hypertensive chronic kidney disease, paroxysmal atrial fibrillation, acute kidney failure, bipolar disorder, and type 2 diabetes mellitus. According to the MDS assessment dated [DATE], R33 had intact cognition. Further review of the clinical record revealed R33's physician order for their code status was FULL CODE. According to the most recent social service quarterly review on 1/21/21, .Resident is alert and able to participate in his daily routine .He is Full Code . There was no documentation that the decision to remain a full code had been discussed with the resident, and this was their decision. Resident #58: Review of the clinical record revealed R58 was admitted into the facility on [DATE] with diagnoses that included: encounter for orthopedic aftercare following surgical amputation, acquired absence of left leg below knee, end state renal disease, type 2 diabetes mellitus with hypoglycemia without coma and with diabetic neuropathy, acute on chronic combined and diastolic heart failure, moderate protein-calorie malnutrition, chronic kidney disease stage 5, dependence on renal dialysis and peripheral vascular disease. According to the admission MDS assessment dated [DATE], R58 had intact cognition. Further review of the clinical record revealed R58 did not have a code status identified. There was no social service assessment, care conference note or any other documentation that the resident had been asked about their decision to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/16/21 at 8:40 AM, an interview and record review for R2, R26, R28, R33 and R58 were conducted with Social Work Manager (SW 'I') who reported they were the only social worker in the facility. When asked about the facility's process for discussing resident's wishes for code status and whether they would like to develop an advance directive, or to clarify their wishes for end of life care or if not already in place to develop a document such as a power of attorney to appoint someone to make these decisions when they are no longer able to, SW 'I' reported code status was usually discussed at the time of the initial assessment and during the 72 hour care conference. SW 'I' reported that documentation might be documented by the MDS Coordinator but would have to follow up. Review of the available documentation for code status for R2, R26, R28, R33 and R58 with SW 'I' revealed there was no documentation this had occurred. The documentation simple identified Full Code and did not identify if that was the resident and/or legal representative's decision. SW 'I' further reported the facility did not have a document if they chose to be a full code but should be documented that was their choice. When asked how it could be determined that was their choice to be a full code if there was no documentation in the clinical record, SW 'I' acknowledged the concern and was unable to offer any further explanation. According to the facility's Residents' Rights Regarding Treatment and Advance Directives policy dated 12/2020: .On admission, the facility will determine if the resident has executed an advance directive, which can designate a DPOAH (Durable Power of Attorney for Health) and/or future healthcare treatment preferences, and if not, determine whether the resident would like to formulate an advance directive .Upon admission, should the resident have an advance directive, the advanced directive will be reviewed to ensure advocates, demographics and wishes are current. If so, copies will be made and placed on the chart as well as communicated to the staff and a physician order written .Decisions regarding advance directives and treatment will be periodically reviewed, the existing care instructions and whether the resident wishes to make any changes related to any advance directives .Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on interview and record review the facility failed to report an allegation of possible abuse/neglect for (R259) out of one resident reviewed for abuse/neglect, resulting in incidents/allegations of abuse/neglect not being reported to the State Agency and the potential for further allegations of abuse/neglect to go unreported and not thoroughly investigated. Findings include: A complaint was filed with the State Agency that alleged R259 contacted the local police to report that they were not receiving their medications, were in pain and needed to leave the facility to go to the Hospital. A review of a police report, documented, in part, the following: .Date/Time .5/30/21 at 2228 (10:28 PM) . Information: .I was approached by two .facility employees regarding their concern of poor treatment of patients .Action Taken: While on scene at the listed location .I was approached by two .facility employees (Certified Nursing Assistants (CNA) R and S). They stated that they were concerned that a lead nurse (Nurse T) was not giving patients in the facility their medication on time. (CNA R) stated that when she spoke to (Nurse T) about patient's medications, (Nurse T) appeared to be unconcerned. (CNA R) stated that (Nurse T) goes to .grocery store and stays 'gone a long time' .I spoke with (Nurse T) regarding patients' care to which she stated that she has a lot of rooms and patients to take care of and that she's short staffed .Interview with (R259) .Before being approached by (CNA R and S), I was on a call for service for (R259, R259) requested to be transported to .hospital due to lack of care from the employees. He stated he had gone over 30 hours without receiving his dose of two IV bags. I observed two empty IV bags next to his bed .(R259) also received his pain medication approximately 2.5 hours later than he should have received it (I observed as he was given his pain medication shortly after my arrival on scene, approximately 2140 (9:40 PM)). (R259) had recently undergone spinal surgery and had a foot long (approximate) scar and staples on his lower back. It was obvious to me that (R259) was very upset and in pain due to his scar and recent surgery . A review of R259's clinical record documented the resident was admitted to the facility on [DATE] with diagnoses that included fusion of the spine (thoracic region), osteomyelitis, the resident was noted as cognitively intact and required extensive one to two person assist with most Activities of Daily Living (ADL). Continued review of the resident's record documented, in part, the following medical orders and medication administration: Ceftriaxone (antibiotic)Sodium Solution Reconstituted .Use 2 gram intravenously one time a day for infection . Hours 6:00 PM - *It should be noted that the last dose was given to the resident on 5/28/21. Normal Saline Flush .Use 10 ml intravenously in the evening for IV before and after administration. *It should be noted that the last Saline Flush was administered on 5/28/21. Vancomycin (antibiotic) HCl Solution .Use 1750 mg intravenously one time a day for infection .Hours 5:00 PM. *It should be noted the last Vancomycin was administered on 5/28/21. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxycodone (pain medication) 10-325 MG - Hours 7:00 PM Give one tablet by mouth every 6 hours for pain. * Last dose noted by Police officer was at 9:40 PM. On 6/16/21 at approximately 4:00 PM an interview was conducted with CNA S regarding the incident on 5/29/21. CNA S reported that she was employed by an Agency and had worked about six weeks at the facility. She indicated that she worked the afternoon shift on 5/29/21 with CNA R and Nurse T. CNA S recalled R259 as being a pleasant person who was at the facility for rehabilitation following surgery. She reported that on 5/29/21, R259 was in a tremendous amount of pain. CNA S could not locate Nurse T and reported that Nurse T had left the building and was out for over one hour. CNA S indicated she tried to provide a warm towel to help with the pain, but he really needed his pain medication. CNA S and CNA R could not locate Nurse T and tried to find Nurse U who was working on the other side of the building so that he could administer R259's medication. CNA S recalled that Nurse U did not have the key to the medication cart where R259's medication was stored. CNA S reported that R259 contacted local police who came to the facility and both her and CNA R gave a report. CNA S indicated that resident was still in pain and was transferred to the local hospital. An attempt to contact CNA R and Nurse T via phone was made on 6/17/21 at approximately 8:30 and 8:35 AM. No return calls were made by the end of the survey. On 6/17/21 at approximately 9:18 AM and interview via phone was conducted with R259. R259 reported that he was admitted to the facility on [DATE] following surgery and continuously had trouble with staff responding to his call light. Often, he would end up contacting someone at the front desk and ask for nursing assistance. On 5/29/21 he was in a tremendous amount of pain and had not received his antibiotic IV medication in over a day. R259 recalled asking the CNAs for assistance, but they were not able to provide medication and they kept looking for the Nurse on duty. R259 reported that he finally called 911, the police arrived and initially could not locate the nurse on duty (Nurse T). Before he was transferred to the Hospital, he was given his medication two and a half hours late and never received his two IV antibiotics. On 6/17/21 at approximately 9:55 AM, Nurse T was interviewed pertaining to the incident on 5/29/21. Nurse T reported that there were only two nurses working in the building that evening. When queried as to whether he was asked to assist R259, he reported that a CNA had asked him to provide pain medication but did not have a key to the medication cart that stored the resident's medication. On 6/17/21 at approximately 10:25AM, the Administrator/Abuse Coordinator was interviewed as to the incident on 5/29/21. The Administrator reported she was aware that R259 had contacted local police. When queried as to why the incident was not reported to the State Agency, the Administrator reported that she did not consider the incident an allegation of abuse. The Administrator further reported that she believed the facility was short staffed challenged after interviewing Nurse T. The Administrator reported that she did not interview CNA R, CNA S and never reviewed the local police reports. When asked if there was any determination as to how long Nurse T had left the facility, the Administrator indicated if staff walk to the local market, they do not need to punch out. When asked if Nursing staff should leave the building with the key to the medication cart, the Administrator indicated they should not. When queried as to whether allegations of neglect are to be reported to the State Agency, the Administrator indicated that they should be. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Abuse, Neglect and Exploitation (revised 12/20) documented, in part, the following: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect .Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Reporting/Response .1. Reporting of all alleged violations to the Administrator, state agency .Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .

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F 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** 34275 Based on observation, interview and record review, the facility failed to ensure hospital/physician wound care orders were implemented timely for one R261 out of three residents reviewed for wounds, resulting in the potential for R261's wound to not heal properly. Findings include: A review of the R261's clinical record indicated that the resident was initially admitted to the facility on [DATE] with diagnoses that included the following: above knee amputation and cirrhosis of liver. A facility Admission Assessment indicated that the resident was cognitively intact and required one to two person assist for most Activities of Daily Living. On 6/15/21 at approximately 10:25 AM, R261 was observed lying in bed. The resident was alert and able to answer questions. When queried as to care provided by the facility, R261 reported that he was admitted to the facility on [DATE] following an amputation of right lower leg. When asked about care of the amputation, R261 reported that it should be wrapped and treated with a dressing. R261 reported informing the ADON (Assistant Director of Nursing) as to his concerns on or about 6/13/21. On 6/15/21 at approximately 2:20 PM an interview was conducted with Assistant Director of Nursing (ADON) C. When queried about treatment to R261, including wounds, ADON C reported that R261 did contact her on Sunday 6/13/21. When asked about the resident's wound, ADON C stated the DON would be able to answer. On 6/15/21 at approximately 2:50 PM, the Director of Nursing (DON) was observed talking with R261 regarding wound treatment and return to the hospital for further care. When interviewed, the DON indicated that R261 was refusing to re-admit to the hospital and wanted to remain in the facility until their follow-up visit with an outside physician. Review of a Hospital Patient Discharge Summary (dated 6/11/21) documented, in part: .This information includes a list of medication(s), procedures .and patient education materials .Patient Education Information: Wound Packing: Leg Amputation, Care After Stump and Prosthesis Care. No further instructions and/or orders for treatment of the dated 6/11/21 were located in R261's clinical record. Continued review of the resident's record included, in part, the following: 6/11/21 Physician Progress Note: Late Entry (6/14/21) .patient with history of present illness .for subacute rehabilitation-admitted therefore<sic> right lower extremity wound which was infected .later ended up with above-knee amputation, stump is partly dehisced (an open wound) and has an open wound-needs dressing changes . 6/12/21(6:43 AM) Nursing Progress Note: Resident alert and oriented x3, complained of pain .Resident refused wound care x3 and said will like to have the blue pad they were using in the hospital and all other materials they used in the hospital before his wound can be changed . No orders for wound treatment were noted for 6/12/21. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order dated 6/15/21 (11 PM) read, Right leg wound, pack with damp iodine-soaked gauze, apply abdominal dressing. Wrap with kerlix. Cover with ace bandage. It should be noted that there was no documentation on the resident's Treatment Administration Record (TAR) that indicated any treatment was done or refused from 6/11/21 to 6/15/21. On 6/16/21 at approximately 1:30 PM an interview was conducted with the DON. When queried as to what treatment for R261's was attempted and/or possibly refused, the DON reported that she believed some type of treatment was done on Sunday (6/13/21), possibly by ADON C while the physician was on a tele-video. The DON was not certain as to the type of treatment that was possibly performed and there was nothing documented in the resident's record to indicate treatment as per facility protocol. On 6/17/21 at approximately 11:44 AM, an interview was conducted with Wound Nurse D. When queried as to the treatment of R261's open wound on the right stump, Nurse D indicated that wound care order was implemented on 6/15/21, but that the resident may have received a treatment on Sunday 6/12/21. When queried as why a treatment order was not put into place upon admission and what type of treatment may have been done on 6/12/21, Nurse D stated that the facility should follow Hospital and physicians' orders before performing care and that R261's hospital instructions/orders for the wound should have been placed into the resident's record and treatment administered accordingly. A review of the Facility Policy titled, Wound Treatment Management and Documentation (Revised 12/20) documented, in part, the following: Policy: to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders .Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders .c. The facility will follow specific physician orders for providing wound care .Treatments will be documented on the Treatment Administration Record .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record review the facility failed to complete accurate weekly skin assessments, identify and report worsening of wounds timely, ensure adequate wound physician follow up, coordinate follow up with the vascular surgeon (R52) and delayed implementation of interventions (R54) for two (R's 52 and 54) of two residents reviewed for pressure ulcers, resulting in the development of and/or worsening of wounds. Findings include: Resident #52: A review of the clinical record revealed the following: A review of the hospital record dated 5/10/21 revealed initial documentation and photographs of the following in part, .Skin: Left foot- necrotic toes, Left heel: PI (Pressure Injury) unstageable, Left later leg- black red with 3 open blisters, Right heel: PI DIT (Pressure Injury Deep Tissue Injury), Sacrum/Left Ischium: Skin intact Evidence chronic friction aeb (as evidence by) skin ridging, deformation and lichenification (secondary skin lesion, characteristic features of skin thickening, hyperpigmentation and exaggerated skin lines), everything blanching . The facility's weekly skin assessments and clinical progress notes failed to identify the unstageable left heel, blisters on the left later leg and right heel pressure injury. A hospital clinical note (dated- Adm (Admission) 5/10/21, D/C (discharge) 5/21/21) documented in part, .Plan of Care: IV (Intravenous) Vanco (antibiotic) ordered .Preliminary results of LLE (left lower extremity) indicates occlusion at the superficial femoral artery and down with no flow detected .Per general surgery: No acute intervention, - May require amputations in the future, - Can follow up in our clinic .Conservative supportive therapy is recommended to prevent progression. With any wound progression, discomfort, or infection, consideration for bilateral above-knee amputation would be best one-step option for management, decision on which can be undertaken in the outpatient setting . R52 was admitted into the facility on [DATE] with diagnoses that included: dementia, osteoarthritis, hypertension, and muscle weakness. A Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 6 (indicating severely impaired cognition) and required staff assistance for all activities of daily living, had no pressure ulcers and was at risk of developing pressure ulcers. A wound consult dated 2/24/21 documented in part, .Wound #2 Left First Toe (Great Toe) Tip of Toe is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 1.2cm (centimeters) length x 1.9cm width with no measurable depth, with an area of 2.28 sq (square) cm .Wound #3 Left Ischium is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status Not Healed. Initial wound encounter measurements are 4cm length x 2cm width with no measurable depth, with an area of 8 sq cm .Plan .Wound #2 Left First Toe .Wound needs sharp debridement for optimal wound healing but before I can safely perform this, I request that a bilateral lower extremities vascular study, venous and arterial is obtained in order to assess patients vascular status . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound consult dated 3/10/21 documented in part, .Wound dressed with same dressing place on wound last week, re-emphasized plan (indicating that staff did not change the wound dressing as directed by the physician's order) .New wounds noted today. Arterial Doppler shows moderate diffuse atherosclerosis with biphasic wave form and normal-moderate systolic velocity so it's safe to perform sharp debridement .Wound #2 Left First Toe (Great Toe) Tip of Toe is an acute Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 1.8cm length x 2.3cm width with no measurable depth, with an area of 4.14 sq cm . Wound bed has 50% eschar .Painful, stable eschar. 25% fluid filled dark blister .Wound #3 Left Ischium is an acute Stage 2 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 1.2 cm length x 0.7cm width x 0.5cm depth, with an area of 0.84 sq cm and a volume of 0.42 cubic cm . Two new additional wounds found on the Left Gluteal Region (stage 2 Pressure Injury Ulcer), measurements 7.5cm length x 1.4cm width x 0.3cm depth, with an area of 10.5 sq cm and a volume of 3.15 cubic cm. The second wound found was on the Right Gluteal fold (Stage 2 Pressure Injury Pressure Ulcer) and measurements 7.2cm length x 2.5cm width x 0.1 cm depth, with an area of 18 sq cm and a volume of 1.8 cubic cm . R52 was assessed again by the wound physician on 3/24/21 for an assessment of all of their wounds. Further review of the clinical record revealed no wound physician consultation notes from 3/24/21 until 5/10/21 when the resident was transferred to the hospital for further evaluation of their wounds. Weekly wound assessments noted the following in part: .4/7/21 .Left gluteal fold (description left blank) .Right gluteal fold (description left blank) .left ischium .lt (left) big toe tip . .4/14/21 .Lt big toe pressure wound .Lt ischium pressure .Left gluteal fold- Pressure .Right gluteal fold- Pressure . .4/21/21 .Left gluteal fold- Excoriation .Right gluteal fold- Excoriation .Other .Left big toe wound . .4/28/21 .Left gluteal fold- Resolving excoriation .Right gluteal fold- Resolving excoriation .Resolving area on left great toe . .5/2/21 .Left lower leg (rear)- Pressure/deep tissue injury at the back of left lower leg above the heel . There are no other documented wounds noted on this assessment. .5/9/21 .Left toe(s)- Degeneration of left big toe, deep pressure injury on left lower leg (back). Treatment in progress . There are no other documented wounds noted on this assessment. A Physician Progress Note dated 5/10/21 at 11:29 am, documented the following in part .Patient was seen by video conferencing .seen for black-appearing toes of his left foot .perfusion to toes poor especially left foot all toes show gangrenous changes-dry at this time .dark dry skin of all distal toes of the left foot and lateral left foot near the fifth toe base .needs urgent evaluation in the ER (emergency room)/vascular studies and evaluation to see if the reperfusion is possible and or further management of gangrenous toes . (continued on next page)

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	235664	A. Building B. Wing	06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The weekly assessments completed by the nursing staff failed to identify the worsening of the resident toe wounds and failed to assess, describe, and document the description of all of the resident wounds. A facility policy titled Skin and Pressure Injury Risk Assessment and Prevention (Revised 12/20) documented in part .A skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter .Documentation of skin assessment: Document observations .type of wound .Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain) .Document if resident declined assessment and why .Assessments may also be conducted after a change of condition or after any newly identified pressure injury . A review of the hospital After Visit Summary paperwork provided to the facility documented it part, .Follow up & future appointments .Follow up with (doctor name redacted) in 1 month .Specialty: Vascular Surgery, General Surgery. Follow up for lower extremity wounds . the doctor address and number was documented on the summary for the facility to follow up. On 6/17/21 at 4:18 pm, a request was made to the Director of Nursing (DON) and Administrator regarding the date of the resident's follow up appointment with the vascular surgeon (as directed by the hospital upon discharge). At 4:37 pm, the DON returned and stated, there is no appointment scheduled. On 6/17/21 at 8:03 am, an observation completed with the facility's Wound Care Nurse (WCN) D was conducted of R52's wounds. The Right Distal Medial Anterior Shin revealed a quarter size healing abrasion. The Left Gluteal Region had a 3-to-4-inch opening and the Right Gluteal Fold had an opening noted as well. The Right and Left heels were observed with black discoloration covering both heels. All 5 toes on the left foot were observed with total black discoloration (to the total anterior and posterior aspect of the left top foot), shriveled, with dried flakes. An open area (the size of a pea) was seen on the Great toe. The Left Shin had a noticeable 6 to 7 inches of an open area that was black in color and dry. It was about 2 inches in width and looked as if black, dried muscle was exposed. When compared to the hospital pictures taken on 5/10/21, all areas had worsened. There was no clinical documentation noted that staff identified the worsening of these wounds. A care plan titled I have potential for alteration in skin integrity . (Revised 3/19/21) documented in part, . Monitor my skin daily and prn (as needed) during care and notify my nurse immediately of any changes to my skin .Skin checks weekly per facility protocol, document findings and notify my physician of any noted changes .reddened areas, discoloration, rashes, open areas . A Physician Progress Note for wound consultation dated 5/28/21 at 5:17 pm, documented in part .patient does have bilateral lower extremities wound left toe from first toe, second toe, third toe fourth .toe appears black and necrotic .right heel has 4 cm x 5 cm unstageable eschar, left heel has 6.3 cm x 7.2 cm unstageable ulcer . The physician failed to assess and document on the sacrum and Ischium wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/4/21 at 7:40 am, a physician progress note which reviewed the resident wounds documented in part . wound left toe from first toe, second toe, third toe, fourth .toe appears black and necrotic .right heel has 4 cm x 5 cm unstageable eschar, left heel has 6.3 cm x 7.0 cm unstageable ulcer does have . eschar . The physician failed to assess and document on the sacrum, Ischium, Gluteal/gluteal fold, and left shin wounds. On 6/17/21 at 9:24 am, WCN D was queried regarding the inaccurate weekly wound assessments and the lack of the wound physician examinations and stated the facility staff have been consistently in-serviced and educated on the accuracy of the weekly assessments. WCN D also stated the facility's previous wound doctor was let go in May of this year and another doctor is basically covering until we get a new wound doctor. When asked why the doctor failed to assess all of the resident wounds when completing a wound visit, WCN D acknowledged that he is supposed to, but he does not assess all of the wounds when he consults with a resident. When asked how the physician and facility staff are able to determine if the treatment is effective if the areas are not being assessed by the wound physician when they visit, WCN D could not provide any further explanation. WCN D was asked to provide any further documentation regarding R52's wounds and wound care. WCN D provided InService education titled low air loss mattress, Critical Element Pathways and Wound Treatment Management & Documentation. No further documentation was provided by the end of survey. 30675 Resident #54: Review of the admission MDS assessment dated [DATE] revealed R54 admitted to the facilty on 9/14/20, had no pressure ulcers, but was at risk for the development of pressure ulcers. Further review of the medical record failed to reveal the facilty had put into place any interventions to prevent the development of pressure ulcers until 4/9/21. Review of the weekly skin sweep dated 4/6/21, revealed R54's skin was intact. Review of the Weekly Skin Sweep note dated 4/13/21 revealed, Open Area .Right toe(s) .Right heel . Resident has a small sore on the R (right) heel and R great toe. Discoloration of the ball of left foot. Review of the Wound Assessment note dated 4/13/21 revealed R54 had a new wound on the right heel with a date of onset of 4/13/21 and was Acquired in-house. The wound was first identified as a vascular wound, but was later assessed to be a Pressure Ulcer. Further review of this document revealed, Site Right Heel . length 7(centimeters (cm)) Width 6 (cm) . Review of the Wound Assessment note dated 4/21/21 revealed, .Wound #1 Right heel .Pressure .5.7 (Length/L) .6.5 (Width/w) .utd (unable to determine) (Depth/D) .Stage Unstageable .%Eschar 50 .50% maroon .Additional skin issue? a. Yes .Is this a new skin condition? .b. No .Wound #2 .Rt 1st toe .Pressure . (L) 0.9 .(W) 0.8 .(Depth) utd .Unstageable .100% dry exudate .Wound #3 .Lt planter 1st toe Pressure (L) 1.2 . (W) 0.7 .(Depth) 0.1 .Stage III . (This assessment was completed with Wound Nurse 'D' and Physician 'J' (who no longer provides services at the facility.) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/15/21 at 11:34 AM, R54 was observed lying in bed on their back wearing protective boots to both feet which were covered by a blanket. The head of the bed was raised slightly, and the resident's head was leaning slightly to the left. There were no positioning wedges or pillows observed in use. The mattress was observed to be a regular mattress (not a pressure relieving mattress). Continued observations on 6/15/21 at 2:15 PM, 3:29 PM, 5:30 PM and on 6/16 from 8:09 AM to 10:20 AM, R54 remained in the same position at each observation without the use of any positioning devices (wedges or pillows). Additionally, during the observations of R54 on 6/16, no staff were observed to enter the room to attempt to reposition the resident. Although the resident had the protective boots on their feet, there was no repositioning of the feet observed at any of these observations. R54 responded to simple questions but due to significant mumbled speech, was very difficult to understand. On 6/15/21 at 2:17 PM, a phone interview was conducted with R54's family. When asked about the resident's pressure ulcers, family reported concerns that they had last spoken to the wound nurse on Thursday 6/10/21 and was told at that time the facility would have the wound physician see R54 and call back with an update. As of this interview, they had not yet heard back from anyone at the facility regarding R54's wounds. The family reported concerns that although the resident has a history of vascular wounds, they were not aware of any pressure ulcers since admission to the facility in May 2020 until the care conference after readmission in May 2021. On 6/17/21 at 10:29 AM, during an observation of R54's wounds, Wound Nurse 'D' removed a dressing dated 6/16/21 from R54's left foot and lifted R54's left leg up off the mattress. R54 began to breath in deeply and then yell that their leg hurt. R54's left foot appeared to have large flakes of dry skin, a thin, linear opening in the skin, approximately 5 cm (centimeters) in length, was observed in a crease on the bottom of the left foot between the great and second toes. R54's left heel appeared to have bruising to the bottom surface of the heel obscured by dry skin. Wound Nurse 'D removed the dressing from R54's right foot, the dressing was observed to be saturated with serosanguineous (blood mixed with serum) drainage. Wound Nurse 'D' lifted R54's right leg off the mattress, R54 again yelled that their leg hurt. The inside of the foam boot was observed to be stained with serosanguineous drainage where R54's right heel would be when in the boot. An open area on the lateral (outside) part of R54's right heel was approximately 5-6 cm in diameter. It appeared to have a pale base with a large amount of slough (non-viable yellow, tan, gray, green or brown tissue) around the wound and throughout the wound bed. R54's right foot had large flakes of dry skin also observed. R54 was asked if their legs hurt all the time, or only when lifted. R54 explained their legs hurt when touched. Review of the clinical record revealed R54 was hospitalized on [DATE] due to concerns with a heel wound, and readmitted on [DATE] with diagnoses that included: peripheral vascular disease, pressure ulcer of right heel unstageable, aphasia, neuromuscular dysfunction of bladder, other seizures, nontraumatic subdural hemorrhage, and contracture left elbow. Review of R54's medical record revealed the following care plans for skin care: I have actual impaired skin integrity r/t (related to) moisture 2/2 (secondary to) incontinence, decreased activity, chairfast most of the time, decreased mobility, Hemiparesis, PAD (Peripheral Artery Disease) initiated on 4/21/21, revised last on 5/20/21. Interventions included: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Added 4/9/21: Assist me to position body with pillows/support devices, protect bony prominences as I allow. Added 4/9/21: Assist me to turn &/or reposition routinely during CNA (Certified Nursing Assistant) rounds while in bed and frequently redistribute my weight if/when I am up in my chair. Added 4/9/21: Assist/encourage me to elevate my heels off the bed. Added 4/9/21: Inspect skin daily with care - Report any concerns to nurse IE: Discoloration, rashes, reddened areas, open areas. Added 4/21/21, revised 5/20/21: Licensed Nurse skin assessment per protocol. Pressure injury, Poor circulation (vascular) initiated 5/20/21 (upon readmission). Interventions included: Added 5/20/21: revised 5/24/21: Keep skin clean and dry. Use lotion on dry skin. Do not apply on wound. Added 5/20/21: Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD. An incomplete care plan included: (left blank) I have a Pressure Injury, Stage: _____; (left blank) Location: _____. (left blank) This wound was (present on admission / developed in facility). initiated 5/20/21. Interventions included: Added 5/20/21: (left blank) Administer wound and skin treatments as ordered and monitor for effectiveness. Notify physician if wound stalls (no change in 2 weeks) or worsens. Added 5/20/21, revised 5/24/21: Avoid positioning me on my back for more that <sic>2 hours. Review of R54's skin assessments from 4/6/21 to 6/14/21 revealed the following inconsistencies with the types of wounds identified (vascular vs. pressure ulcer), the location and descriptions of the wounds identified, and what treatment interventions were reviewed and/or revised following these assessments. Additionally, review of the physician wound documentation revealed similar inconsistencies as to the types of wounds, lack of identification/evaluation of all wounds during their assessments and changes to interventions. Review of the resident's skin assessments following 4/6/21 included: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/14/21 an eINTERACT Change in Condition Evaluation noted, Skin wound or ulcer .This started on: 4/14/2021 .Afternoon .Right lateral foot .This condition, symptom or sign has occurred before .No . Summarize your observations, evaluations and recommendations (left blank) .Were the change in condition and notifications reported to primary care clinician Yes .4/14/2021 12:00 PM .Recommend resident sees vascular surgeon .Skin prep to bilateral feet. Sheepskin shoes as tolerated .Resident Representative Notification (left blank) . (This assessment was completed by Wound Nurse 'D'). On 4/20/21 a weekly skin sweep noted, .discoloration .open area .Right heel open area and rt great toe and left heel discoloration/redness . On 4/27/21 a weekly skin sweep noted, .Discoloration .Open Area .Right heel .Right Toe (s) .(description left blank) . (There was no identification or further mention of the left foot/toe pressure ulcer as identified on 4/21/21.) On 4/28/21 a wound assessment noted, .Wound #1 .Right heel pressure (measurements and stage left blank) .Wound #2 .Right toe(s) pressure .(measurements and stage left blank) . (There was no identification or further mention of the left foot/toe pressure ulcer as identified on 4/21/21.) On 5/4/21, a weekly skin sweep noted, .Discoloration .Open Area .Rt heel, rt great toe open area and left heel skin discoloration . (There was no description for any of these wounds noted.) On 5/11/21, a weekly skin sweep noted, .Discoloration .Open Area .Rt heel, rt big toe wound .Bilateral dry foot with discoloration and bilateral edema .Buttocks redness . On 5/13/21 an eINTERACT Change in Condition Evaluation noted, .Skin wound or ulcer .This started on: 5/13/2021 .Morning .Sent to (name of local hospital) for heel wound evaluation .Right heel .Left heel .Wound . Resident was sent to (name of local hospital) at about 5:00pm per (name of Physician 'K') for heel wound evaluation . On 5/20/21 a nursing admission/readmission assessment noted, .Skin/Braden Assessment .Right heel Pressure .Right toe(s) Vascular .Left toe(s) Vascular .Coccyx Pressure . On 5/20/21 a physician progress note by Physician 'K' noted, .Readm (readmitted) from (name of local hospital) - was recently admitted there for worsening right heelwound-evaluated by-vascular surgery and podiatry. Also peripheral arterial disease-without requiring any interventions vasc surgery. also seen by podiatry who did not feel there was any need for further debridement of the heel wound .Skin: RT HEEL ULCER .SKIN .old scar to coccyx, dry flaky BLE (bilateral lower extremities) otherwise generally intact -right heel with large wound with necrotic areas .Right heel ulcer/wound-seen by podiatry and vascular, while in the hospital- no immediate interventions continue with current treatment/chemical debridement . On 5/24/21, a weekly skin sweep noted, .Discoloration .Open Area .Right heel Vascular Pressure wound present on admission .Right toe(s) Vascular Pressure wound present on admission .Left toe(s) Vascular Pressure wound present on admission .Coccyx Pressure wound present on admission . On 5/31/21, a weekly skin sweep noted, .Open Area .Right heel .Stage III pressure injury . (There were no other wounds identified and/or documented.) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/4/21, a physician progress note by Physician 'K' noted, .Patient seen for the wound management, he has right heel unstagable <sic> ulcer and left planter DTI (Deep Tissue Injury) He has been getting santyl to the right heel, and dry dressing to the left planter region He has heel protector shoes, and does have low air loss matress <sic>, he does gets turn frequently .SKIN .old scar to coccyx, dry flaky BLE otherwise generally intact -right heel measuring 4.5x3.0 cm, has mild bleeding, central region has slough, surrounding skin has good granulation, Left planter DTI,MEASURING 1X0.5 CM, NO DISCHARGE .Right heel unstageable <sic> ulcer, will use Santyl to the slough region, with 4x4 dressing and kerlix, change daily, continue to use protective boots Left planter has a DTI, keep protective boots on Keep tyrning <sic> patient frequently, while in bed to reduce the pressure to the bony prominence. On 6/7/21, a weekly skin sweep noted, .Rash/excoriation .Resident has a resolving excoriation on coccyx, and also resolving pressure wounds to both heels . On 6/14/21, a weekly skin sweep noted, .Rash/excoriation .Suspected Deep Tissue Injury . (This electronic document prompted the writer to put a site and description which were left blank.) On 6/14/21 a second weekly skin sweep noted, .Rash/excoriation .Suspected Deep Tissue Injury .Right heel unstageable pressure .Lt planter DTI .MASD (moisture-associated skin damage) Buttocks . On 6/16/21 at 2:24 PM, an interview and record review was conducted with Registered Nurse (RN) (Wound Nurse 'D') who also reported they were functioning as the facility's east unit nurse manager, clinical care coordinator and wound nurse. When asked about the R54's wounds and review of the conflicting documentation and what was provided to prevent further breakdown and/or improvement, Wound Nurse 'D' reported there were concerns with the care and treatment provided by Physician 'J' which was why they no longer treating residents at the facility and that Physician 'K' was temporarily covering as they also followed residents at the facility as their attending physician. Upon review of the above documentation for R54, Wound Nurse 'D' confirmed similar concerns with conflicting documentation. When asked what the facility's process was for assessing the residents' skin, Wound Nurse 'D' reported the nurses that worked on the floor were responsible for completing the weekly skin sweep assessments. Wound Nurse 'D' reported the skin assessments were conducted and details of the wounds were reported by Physician 'J' (previously) and Physician 'K' (currently). When queried about the lack of identification of all wounds/skin concerns during these assessments and as reflected from their documentation as well as the conflicting identification of vascular vs pressure ulcer, Wound Nurse 'D' reported they had similar concerns as well but offered no further explanation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	When asked to review the documentation from 4/6/21 which identified there were no skin issues for R54 and what interventions were in place at that time, Wound Nurse 'D' reported R54 had readmitted to the facility the end of March 2021 but had not been identified correctly on the nursing readmission assessment. When asked to clarify why that had not been identified on the assessment then on 4/6/21, or the MDS assessment on 5/25/21, Wound Nurse 'D' offered no further response. When about what interventions were in place to promote healing or prevent further skin breakdown, Wound Nurse 'D' reported the resident wore protective boots and should be repositioned frequently. When asked what they meant by frequently, Wound Nurse 'D' reported less than every two hours. At that time, Wound Nurse 'D' was informed of the observations of lack of repositioning on 6/15 and 6/16. When asked about if even though R54 had protective boots, would that still put additional pressure to the heel areas if not being repositioned frequently, Wound Nurse 'D' confirmed that would which was why staff should be repositioning frequently and utilizing the pillows and wedge cushions. When asked if there was any consideration for a specialty mattress such as a low air loss mattress as identified in the physician progress note on 6/4/21, Wound Nurse 'D' reported they probably should but that the facility's process was only for more serious level pressure ulcers on their backside which R54 had only excoriation and did not offer any explanation as to why the physician noted that as an intervention but not implemented. Wound Nurse 'D' was asked about the delay in identification of R54's skin changes on 4/13 and why the physician and family had not been notified until the next day and they reported they were unable to offer any explanation for that. Wound Nurse 'D' was unable to explain why there were no changes to the care plan interventions since 5/20/21. Wound Nurse 'D' was requested to provide additional documentation in regard to R54's wounds since 4/6/21, what interventions were implemented and/or changed and reported they would follow up. The only additional documentation provided by the Director of Nursing (DON) on 6/16/21 at 5:00 PM was Physician 'J's consultations from 4/19/21 to 5/10/21. A facility policy titled Wound Treatment Management and Documentation (revised 12/20) documented in part, .To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence- based treatments in accordance with current standards of practice and physician orders. The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment .Treatment decision will be based on etiology and characteristics of the wound .The effectiveness of treatments will be monitored through ongoing assessment of the wound. Consideration for needed modifications include: Lack of progression towards healing, Changes in the characteristics of the wound .The following element are documented as part of a complete wound assessment .Type of wound .Stage of wound .Measurements .Description of wound characteristics .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to ensure that a portable oxygen tank was properly secured while left unattended for one resident (R28) reviewed for oxygen. Findings include: On 6/15/21 at 12:00 PM, R28 was observed seated in their wheelchair with oxygen being administered via nasal cannula from an oxygen concentrator machine. At that time, along the wall leading to the bathroom, a freestanding oxygen cylinder was observed stored directly on the floor. R28 was asked about the oxygen cylinder and reported Had that there since yesterday when I visited with my sister. On 6/15/21 at 12:07 PM, Nurse 'M' came into the room and when asked about the oxygen cylinder stated, It should be in a holder. Nurse 'M' proceeded to lift the oxygen cylinder with their hands and carry down to the oxygen storage room without using any storage cart/holder. Review of the clinical record revealed R28 was admitted into the facility on [DATE] with diagnoses that included: heart failure and acute respiratory failure with hypoxia. According to the Minimum Data Set (MDS) assessment dated [DATE], R28 had intact cognition and used oxygen. R28 had a physician's order for Oxygen at 3 L (liters)/min (minute) via Nasal cannula q (every) shift prn (as needed). According to the facility's Oxygen Safety policy dated 1/11/21: .Cylinders will be properly chained or supported in racks or other fastenings (i.e., sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty . Handling Oxygen Cylinders .Protect cylinders from damage by not storing in locations where heavy objects may strike them or fall on them, or where they can be tipped over by foot traffic or door movement .

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	235664	A. Building B. Wing	06/17/2021

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Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review, the facility failed to coordinate dialysis care services for one (R#58) of one resident reviewed for dialysis services, resulting in lack of consistent communication between the dialysis provider and the facility, and the increased potential for miscommunication of an unidentified change of condition and other medical complications. Findings include: On 6/15/21 at approximately 3:20 PM, R#58 was observed seated in a wheelchair with family in the front conference room. The resident was alert and able to answer some questions. The family reported that R58 expressed concerns that staff were not assisting with care on time and indicated the resident went to Dialysis three 3 times per week. Review of the clinical record revealed R#58 was admitted into the facility on [DATE] with diagnoses that included: End Stage Renal Failure and Type II Diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R58 had a Brief Interview for Mental BIMS) score of 13/15 (intact cognition). The record indicated R58 was to receive dialysis treatment on Tuesday, Thursday, and Saturday. On 6/16/21 at approximately 9:52AM, the facility provided R58's Dialysis Binder that contained the communication forms. A review of the contents of the binder revealed multiple missing and/or incomplete communication forms between the facility and the dialysis center. On 6/17/21 at approximately 2:47 PM, an interview was completed with the Director of Nursing (DON) to discuss the facility's process for dialysis communication to ensure coordination of services. The DON indicated that the facility would complete a form prior to the resident leaving the facility and the dialysis center needs to complete their portion so that it can be reviewed and followed when the resident returns. The DON reviewed the binder and indicated that there were several missing forms and forms that had not been fully completed. The DON reported that she would look to see if the forms were somewhere else in the building. On 6/17/21 at approximately 4:00 PM, the DON reported that she was not able to locate any further completed forms. A review of the Facility Policy titled, Care Planning Special Needs-Dialysis (revised 12/20) documented, in part, the following: Policy: This facility will provide the necessary care and treatment, consistent with professional standards of practice .Policy Explanation and Compliance Guidelines .3. Nursing staff will provide a report to the dialysis provider regarding the resident's condition and treatment provisions each dialysis treatment day, and as needed .if no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34275 This citation pertains to Intake #MI00120548. Based on observation, interview and record review, the facility failed to ensure sufficient staffing to meet resident needs for three (R259, R261, and R58) of three residents reviewed for staffing, and five of five residents that attended the confidential Resident Council Interview, resulting in complaints of prolonged response to activated call lights, inadequate care for activities of daily living (ADLs), late administration of medication, and uncontrolled wandering residents. This deficient practice had the potential to affect all residents in the facility. Findings Include: R259 A complaint was filed with the State Agency that alleged the facility was short staffed. The complainant further indicated that R259 contacted the local police to report that they were not receiving their medications. A review of the police report, documented, in part, the following: .Date/Time .5/30/21 at 2228 (10:28 PM) . Information: .While on scene at the listed location for a medical .I was approached by two facility employees (Certified Nursing Assistants (CNA) R and S). They stated that they were concerned that a lead nurse (Nurse T) was not giving patients in the facility their medication on time I spoke with (Nurse T) regarding patients' care to which she stated that she has a lot of rooms and patients to take care of and that she's short staffed He (R259) stated he had gone over 30 hours without receiving his dose of two IV bags. I observed two empty IV bags next to his bed .R259 also received his pain medication approximately 2.5 hours later than he should have received it (I observed as he was given his pain medication shortly after my arrival on scene, approximately 2140 (9:40 PM)). A review of R259's clinical record documented the resident was admitted to the facility on [DATE] with diagnoses that included fusion of the spine (thoracic region), Osteomyelitis, the resident was noted as cognitively intact and required extensive one to two person assist with most Activities of Daily Living (ADL). A review of R259's Medication Administration Record (MAR) indicated that R259 did not receive the following medications as ordered.: Ceftriaxone (antibiotic)Sodium Solution Reconstituted .Use 2 gram intravenously one time a day for infection . Hours 6:00 PM - *It should be noted that the last dose was given to the resident on 5/28/21. Normal Saline Flush .Use 10 ml intravenously in the evening for IV before and after administration. Hours 6:00 PM *It should be noted that the last Saline Flush was administered on 5/28/21. Vancomycin (antibiotic) HCl Solution .Use 1750 mg intravenously one time a day for infection .Hours 5:00 PM. *It should be noted the last Vancomycin was administered on 5/28/21. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no further documentation in the resident's record as to why the medication was not provided. R261 On 6/15/21 at approximately 10:25 AM, R261 was observed lying in bed. The resident was alert and able to answer questions asked. When queried as to care provided by the facility, R261 reported that he was admitted to the facility on [DATE] following an amputation of right lower leg. He indicated that since admission, he often had to wait several hours for assistance and would push a call light, only to have a staff person turn it off and say they would return. R261 stated that several times, no staff would return, and he would be left in a soiled brief. A review of the R261's clinical record indicated that the resident was initially admitted to the facility on [DATE] with diagnoses that included the following: above knee amputation and cirrhosis of liver. A facility Admission Assessment indicated that the resident was cognitively intact and required one to two person assist for most Activities of Daily Living. On 6/17/21 at approximately 1:47 PM the DON reported that R261 had placed a grievance concerning staff and call-light response. R58 On 6/15/21 at approximately 3:20 PM, R#58 was observed seated in a wheelchair with family in the front conference room. The resident was alert and able to answer some questions asked. The family reported that R58 reported to them issues with staff assisting with care on time and often had to wait long periods of time for assistance. On 6/16/21 at approximately 9:30 AM and interview was conducted with the Director of Nursing (DON) pertaining to staffing. The DON reported that approximately 70% of our nursing staff is employed by other Agencies. The DON stated that last week we were supposed to have six (6) Agency nursing staff in the building and three to four of them called in and it was difficult to replace them. The DON reported if we try to discuss the importance of providing necessary care, the Agency staff just leave and do not return. On 6/17/21 at approximately 10:25AM, the Administrator/Abuse Coordinator was interviewed as to the incident on 5/29/21 involving Nurse T who reported the facility was short staffed. The Administrator reported she was aware that R259 had contacted local police about not receiving his medication. When queried as failure to provide the medication, the Administrator reported that she believed the facility was short staffed challenged on that day. When queried about other residents who have reported waiting long periods of time for care, the Administrator further stated that they continue to hire staff, offer incentives, but nothing is working well and indicated that Agency staff had called in this morning (6/17/21) and we had to try to cover the units. 27265 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/16/21 at 10:24 a.m., one resident that participated in the confidential Resident Council Meeting stated, When staff come in to answer my call light, they say 'Who put this light on', like you committed a crime. Another resident complained that Sometimes it takes a 1/2 hour to an hour. I just wanted some water. They have agency staff that come in because they are so low . One resident stated, They're just dragging. They say they don't have no help. It takes too long to go to bed. It took three hours. They (nurses) say they are short of staff. The staff are coming and going all the time. Another resident stated, On the afternoon shift, it depends on who it is. The longest wait I had was a half hour. I feel very strongly about this . The resident further stated, Last night, on the afternoon shift, there were three people, and one left. The other two had to handle the slack . When asked about medication administration times, one resident reported, One day you get it and one day you don't get it at all . When I asked, they said they can't tell me what the other shift do. Residents in the confidential Resident Council Meeting had concerns about wandering residents. One resident stated, We have all seen that happening. We see [Name Redacted] walk by our room with hardly any clothes on. Another resident reported [Name Redacted] came in my room and got in be with my former roommate. [Name Redacted] came in my room three times and sat on my bed. [Name Redacted] just had his brief on and no T-shirt. [Name Redacted] said, 'This is my room, and I can do what I want .' On 6/16/21 at 2:45 p.m., during an interview with the DON, when queried about the concerns from the confidential Resident Council Meeting, the DON reported, We have no medication complaints. Call lights - everybody complains about the call lights. It's not that call lights are not being answered, it's that they don't give the care in a timely manner. They (staff) go in, say they will be right back, and it takes 45 minutes to an hour, and the residents turn the call lights back on again. This is primarily happening on the afternoon shift. The DON further explained that there was no facility staff, it was all agency staff. In regard to the wandering residents, the DON explained Resident, [Name Redacted], we provide activities, watching TV in the conference room, giving snacks, and monitoring. We used to put up a Red Stop Sign, but they takes it down. We don't have the space for wanderers. We are on top of each other . On 6/16/21 at 3:15 p.m., an interview was conducted with the Administrator. At that time, the Administrator stated she did not have any grievances for call lights. However, she did Resident Council a week ago, and residents said they (staff) are slow to answer . The Administrator was asked if there were complaints about residents receiving medication late, and stated, she did not have any grievances. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/16/21 at 3:22 p.m., Activity Director 'X' was interviewed about residents' reported concerns. Activity Director 'X' stated, If residents report dissatisfaction, I report it the Department Heads and also the Administrator is aware and goes to the department about the concern. Activity Director 'X' further reported, Residents have complained about call lights that were slow to answer, and not answered in a timely manner. When queried if residents had reported they received their medications late, Activity Director 'X' stated, I have heard about residents saying medications are late, but never heard that they did not receive their medications. Activity Director 'X' was asked if residents complained about residents that wander in their room, and stated, Yes, but not often. They (residents) would say, 'I seen somebody in my room', but they don't identify who it is. When asked how resident concerns were addressed, Activity Director 'X' explained resident concerns were addressed at every resident council meeting, with the Administration, and in the morning meeting the next following day. 39592

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to provide timely medically related social services which addressed the resident's psychosocial, mood and discharge planning needs for one (R58) of five residents reviewed for social services, resulting in the increased potential for unaddressed physical, mental, and psychosocial needs of the resident. Findings include: Review of the clinical record revealed R58 was admitted into the facility on [DATE] with diagnoses that included: encounter for orthopedic aftercare following surgical amputation, acquired absence of left leg below knee, end state renal disease, type 2 diabetes mellitus with hypoglycemia without coma and with diabetic neuropathy, acute on chronic combined and diastolic heart failure, moderate protein-calorie malnutrition, chronic kidney disease stage 5, dependence on renal dialysis and peripheral vascular disease. According to the admission MDS assessment dated [DATE], R58 had intact cognition, had trouble falling or staying asleep or sleeping too much and felt tired or had little energy for 7-11 days during this assessment period. Further review of R58's clinical record revealed there was no social service evaluation or progress notes since the resident's admission on 5/27/21. On 6/16/21 at 8:40 AM, an interview and record review was conducted with Social Services Manager (SW 'I') who reported they were the only SW for the facility. When queried about the frequency and timeliness of when residents were assessed by social services upon admission into the facility, SW 'I' reported within a few days and that there was usually a care conference in within 72 hours of admission. Upon review of R58's documentation, SW 'I' confirmed that had not occurred for R58 and was unable to offer any further explanation. According to the undated documentation provided by the facility, Assessments/Notes for Social Services: On Admission-Complete the Social Work discharge assessment (by day 3) .Complete the Social Services Admission progress note .

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	235664	A. Building B. Wing	06/17/2021

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27265 Based on interview, and record review, the facility failed to provide evidence of documented monthly pharmacy medication regimen reviews (MRRs), and ensure the physician promptly completed and addressed irregularities which had been identified by the pharmacist in a timely manner for three residents (R2, R6 and R16) out of five residents reviewed for unnecessary medications. This deficient practice resulted in missed monthly reviews with the potential for unnecessary medications and/or medication side effects. Findings Include: R6 A review of the clinical record revealed R6 was admitted into the facility on [DATE] with diagnoses that included in part: Cerebrovascular Accident (Stroke), Traumatic Brain Injury, and Hemiplegia. Further review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R6 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition and required extensive assistance with one-person physical assist for most activities of daily living (ADLs). The MDS further revealed R6 received Anticoagulant and Diuretic medications for 7 days of the assessment. Further review of R6's MRRs for 6/19/20 through 6/12/21 revealed two pharmacy reviews were missing for the months of 10/2020 and 11/2020. It was also noted that recommendations were made on MRRs by the pharmacist for 6/19/20, 8/11/20, and 9/18/20. These recommendations were found to be incomplete and not addressed by the physician at the time of the review. According to the facility Progress Notes and R6's clinical record, there was no documentation that the pharmacy's recommendations were reviewed and addressed. On 6/17/21 at 9:20 a.m., during an interview, when asked about the missing and incomplete MRRs, the Assistant Director of Nursing (ADON) did not have an explanation and stated she would check on it. On 6/17/21 at 9:55 a.m., interview with Director of Nursing (DON) was conducted. The DON stated, Usually there is documentation in the progress notes, I need to start putting in a hard note . I will reach out to the Pharmaceutical Rep. On 6/17/21 at 3:01 p.m., when queried about the facility's process, and follow-up of pharmacy MRRs, the ADON stated, The DON usually forward those (MRRs) to me, and Unit Manager D, depending on what the recommendations are, and we follow through. On 6/17/21 at 3:20 p.m., The DON reported that she had reached out to Pharmaceutical Representative 'P', but they had not called her back . No other documentation pertaining to the resident's MRR recommendations or physician response to the recommendations was provided prior to the exit of the survey. 41415 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235664	A. Building B. Wing	06/17/2021

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2 A review of the clinical record revealed the following: R2 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction, atrial fibrillation, hypertension, and combined systolic and diastolic congestive heart failure and required staff assistance for all activities of daily living. Review of the Pharmacy Progress Note dated 4/26/21 at 10:10 AM revealed, . X Potential Irregularity. See report for any noted irregularities and/or recommendations. Review of the Pharmacy Progress Note dated 6/12/21 at 9:03 AM revealed, . X Potential Irregularity. See report for any noted irregularities and/or recommendations. On 6/16/21 at 10:44 am, the Director of Nursing (DON) was asked where the reports of the monthly medication reviews conducted by the pharmacist be located in the resident charts. The DON stated they kept the recommendations in a binder. When asked to provide R2's 4/26/21 and 6/12/21 reports, the DON stated they would locate them to provide for review. At 1:24 pm, a second request was made to the DON regarding the pharmacist recommendations for R2 on 4/26/21 and 6/12/21. On 6/16/21 at 1:54 PM, a request was made to the Administrator. Shortly after the DON provided the requested reports. A Consultation Report dated 4/26/21 documented in part, . CLINICALLY URGENT RECOMMENDATION: PROMPT RESPONSE REQUESTED . ORIGINAL COMMENT MADE MARCH 31, 2021 and was TIME SENSITIVE (spoke to DON name redacted 3/30/21 4:25 pm) . Hospital discharge order: Apixaban 5mg (milligram) q (every) 12 hrs. (hours), Facility order: Apixaban 5mg once daily . Recommendation: Please consider clarifying these medication orders, communicating with the prescriber and pharmacy as appropriate. Response Requested . The DON signed the form and dated it 4/1/21. The clinical chart was reviewed and revealed no documentation that the physician had been notified of the pharmacist recommendation. A Consultation Report dated 6/12/2021 documented in part, . REPEATED RECOMMENDATION from 4/26/2021: Please respond promptly to assure facility compliance with Federal regulations . CLINICALLY URGENT RECOMMENDATION: PROMPT RESPONSE REQUESTED . ORIGINAL COMMENT MADE MARCH 31, 2021, and was TIME SENSITIVE . WAS THIS ADDRESSED? . The medication reconciliation process revealed the following discrepancies on the admission orders: Hospital discharge order: Apixaban 5mg q12hrs, Facility order Apixaban 5mg once daily . Recommendation: Please consider clarifying these medication orders, communicating with the prescriber and pharmacy as appropriate. Response Requested . The Physician's Response and Signature was left blank, as well as the Director of Nursing's Comments and Signature sections. R2's medications was reviewed and revealed their Apixaban 5mg order remained unchanged and was being administered one time a day as documented by the pharmacist. The clinical record was reviewed and revealed no documentation that the physician had reviewed or responded to the pharmacist recommendation. R#16 A review of the clinical record revealed the following: (continued on next page)

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	235664	A. Building B. Wing	06/17/2021

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16 was admitted into the facility on [DATE] with diagnoses that included: malignant neoplasm of larynx, tracheostomy and seizures and required staff assistance for all activities of daily living. Review of the Pharmacy Progress Notes dated 4/26/21, 5/17/21 and 6/14/21 revealed, . X Potential Irregularity. See report for any noted irregularities and/or recommendations. The clinical chart was reviewed and failed to contain the pharmacist reports for the above dates. On 6/16/21 at 10:44 AM, the Director of Nursing (DON) was asked to provide R16's 4/26/21, 5/17/21 and 6/14/21 pharmacy reports, the DON stated they would locate them to provide for review. At 1:24 pm, a second request was made to the DON regarding the pharmacist recommendations for R16 on the requested dates. At 6/16/21 at 1:54 pm, a request was made to the Administrator. Shortly after the DON provided the requested reports. Review of the Consultation Report dated 4/26/21 revealed, . receives a magnesium supplement but does not have a serum magnesium concentration documented in the medical record in the last 6 months. Recommendation: Please monitor a serum magnesium concentration on the next convenient lab day and every 6 months thereafter . Response Requested . Review of second Consultation Report dated 4/26/21 revealed, . CLINICALLY URGENT RECOMMENDATION: PROMPT RESPONSE REQUESTED . receives Phenytoin 125ml/5ml (milliliters): 8ml (200mg) Q8hrs and the most recent phenytoin concentration was 24 ug/ml on 4/23/2021 above normal range (10-20 ug/ml), Recommendation: Please evaluate and consider a dose reduction and repeat a phenytoin trough concentration 1 week after the dosage change. Rational for Recommendation: Supratherapeutic phenytoin concentrations increase the risk of adverse consequences. If this therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences (e.g., abnormal eye movements, somnolence, confusion, gait changes, vomiting) . Response Requested . On both consultation reports the physician response and signature sections as well as the DON comments and signature sections were all left blank. This indicated that the DON nor the physician had reviewed or responded to the pharmacist recommendation. Review of a Consultation Report dated 5/17/21 revealed, . REPEATED RECOMMENDATION from 4/26/2021: Please respond promptly to assure facility compliance with Federal regulations . CLINICALLY URGENT RECOMMENDATION: PROMPT RESPONSE REQUESTED . receives Phenytoin 125ml/5ml (milliliters): 8ml (200mg) Q8hrs and the most recent phenytoin concentration was 24 ug/ml on 4/23/2021 above normal range (10-20 ug/ml), Recommendation: Please evaluate and consider a dose reduction and repeat a phenytoin trough concentration 1 week after the dosage change. Rational for Recommendation: Supratherapeutic phenytoin concentrations increase the risk of adverse consequences. If this therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences (e.g., abnormal eye movements, somnolence, confusion, gait changes, vomiting) . Response Requested . The consultation report revealed the physician response and signature sections as well as the DON comments and signature sections were all left blank. This indicated that the DON nor the physician had reviewed or responded to the pharmacist recommendation. (continued on next page)

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	235664	A. Building B. Wing	06/17/2021

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R16's medication revealed no changes made the Phenytoin 8 ml order administered three times a day and no repeated labs as recommended by the pharmacist consultant. On 6/17/21 at 9:51 am, the DON was queried regarding the concerns of the physician not reviewing or being informed of the consulting pharmacist recommendations. The DON acknowledged the concerns. A facility policy titled Medication Monitoring dated June 2019 documented in part, . The Consultant Pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly . All findings and recommendations are reported to the attending physician, the Director of Nursing, the Medical Director, and if appropriate, the Administrator . Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's medical record and reported to the attending physician, the Director of Nursing, the Medical Director . The Consultant Pharmacist's recommendations are acted on by the prescriber and/or the facility's nursing staff .

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	235664	A. Building B. Wing	06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Beverly Hills	18200 W 13 Mile Road Beverly Hills, MI 48025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to follow it's policy and ensure medications and supplies were appropriately labeled and/or stored in one of two medication carts resulting in: [1] discharged resident's medications left in the medication cart; [2] undated insulins and glucometer test strips. Findings include: On 6/17/21 at 1:36 PM, a review of a medication cart was performed with Licensed Practical Nurse (LPN) E. Upon reviewing the medication cart a Lispro Kwik Pen, was found and was dated as opened on 5/16/21. LPN E was asked how long insulin was allowed to be used after opening. LPN E explained insulin was only good for 28 days, and the Lispro Kwik Pen was four days past expiration. Two different types of glucometer test strip containers were observed to be opened and undated were also observed inside of the medication cart. In the upper left drawer, approximately six loose pills were observed in the bottom of the drawer. In the middle left drawer, a large number of loose pills, of all shapes, sizes and colors were observed along the back of the drawer. LPN E was asked about the large number of loose pills in the medication cart. LPN E explained she was a pool nurse from a different facility, this was the first time she had worked at this facility, and that her cart at her facility would never look like this cart. Review of the resident whose Kwik Pen insulin was expired, revealed the resident was discharged on [DATE]. Review of a facility policy titled, Medication Storage in The Facility dated June 2019 read in part, .Outdated, contaminated, or deteriorated medications and those in container that are cracked, soiled, or without secure closures are immediately removed from the medication supply, disposed of according to procedures for medication disposal and reordered . All expired medications will be removed from the active supply .

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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** 27265 Based on observation, interview, and record review, the facility failed to provide sanitary conditions in the kitchen, resulting in the increased potential for foodborne illnesses. This deficient practice had the potential to affect all residents in the facility that received food from the kitchen. Findings Include: On [DATE] at 9:51 a.m., during the initial tour of the kitchen with Dietary Manager (DM) 'Q' , the following items were observed: Reach-In Refrigerator in Kitchen 1 Bottle of Ranch Dressing labeled [DATE] - [DATE]. 1 Large Container of Tuna labeled [DATE] - [DATE]. 1 Large Container of Tuna labeled [DATE] - [DATE]. 1 Small Cup Deli Meat (appeared to be a side of ground meat) not labeled. When asked who was responsible for labeling and discarding food with an expiration date in the refrigerator, DM stated, All of us. Everybody that put anything away, myself included. I try to go through it every morning to make sure everything is dated . When queried why there was still food with expired used by dates in the refrigerator, DM 'Q' stated, I don't recall seeing that. On [DATE] at 10:15 a.m., the following items were observed: Walk-In Refrigerator 1 Larger Container of Multiple Topping dated ,d+[DATE]-21 - [DATE] 1 Large Jar of Cherries opened and undated. On [DATE] at 10:25 a.m., the following items were observed: Freezer 1 Large Bag of Crinkle Fries that were opened, half used, and undated. 1 Bag of Snap Peas opened, half used, and undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 1:55 p.m., during an interview, when asked about storage, labeling, and dating of food in the facility's kitchen, the Administrator stated, The Dietary Managers and the kitchen staff should be monitoring any items that are opened. They should be immediately dated. They should be monitoring the expiration dates and discard as needed daily. Nothing should be in there unlabeled or undated. At that time, a policy pertaining to kitchen sanitation was requested. On [DATE] at 4:15 p.m., a policy was provided, however, the policy did not address storage, labeling and dating of food in the facility's kitchen. According to the 2013 FDA Food Code Section ,d+[DATE].17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, intervention and record review, the facility failed to implement effective infection control practices for two (R24 and R31). This deficient practice had the potential to affect all residents at the facility. Findings include: R24 On 6/15/21 at 12:14 PM, R24 was observed dressed and lying in bed. R24's room had signs and an isolation cart outside of the room announcing droplet/contact precautions. R24 was asked if staff always wore personal protective equipment (PPE) when they were in the room. R24 explained not all the staff wore PPE all the time, some did, and some did not. Review of the clinical record revealed R24 was admitted into the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary disease, heart failure and hypertension. According to the Minimum Data Set (MDS) assessment dated [DATE], R24 scored 15 on the Brief Interview for Mental Status (BIMS) exam, indicating intact cognition. The MDS assessment also indicated R24 required the extensive to total assistance of staff for all activities of daily living and was incontinent of bowel and bladder. Further review of R24's medical record revealed an active physician order for contact isolation for C. diff (Clostridium difficile - a contagious infection of the large intestine caused by bacteria) was noted. On 6/16/21 at 8:37 AM, during an observation, Licensed Practical Nurse (LPN) H was observed preparing multiple medications, oral and injectable, and then to walk into room R24's room directly past two signs on the door: one in large font that read, PLEASE SEE NURSE BEFORE ENTERING; and one that read, COVID-19 Personal Protective Equipment (PPE) for Healthcare Personnel and described in words and pictures what PPE was required. On the wall, next to the doorway in the hall was an orange sign that read, ENHANCED DROPLET-CONTACT PRECAUTIONS and described in words and pictures what was required to enter room. Under the orange sign in the hall was a three drawer isolation cart with disposable gowns and gloves in the drawers. LPN H was observed standing at the far side of the room next to R24. LPN H was asked if the room was an isolation room. LPN H stated, No, then walked to the door, was observed to read the signs on the door, walk out of the room, look at the orange sign on the wall and the isolation cart, then explained she would have to check to see if the room was an isolation room. LPN H walked across the hall to the medication cart, place the medications on the cart and looked at the computer. No hand hygiene was observed. LPN H then asked the assigned Certified Nursing Assistant (CNA) if R24 was in isolation. The CNA was heard to tell LPN H that R24 was in isolation for C. diff. LPN H then explained R24 was in isolation and PPE was required to enter the room. LPN H was asked if she had been given report that R24 was in isolation. LPN H stated, No. On 6/17/21 at 9:15 AM, the Assistant Director of Nursing (ADON) B, who served as the facility's Infection Control nurse, was interviewed and asked about PPE use for R24's room. ADON B explained a gown and gloves were required for any patient care, and a face shield could be worn if staff felt they needed it. When asked if giving medications required PPE use, ADON B explained a gown and gloves were required for a medication pass. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/17/21 at 10:08 AM, LPN G was observed about to enter R24's room when the assigned CNA stopped LPN G and explained R24 was in isolation. LPN G was asked if she had been given report that R24 was in isolation. LPN G explained she had not been given report when she started her shift. On 6/17/21 at approximately 10:15 AM, the Director of Nursing (DON) was interviewed and asked if staff should receive report if a resident was in isolation, and what room they were in. The DON explained both LPN H and LPN G were agency nurses and had not worked there before, but agreed it was important information to be passes along in report. 30675 On 6/17/21 10:51 AM, Housekeeper 'M' was observed inside of R24's room cleaning the surfaces directly near R24 wearing only a surgical mask and disposable gloves. Upon Housekeeper 'M's exit to their cart in the hallway, they were queried about whether or not they were aware room [ROOM NUMBER] was on contact isolation precautions. Housekeeper 'M' responded, I didn't know. When asked if they saw the signage posted on the wall near the doorframe and the door, they stated No. When asked what should be worn in rooms that are on contact isolation precautions, Housekeeper 'M' stated, Gown, goggles, hairnet, double gloves. When asked if that was what they were trained on, they stated Yes. At that time, the Assistant Director of Nursing (ADON)/Infection Control Nurse came down the hallway and was informed of the observation. On 6/17/21 at 10:55 AM, an interview was conducted with the facility's housekeeping District Manager (Staff 'O') to inform of the observations and interview with Housekeeper 'M'. At that time, Staff 'O' was requested to provide any documentation of education for infection control practices for Housekeeper 'M'. On 6/17/21 at 11:19 AM, Staff 'O' provided documentation of education for infection control for Housekeeper 'M' on 3/10/21, 3/31/21, 4/8/21, and 5/24/21 and reported, It's disappointing cause she was recently in-serviced on c-diff precautions and will need more education. Review of a facility policy titled, Management of C. Difficile Infection reviewed 12/2020 read in part, .All staff are to wear gloves and a gown while providing care for the resident with C. difficile infection or having direct contact with items in their environment .Maintain contact precautions for the duration of illness . Housekeeping staff shall adhere to stand and contact precautions . 27265 R31 A review of the clinical record revealed R31 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included in part: Neurogenic Bladder, Multiple Sclerosis, and Renal Insufficiency. Further review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed R31 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated intact cognition and extensive assistance with one-person physical assist for most activities of daily living. The MDS revealed R31 had urinary incontinence and an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/15/21 at 11:54 a.m., R31 was observed in bed with a catheter bag that was lying flat on the floor. When asked who provided care for their catheter bag, R31 stated, The aides (Certified Nursing Assistants - CNAs) empty my bag. When asked how often the CNAs emptied their catheter bag, R31 stated, It should be three times a day . When asked if any staff (nurse/CNA) had been in their room to provide care for them on that morning shift, R31 stated, The nurse came in to bring me my medication. On 6/15/21 at 3:35 p.m., R31's door was observed closed; when entered, R31's catheter bag was observed still lying flat on the floor. On 6/16/21 at 8:30 a.m., R31 was observed in bed eating breakfast. At that time, R31's catheter bag was observed hanging on the side of the bed. When asked about care of the catheter bag, R31 stated, Yeah, somebody hung it up last night. On 6/16/21 at 8:55 a.m., during an interview with Registered Nurse (RN) 'Y', when asked who was responsible provided care for R31's catheter, RN 'Y' stated, For patient care, the aides are, but nurses are in charge for proper drainage and insertion, and overall patient care. RN 'Y' further stated, The aides are responsible for making sure that the bag is in the right position, but the nurses are in charge and responsible for everything (to be sure that it's right). RN 'Y' explained that at 2:00 p.m., the bags are usually emptied before the end of the shift . On 6/16/21 at 9:35 a.m., during an interview, when queried who was responsible for the proper position of T31's catheter bag, CNA 'Z' pointed at their self. When asked where the catheter bag should be positioned, CNA 'Z' stated, Lower than the resident. Never on the floor. On 6/16/21 at 2:00 p.m., an interview was conducted with the Director of Nursing (DON). When asked about positioning of the catheter bag, the DON stated, It's supposed to be hanging at the end of their bed, and the CNA and whoever see it is responsible. A review of facility's policy did not address positioning of the catheter bag.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure residents were offered and received the pneumococcal immunization series recommended by the Centers for Disease Control and Prevention (CDC) for three (R2, R26, and R54), of 5 reviewed for immunizations, resulting in residents not receiving pneumococcal immunizations per CDC guidelines, the potential for incomplete vaccination, and the potential for serious illness and complications from pneumococcal disease. A facility policy titled, Pneumococcal Vaccine (Series) dated 12/2020 documented, It is our policy to offer our residents immunization against pneumococcal disease in accordance with current CDC (Centers for Disease Control) guidelines and recommendations .Each resident will be assessed for pneumococcal immunization upon admission .Any additional efforts to obtain information may be documented, including efforts to determine date of immunization of type of vaccine received .Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization .A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record .The type of pneumococcal vaccine (PCV13, PPSV23/PPSV) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations .The resident's medical record shall include documentation that indicates at a minimum, the following: a. The resident's representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization. b. The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal . On 6/17/21 at 11:45 AM, an interview was conducted with the facility's Infection Control Preventionist (ICP), education, consents, and proof of administration of influenza and pneumococcal vaccinations were requested for five residents including R2, R26, and R54. Review of the medical record and information provided by the ICP revealed the following: Resident #2: There were no pneumococcal consent, declination, or education forms available for review in their clinical record. According to the documentation available under R2's immunization tab of the electronic medical record (EMR), Prevnar 13 Not Eligible. There was no clinical documentation to support the reason for ineligibility, as well as if a dose of PPSV23 was considered. There was no further documentation provided by the end of the survey. Resident #26: There were no pneumococcal consent, declination, or education forms available for review in their clinical record. According to the documentation available under R26's immunization tab of the EMR, Prevnar 13 - Not eligible. There was no clinical documentation to support the reason for ineligibility, as well as if a dose of PPSV23 was considered. There was no further documentation provided by the end of the survey. Resident #54: There were no pneumococcal consent, declination, or education forms available for review in their clinical record. According to the documentation available under R54's immunization tab of the EMR, pneumovax dose 1 - consent refused. There was no date this consent was refused nor there were no pneumococcal consent/declination forms or education available for review in the clinical record. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/21 at 12:05 PM, the Director of Nursing (DON) was requested to provide additional documentation for pneumococcal immunization for R2, R26 and R54 since the ICP was working as a nurse on the floor. On 6/17/21 at 1:22 PM, the ICP reported they were still looking for additional documentation and would continue to search. They were informed that documentation would be accepted for review until the end of the survey. On 6/17/21 at 2:50 PM, the ICP provided only one declination form for another resident and reported they were currently trying to access an electronic record system to find the data. There was no further documentation provided for R2, R26 and R54 provided by the end of the survey. According to the Centers for Disease Control (CDC), Recommendations for PCV13 Pneumococcal Conjugate Vaccine, Recommendations for Adults with no Previous Pneumococcal Vaccinations, The Advisory Committee on Immunization Practices (ACIP) recommends that all adults [AGE] years of age or older receive a dose of PCV13 followed by a dose of PPSV23 at least 1 year later. Recommendations for Adults with Previous Pneumococcal Polysaccharide Vaccinations (PPSV23) Adults [AGE] years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose. (http://www.cdc.gov/vaccines/vpd-vac/pneumo/vac-PCV13-adults.htm). According to the CDC Morbidity and Mortality Weekly Report Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged [AGE] years: Recommendations of the Advisory Committee on Immunization Practices (ACIP), Pneumococcal vaccine-naive persons. Adults aged [AGE] years who have not previously received pneumococcal vaccine or whose previous vaccination history is unknown should receive a dose of PCV13 first, followed by a dose of PPSV23.(http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22960 Based on observation and interview, the facility failed to maintain a safe, clean, and comfortable environment which affected multiple residents throughout the facility, resulting in an unkempt physical environment and the potential for injury. Findings include: On 6/16/21 between 1:30 pm-2:30 pm, during an observation of the facility with Maintenance Staff V, the following items were observed: room [ROOM NUMBER]: In the bathroom, there was a toilet riser with multiple areas of rust on the frame, and the surface was no longer smooth and easily cleanable. When queried, Maintenance Staff V stated, We'll have to replace that. room [ROOM NUMBER]: There were numerous broken, missing panels on the window blinds, leaving large gaps with no privacy afforded to the resident from outside. When queried, Maintenance Staff stated, I'll get those replaced. In addition, there was no emergency pull string attached to the call light box in the bathroom. There was no functional, interior lighting inside the E hall shower room. when queried, Maintenance Staff V stated, This light has to be replaced. room [ROOM NUMBER]: The wall mounted light fixture, located directly above bed 2 was observed to be detached from the wall on the right side, and dangling down from the left side bracket. Maintenance Staff V stated, Can you excuse me? I need to fix that right now. In addition, in the bathroom, the sink basin was pulled away from the Formica counter, leaving a large gap with exposed sharp particle board. room [ROOM NUMBER]: The privacy curtain for bed 1 was observed to be soiled with a red, brown, and black substance. On 6/16/21 at 2:00 pm, Housekeeping Manager W was queried about the cleaning schedule for the privacy curtains and stated, We take them down every 2 weeks to be washed. That one needs to be changed. At the end of the isolation hall, there was a floor vent cover with sharp edges that were bent upwards, instead of lying flush to the floor. In the laundry room, there was a large floor fan, with dust and lint coated on the fan blades and outer caging. The soiled fan was blowing air into the clean side of the of the laundry room. When queried about the cleaning schedule for the fan, Housekeeping Manager W stated, Maintenance is supposed to clean that. 30675 (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/15/21 at 11:31 AM, room [ROOM NUMBER]-B had a tube feeding pole that was observed to be soiled with what appeared to be dried, tan colored tube feeding formula on the base of the tube feeding pole, the laminated card secured to the tube feeding machine and the screen of the tube feeding machine. The light above the bed appears to be leaning higher on the left side as if broken. The privacy curtain was also soiled with dark colored stains. The resident was lying in the bed but did not respond to verbal communication.